

Meaningful Use Workgroup
Draft Transcript
July 27, 2012

Presentation

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you, good afternoon, everyone, this is MacKenzie Robertson in the Office of 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 is 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, VP & CMIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. Michael Barr? David Bates?

David Bates – Brigham and Women's Hospital

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Christine. Neil Calman? Tim Cromwell? Art Davidson?

Art Davidson – Denver Public Health Department

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Art. Marty Fattig?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marty. Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Leslie. Yale Harris? David Lansky? Deven McGraw? Greg Pace?

Greg Pace – Social Security Administration – Deputy CIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Greg. Latanya Sweeney? Robert Tagalicod? Charlene Underwood?

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. And Amy Zimmerman?

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Amy. Is there any staff on the line?

Emma Potter – Office of the National Coordinator

Emma Potter, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Emma. Okay, Paul, I'll turn it to you.

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

Great, thanks, MacKenzie. So, sorry we've got some policies that we got started a little bit later, cause we've got some organizational, um, um, logistics out of the way. This is our final call before presenting to the entire Policy Committee, the first, the, the draft of the preliminary recommendations for Meaningful Use Stage 3 and this is one of many discussions we'll have on the way to our final recommendations, which won't be until May of 2013.

This is preparatory to us making re-revisions based on the Policy Committee's feedback before coming up with essentially our final recommendations in October for recommendations just for the re—request for comments, but we are trying to get this as right as possible, as close as possible as precise as possible, so that we've produced something that can, can get meaningful feedback. Something vague gets a lot of feedback that doesn't narrow in on the point.

So one our, we're taking a look, now we've gone through each of the categories looking at the full repertoire we have for Stage 3 and trying to move the ball without kicking people off the escalator. So we're looking for a parsimonious set of additional, um, requirements, and, and changes to the exist—the Stage 2 requirements that would move the ball forward at a pace that, ah, that the broad community can keep up with. Ah, so for each category, we're looking for an update on the new objectives or the significantly changed objectives from Stage 2 recommendations or significant, you know, significantly high, let's say over 65% change in the threshold.

And, we've use, um, in theory, we've use the, the five criteria that we set up prospectively to say we really like to achieve as high as possible of each one of those criteria, of course the new care model, which addresses national health priorities, broad applicability and in types of practices and rural urban. It wouldn't already narrowly be market driven and where there's mature adopted standards. And by the way we all know that we've gotten some input from the Standards Committee, it's a very ... quick turnaround kind of input, but some of the questions are easily answered, in other words, while there isn't any standards at all in this space and that should, that should, um, color opinion whether this is ready for 2016.

So, we'll, let's, any questions on that and then we'll just go category by category?

Okay, so why don't we start with category one and David Bates will lead us through the new discussion there?

David Bates – Brigham and Women's Hospital

Great, so let's start with, with 130, which is, ah, new for Stage 3 and this is to use—

W

Can you speak up?

David Bates – Brigham and Women's Hospital

Sure. This is 130, which is new for Stage 3, and in this what we're proposing is, is to use computer order entry for referrals, ah, or and transitions of care, ah, which, which are entered by any, ah, licensed, ah, professional who's going to enter who's going to enter orders. And the measure is, ah, more than 20% of these quarters, orders, ah, or transition of care orders being to be included.

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

Okay, how would you get the denominator ... question of if it's on paper ...?

David Bates – Brigham and Women's Hospital

Sure, well, I mean that would be a challenge how do we get the denominator for any of these, any of these things. I mean I think it would be in the same way that someone would have to do some spot checking.

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

Okay.

David Bates – Brigham and Women's Hospital

The, the point is that we, we would like the measures to, that, that these things are, are done through, through orders. We'd like to send a signal to the industry that they, um, should be done this way.

Charlene, do you want to say any more?

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

Yes, again, Paul, this was on some testimony that we had in terms of looking, establishing, um, the fact that there is a transition of care regardless if it's a referral and/or a transition. This gave us the capability via an order to start to set that denominator, and that request actually came from the vendor community, so we start to gauge through that kind of order, um, the fact that one exists, and then we can start to use that as our denominator.

The other feedback from the testimony was these, the standards for these transitions, these referral orders, um, exist and can encompass transitions of care, um, and, um, could be deployed in this timeframe.

M

Okay.

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

But it's probably fairly understood about referrals, um, transition of care, let's say, going to home, might, ah, might be, ah, a new kind of a thing in the work flow, but anyway—

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

We know—

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

—you all know that this is an important concept.

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

Yes.

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

So questions or comments? Okay, I'll take that as a let's go forward with this.

David Bates – Brigham and Women's Hospital

And I'm going skip by a number and if anybody see something that they want to talk about, um—

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

Are we, this is just Amy, it's a process question, are we using the spreadsheet or the slides?

David Bates – Brigham and Women's Hospital

I'm finding it easiest to use the slides, but I guess I'm okay either way. I can just tell where I am in the spreadsheet better.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

Yes, I'm using spreadsheet, okay thank you.

David Bates – Brigham and Women's Hospital

Um, okay, so the next one that I would like talk about is, is, is 113 and it's hard for me to tell whether this is different enough to, to meet Paul's criterion, but I think it's important, so I wanted to just review it with the group. So this is about clinical decision support and what we've said here is that, that, um, that, ah, it's used, by using, ah, clinical decision support on high priority health conditions that the measure would be to implement 15 clinical decision support interventions related to five or more clinical measures, if applicable, at a relevant point in patient care for the, for the entire reporting period.

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

Okay, this is a, a, an increase from 5 to 15.

David Bates – Brigham and Women's Hospital

Correct.

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

And still correlated with at least five quality measures.

David Bates – Brigham and Women's Hospital

Right, and, and the rational for this is you need, you need a number of measures to, to get benefit. Clearly there's going to be variability by type of provider as to, as to exactly which ones you need, and, and, ah, we tried to come up with language that would, would meet, that would be applicable for a variety of provider types.

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

And you did have, um, you gave the choice of 15, but 1 of the 15 you had mandatory for renal dosing, right?

David Bates – Brigham and Women's Hospital

Correct, right.

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

Other comments or clarifications on this?

Art Davidson – Denver Public Health Department

So would, this is Art, David, would a clinical decision support around immunizations be valid here?

David Bates – Brigham and Women’s Hospital

I think it would. I mean I don’t want to get into double counting and you might have another immunizations one.

Art Davidson – Denver Public Health Department

Well, no, I would think that maybe we could move it into this group if someone would, would take advantage of that.

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

That’s a good point, so if we had duplicatively in the population of public health that you got to do an immunization clinical decision for it. Well, ...

Art Davidson – Denver Public Health Department

Right.

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

And so maybe the only other question is do you think we need, or is it just to, um, ... to categorize this, there’s some on management of diseases and there’s some on, ah, conditions and some on preventive services.

David Bates – Brigham and Women’s Hospital

Well, there are some providers who deliver very little in the way of preventive services, so we’re just trying to be—.

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

Okay, you thought about it and that’s how you came at it.

David Bates – Brigham and Women’s Hospital

Yeah, exactly.

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

And I think the Standards comment, yeah, there’s no current standard for decision support. They’re all done individually, but, I, ah, you know, we know already know that these can happen and I don’t know that we want to wait for standards to have them interrupt exchange.

David Bates – Brigham and Women’s Hospital

Exactly.

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

Everybody fine with moving this forward?

W

The other one that David captured on there was the ability to capture the response, you know, the feedback loop.

David Bates – Brigham and Women’s Hospital

And that, that is very important, too.

W

So in Stage 3.

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

Actually, George, so as we present, so for these kinds of things as an, ah, you know for example, 15 is highlighted here, which is really good, we might want to highlight some of the, um, things that are new, the requirements like to find what, how the provider responded, so our renal dosing. So we'll just make it easier to for the committee to see what we've added.

Art Davidson – Denver Public Health Department

Okay, I don't, we have to be careful not to highlight things that are really low impact for the provider. In other words, I don't want people to get scared—

W

Right.

Art Davidson – Denver Public Health Department

And say, oh, I don't want them to do all this extra work. There's no extra work. It's just an EHR requirement.

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

That's correct, and we, we should, ah, we'll try to point that out as we present it, but we want people to, essentially no track changes.

David Bates – Brigham and Women's Hospital

Yeah, this, this did somehow get dropped.

W

Um hmm.

Jacob Reider – Office of the National Coordinator

This is Jacob. Paul, I think that would be important to capture and then pass on of course to the Standards Committee—

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

Right.

Jacob Reider – Office of the National Coordinator

—as an expectation of the system. David, I would, I would ask is, is there thought or was there con— discussion of other kinds of decision support that, that, as folks noticed in our NPRM for Stage 2, we talked about different types, specifically referential, um, and, and are there, was there conversation about consumer facing decision support that, that might also be relevant for Stage 3?

David Bates – Brigham and Women's Hospital

Ah, we did talk about that and, and, ah, we thought that it was being captured elsewhere.

W

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, this is Leslie and I, I don't think it is being captured elsewhere that, ah, the, the a, actual SNI committee or framework that's working on clinical decision support has also bundled consumer decision support or shared decision making in that group.

Christine Bechtel – National Partnership for Women & Families

Yeah, yeah, it's Christine, I confirm that. We, we did a referral to subgroup one pretty early on in the process, so maybe it just didn't make it you on that, David.

David Bates – Brigham and Women’s Hospital

Okay, I think we tried to refer it back and got the, got the word that you were working on it.

Christine Bechtel – National Partnership for Women & Families

No.

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

I think they’re, they’re actually very different functionalities.

David Bates – Brigham and Women’s Hospital

They are.

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

Yeah.

David Bates – Brigham and Women’s Hospital

I’d feel more comfortable having them in two different places personally. I mean I think they’re both worthwhile and important.

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

And I want to be careful not to conflate consumer, because I get asked two questions. There was the consumer piece, but also the referential piece that, you know, is sort of is not exactly the same as the more sort of action oriented alerts reminders, but it could be.

David Bates – Brigham and Women’s Hospital

Yeah, as a matter of fact, we, we talked about that as well and I, and I thought that that was covered elsewhere, too.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So ... there was a discussion about, this is Leslie, so for instance if you took the model, the current referral model, it might be that an advanced directive could be an example of a shared decision making instrument, but if you took it to much more a collaborative care kind of structure in the future that wasn’t based upon an order, that might be something differently, but the, in the testimony, ah, that we heard, um, in patient generating data, we did talk about potentially the first place where there’s shared decision making could be an advanced directive, so—

Christine Bechtel – National Partnership for Women & Families

So it’s Christine, not to complicate matters, the referral we made had its roots in patient decision made for preference sensitive care, but the way that the subgroup thought about approaching it was to put it under the CDS category, um, by creating alerts for providers, um, for high value preference sensitive conditions and like a small number of those and, and use the list that the Foundation for Informed Medical Decision Making have. And then if that was in part one, then, um, I, then our subgroup could add a measure of capturing patient preferences for those decisions.

David Bates – Brigham and Women’s Hospital

We, we actually do have a statement in, in this once about the—which I did not highlight, about the ability to capture preferences and deliver recommendations to, to patients.

Christine Bechtel – National Partnership for Women & Families

Yep, that was the referral.

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

So even, so Paul remember when we, this is Charlene, we talked about perhaps at a minimum making it a certification requirement way back at the beginning, so that was another way to start to, it’s another type of clinical decision support that we wanted people to start to think about.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And this is Leslie, and, and Christine is right. We talked about how do we identify preference sensitive care as the first step of making a criteria around identifying that and then, and then, um, allowing for, ah, patient, patient and shared decision making is maybe the next step.

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

So that's a good, so it turns out that, um, ONC has already made use of having certification criteria that serves things that are not yet addressed in meaningful use, you know, what providers have to do. So maybe these three that are labeled ability are, are those that we'll keep in there the ability of the EHR i.e. certification requirements, so that the EHR can do these three things, even though we're not necessarily supposed to be measuring it in this stage, but probably anticipate measuring it in future stages.

David Bates – Brigham and Women's Hospital

Correct.

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

Is that how you meant that?

David Bates – Brigham and Women's Hospital

Yes.

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

Okay. Okay, well that's, so that's another form of signals.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah, this is Leslie, then if it's ability, I think we should add something around preference sensitive care identification.

David Bates – Brigham and Women's Hospital

Well, it says the ability to capture preferences and, and I mean we could reword that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah, the preference I think that says what is the patient preference. So the preference of ... care is, hey, this is something that could, ah, provide decisioning to a patient, 'cause we know it's preference of care based on the foundation's recommendation.

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

It's probably included under this, this thing, but as David mentioned, it probably could be, um, worded a little differently.

David Bates – Brigham and Women's Hospital

Yeah.

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

Okay, it sounds like we're in pretty agreement here and we'll just, um, ah, highlight the new, ..., new kind of features we have and also distinguish what, what the certification requirement versus a use requirement fits at this stage.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And then in our signaling put that we would expect ... this is Leslie, sorry, that that would include the patient.

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

Yes, we could do that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay.

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

Okay, next David.

David Bates – Brigham and Women’s Hospital

Okay, I’m just having trouble with the spreadsheet here, okay, I’m hoping I don’t miss—

W

... and then we’ll find it.

David Bates – Brigham and Women’s Hospital

Right, um, I think the, the next one is, is 120 I, I think, which—

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

There is one, 114 it does, ah, meet the criteria of over 65%, and I noticed there’s a note from Michelle, I think, so this is moving from clin lab from 55% to 80% is your proposal.

David Bates – Brigham and Women’s Hospital

Correct, yeah.

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

And Michelle said, and I don’t know where the data comes from, among all office-based physicians in 2011, 67% have capability to view lab results electronically. And the question is would, can we can get to 80, um, by 2016?

David Bates – Brigham and Women’s Hospital

We thought that would be plausible, but I’d be interested to hear people’s feedback.

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

Others?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Yeah, this is Marty. I, I think that’s doable by, you know, by Stage 3.

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

But here’s another piece from Michelle, so the first statistic I quoted you was from all office-based physicians, so office state physicians within EHR in 2011, um, she said, ah, 87 have computer ability to view electronically and 73 have the capability to incorporate these lab results also into an EHR to 73, so that, that sounds you might be in within reach.

Any problems with moving forward with the 80%? ... okay.

And you were saying 130 did you say?

David Bates – Brigham and Women’s Hospital

Ah—

W

What’s the name, the reference name?

David Bates – Brigham and Women’s Hospital

I think it is 1120, ah, which is, which is, ah, which is to record electronic notes in, in patient records for, for more than some percentage of offices within four calendar days. Now there’s some, it says here acts and I would use some percent like 30%.

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

Okay.

Emma Potter – Office of the National Coordinator

This is Emma. I believe that we just didn’t know what percentage ... searching for, so we just thought ... give us that now.

David Bates – Brigham and Women’s Hospital

Sure, how about filling it in, filing in a 30.

Emma Potter – Office of the National Coordinator

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And this does not mention the hospitals, this is Leslie. This is only assumed ambulatory, is that correct?

David Bates – Brigham and Women’s Hospital

Yeah, so this is, this is, ah, just for ambulatory, just for eligible providers. Charlene, did, that’s, that’s what we discussed, is it not?

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

And then the other one we talked about was at a minimum, we really wanted to raise the bar on the discharge summary, maybe not all notes, but at least the discharge summary to see if we could, and I don’t know if we captured that elsewhere—

David Bates – Brigham and Women’s Hospital

Yeah, that’s coming up.

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

Okay, all right, if you’ve got it, that’s fine, okay.

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

Okay, so this looks like it’s pretty much our formal recommendation. It does add a timeline, which is reasonable. Any problem with moving this forward?

Okay.

David Bates – Brigham and Women’s Hospital

Okay, next one is 122, which is the, which is, um, you know, here is that a, a request for timely transition document that’s available electronically. We need to include there some specificity around timelines. This one we just added. I think I would say, again within four calendar days unless we think we could do it sooner.

Charlene, what—

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

Yeah, and, and this was kind of calling the question by Stage 3 especially because, um, to make transitions to some of these sites, they need it like immediately, do we—

David Bates – Brigham and Women’s Hospital

We could even say within 24 hours or you know that—

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

It’s at transition—

David Bates – Brigham and Women’s Hospital

Yeah.

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

So we’re starting to actually try to make it real time by Stage 3 and that would imply at a minimum if it contains some of the, you know, discharge summary information that would be available then, so then it really starts to raise the bar up making that transition information available when the transition occurs. That’s what we were trying to get to happen in Stage 3.

M

Charlene or David, what is it, what kind of document?

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

Well—

M

Or is it ... document?

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

Well, we were thinking of hospital electronic notes, we kind of backed off and said at a minimum if we could get, you know, if you look at the transition, it’s a transition of care document, but you need the discharge summary to do the transition of care document to get that embedded, so that that was available. That was around the discussion we had.

Christine Bechtel – National Partnership for Women & Families

So Charlene, it’s Christine. Is the summary of care document from Stage 2 does include, I believe, I can double check, discharge instructions. So is this really just a timely summary of care document?

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

Well, it’s actually both because you’re required to do the discharge summary in addition, so remember how we deferred on the dis—it was in Stage 1 and then it got, I think it got dropped out of Stage 2, I forget what—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie. I think that’s because all the components of the, of the discharge summary are included in the summary of care document and ... it then it little bit more and then we wanted to make sure that this was available at transition and then also understood that if it wasn’t incomplete, that further information as it was available would be com—apparent, so not wait for something. Send as much information as available at transition.

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

Right, so that was what I think across the groups we were trying to work toward and my, again, I, again, this is what the requirement is and one of the elements of that is some narrative around the discharge summary, the course of care and capturing that; and I know that that’s often done after the fact now, but it’s required up front in many cases, and we were trying to move to the point where that would be, um, made available in a more timely manner.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Yeah, this is Marty. My understanding of that was that when, when we transfer a patient, we have to provide, you know, paperwork to send along with that transfer and my, my thought was that that would be electronic instead of, of paper, an envelope full of papers.

W

Yep.

David Bates – Brigham and Women’s Hospital

Exactly, and it goes beyond the summary of care document, so for example if somebody is on Coumadin, there are a bunch of things that need to go with them beyond, beyond just that they’re on Coumadin.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Yes, it’s much, much more than just the discharge summary.

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

So is this spelled out somewhere?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

It must not be or this, we wouldn’t be having this discussion.

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

So we will have, what we’re trying to avoid is having the same coverage, that we could even say that we’re going to flush it out and bring it back in our October discussion prior to the RFC, but we probably can’t just leave it this way.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

If we would say transfer documents available electronically—

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

And then come back and say we’ll come back and, and, ... the content.

David Bates – Brigham and Women’s Hospital

Sure.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Right, right.

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

And Paul, it may be just then relevant to the, um, you know, transition of site, you know, that issue that was—

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

Right.

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

...so we could caveat it, you know.

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

Okay, so for I’ve heard this is a transfer document when transitions happen between sites—

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

Um hmm.

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

And that it is available, are we going to say immediately, electronically?

David Bates – Brigham and Women’s Hospital

Yeah, immediately electronically.

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

Okay.

Bruce Gellin – National Vaccine Program Office – Director

This is Bruce Gellin. I’m brand new to this so I’ll plead objectivity, but could this then be just the PDF version of all those pieces of paper in a folder, or are you just looking for something else?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

I was looking for something else, this Marty. I want something that I can incorporate into my record rather than just have a PDF of it.

Bruce Gellin – National Vaccine Program Office – Director

Right, I agree something that’s more of an integrated summary rather than somebody who has a machine where they can just scan everything. Okay, that’s what, I just want to be clear on what you meant, what the, what type of electronic transfer you were looking for.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Charlene, do you agree with what I said?

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

Yeah, and again it’ll be the data elements that we’ll have to work through, but I think Paul’s position is right. Let’s just—I’m sure there’s overlap between this transfer document and what we’ve got in the summary of care record and, um, what’s in the discharge summary, so we just need to do some homework there.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Is this EP or EH or both?

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

Um, if it’s to site, it’s between sites of care, it can be. There are EP ramifications here, too, I think.

M

Most definitely EH, but I, I would have to think about EP.

David Bates – Brigham and Women’s Hospital

I was thinking just EH.

M

I was, too.

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

Or we could start there.

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

Let’s start with EH then.

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

Let’s start there.

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

Does anybody know are the elements that you expect in this transfer document, are they already part of the consolidated PDA?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, I believe so. It's meds, latest meds, latest labs, discharge instructions, patients instructions, ah, a, allergies, date of birth, um, ah, ah, reason or instructions for movement. I can't remember what else, but it's more than just a discharge summary.

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

Right, so, so, so it sounds like it can be a combina—we'll just, we'll just one come back and enumerate the, the actual data elements and the confirm that it's all already covered in their CD, CCCD, CCDA.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes, but that's what I, I see as like this order discharge—I mean, it's the discharge order itself, but there's orders that are sent over some which are meds, so it's just, there's other orders that go, so I don't know whether that's called intervention, but that's the gap I see, so we've got to track that down.

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

We'll track that down or ask Standards to help us.

M

Also the required and tele-documents would be to go with that.

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

Good, oh, good, so we'll, we'll present what we have and, and then owe them something else for October. Okay, thank you.

Um, next one.

David Bates – Brigham and Women's Hospital

So the next one is a request for, for, ah, a list of contraindications. I would not include allergies here, actually.

W

Right.

David Bates – Brigham and Women's Hospital

That would include prior adverse reactions or a procedural intolerance.

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

So one of the things we discussed in care coordination just this morning—

W

Um hmm.

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

—is whether we should put this down—since contraindication that, that, that concept, um, actually was new to us and clearly new to the field, but is desired, do we want to signal that, in for Stage 4 to create this time for everybody to create the products and the, the work flow to do this?

David Bates – Brigham and Women's Hospital

That would be fine. I mean this is one that, that's on the fringe.

W

Yep, yep.

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

Okay, okay. We know that all the providers want this place, a better place than med allergies and put this up in, um, and we just need to give the vendors enough time to get it there.

W

Uh, huh.

David Bates – Brigham and Women’s Hospital

Yes.

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

Okay, good.

David Bates – Brigham and Women’s Hospital

Okay.

Art Davidson – Denver Public Health Department

Paul, this is Art, just to mention, there is a contraindication standard for vaccines I believe, so, I, I see the note there from the HIT Standards Committee, but there is a table that NIT has produced.

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

Good.

W

Good.

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

Who knows, that might our first contraindication.

David Bates – Brigham and Women’s Hospital

Yeah, okay, next, next one is, is 126 and here the request is that within the personal health record, the patient should have the ability to compare themselves with other patients to see their risk status and get evidence about their own con-ah, ah, condition and, and so on.

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

That’s a big one.

David Bates – Brigham and Women’s Hospital

This was a late referral from subgroup two.

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

Yeah, that’s a big one.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children’s Preventative Services

So this is Amy, I’m not sure how I see meaningful use applying to the PHR.

Christine Bechtel – National Partnership for Women & Families

Yeah, hang on, it’s Christine. This was actually a very early referral and I don’t think it’s characterized correctly, so I need to cal—to pull up what it was, so why don’t you go to the next one, while I figure it out?

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

Okay.

Christine Bechtel – National Partnership for Women & Families

Yeah, in fact I've got, you know what I have it. It was, it, it wasn't necessarily within a PHR. I don't know where that came from. We just said ability to compare self with other patients, see risk status, understand evidence-based care for the patient's condition and we were asking for subgroup one to think it through 'cause we didn't, we weren't there. So if it hasn't been thought through, I don't think it's worth discussing. We weren't referring it as is.

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

Okay.

David Bates – Brigham and Women's Hospital

But we did, we did spend a half hour on it.

Christine Bechtel – National Partnership for Women & Families

Oh, great.

David Bates – Brigham and Women's Hospital

I, but I don't imagine patients are going to have access to the EHR.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie and this, the genesis of this was the Standards Communication Engagement Team had said how do I compare, which was at the point of care being able to see patient specific dashboards. That would be sort of the end game, so the patient, you could say to the patient, this is how you compare, how your care compares to other quality initiatives, um, and how the institution and how I'm doing. But that was, that was sort of the genesis and it's more. So what Christine said is more where we ended up and, ah, but this does not reflect that.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

So is this, are you suggesting that that be part of the patient portal attached to the, that's part of the EHR?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes, yes, it was not, it wasn't, we didn't rec—recommend a specific technology platform, but because it requires information that comes from the EHR and, you know, potentially other places, but it's a patient view, then, you know, that's how we ended up where it is, but it wasn't necessarily connected to a PHR, although it could be there I guess.

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

So I wonder if, it does sound like this probably could be, well, it obviously needs to be flushed out more. I'm almost wondering whether it should be part of the group two discussion, though, since it really patient-facing, however you get it there.

M

Well, no, but Leslie just said it's part of EHR, this is provider facing to discuss with the patient. It's not a unreasonable request, but it might be Stage 4, but it's kind of patients like it's, it's the provider's view of the patients like me database, it's not an unreasonable thing. It might not be Stage 3, given the number of other objectives, but it could be to the EHR, because the doctor could have a view, or I mean, the eligible professional could have a view into such a thing.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So for instance, Kaiser is doing something like this it says here's as a total population, here's a patient that patient with diabetes and, ah, if they're A1C retinopathy, neuropathy or such and obesity as such, this is their life trajectory. Here is what we're doing at Kaiser and here's their trajectory of health, and here, patient, is your trajectory of health. So it's a very, it's making quality initiatives patient specific in a view inside the EHR.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

So is this requiring the EHR to go out and get ... I can see this being compared to other patients in the practices that are in the same EHR. I'm having a harder time envisioning how this would apply to a broader population and how the EHR would be able to access that kind of data to do that three-way comparison to sort of nationally, our patients, and you.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So it could a Stage 4 initiative that the idea of having, ah, access to, to, external information we do today when we go to the National Library of Medicine or we go to *JAMA* articles or other kinds of information that gives us national dashboards and national articles and then the idea of this committee was let's get something that is patient specific, but set the stage, so that we're not just talking about health in general. We're talking about health trajectories for individuals.

Christine Bechtel – National Partnership for Women & Families

This is Christine, Paul. Why don't, if I could just make a suggestion that Leslie, since you know so much about this field, maybe you could revise and tighten up the language so it's more accurate, and then share it with David and I and then we could put it in the Stage 4 column.

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

Yes, I, I would suggest we tighten it, yeah, exactly.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I'll be happy to do that.

David Bates – Brigham and Women's Hospital

And something could be put in the registry part of things, because I would imagine the provider facing part of this is happening in the, in, in, you know, under, under whatever our registry item is, um, but I also think it's, it's pretty powerful to give the patients themselves, ah, in, information like this and we're, we're doing a trial of that now. And, ah, there's a lot of reason to believe it could help self-efficacy and so forth. If you realize that you are, you know, where you are relevant where it is compared to other diabetics, say, that's, that's a useful thing.

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

And so this is Charlene. One of the pieces of parsimony I think we referred it to group four, but it was that same under care coordination, we had that need to be able to detect patients from populations, you know, and be able to manage them. So again, it's, there's some parsimonious, you know, this was the provider facing one which you could, you know, detect patients who are obese or whoever else, you know, or based on certain conditions and everything we talked about, and then extending that to the patient would make sense as maybe a subsequent to that.

David Bates – Brigham and Women's Hospital

So, let's, let's move this to, uh, offline and we'll tighten it up, get a better, better and clearer definition under discussion for Stage 4.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay, and then bottom half of this slide, this is Leslie, maybe the, this is the decision and conversation, does this go back into the CDS section?

David Bates – Brigham and Women’s Hospital

Yes, I, I think so.

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

And to follow up, know you how we started with patient lists in Stage 1, it seems like that patient list is evolving to the kind of conversation, you know, more interactive in stage as we move through these stages, whether it’s a registry or whatever, but it starts to become a more interactive tool in identifying patients.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah. This is Leslie again. One of the things this committee talked about is that, that whole personal health trajectory that I said as we compare new population ... I think that’s reasonable for, for Stage 4, but potentially Stage 3 just being able to demonstrate, a, a, patient’s health trajectory, ah, just to say, hey, this is where you’re headed. Um, is that something we could still have in Stage 3 just for that patient?

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

I think that, there’s a, I mean the field isn’t even there yet. It’s a good direction that I think we’re not talking about, um, for Stage 3. It’s, it’s still a work in progress.

Christine Bechtel – National Partnership for Women & Families

Leslie, it’s Christine. I actually think I’m going to pick up on something that is as close to that as you can get, but, but still very doable today in patient and family engagement under the self-reported, ah, patient generated data, so, ah, ah, which is to how’s your health approach, ‘cause it does cover—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

That would be a great way to start in three and, you know, the rest in four.

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

And that is, that is being picked up I think in, ah, quality measure.

W

Right.

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

Okay, so we’ll work more on this, um, with an eye toward Stage 4 and we’ll just tighten this up, and David, you’ll look at, ah, how you might fit in the patient’s sensitive decisions perhaps in the

David Bates – Brigham and Women’s Hospital

Yeah.

M

I wouldn’t just take this and dump into the

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

Yeah, I agree.

M

No one understand it, the HITPC, you know, never mind approval.

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

Yeah, so there’s just some, um, this can be one of those 15 kind of a thing.

David Bates – Brigham and Women’s Hospital

Right.

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

Okay, want to go to the next one? We're doing, we're putting in our time here.

David Bates – Brigham and Women's Hospital

Sure, okay, good. Um, so, ah, the next one, ah, relates to lab tests and I'm actually not sure where this one came from, ah, it's 128, lab and radiology tests. I, I, I thought that this would be handled within the, the CDS one above actually.

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

It probably looks like it's coming into the category of all the 15, just like you made renal dosing 1 of 15—

David Bates – Brigham and Women's Hospital

Yeah.

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

Do we want to address sufficiency I think, um, with—

David Bates – Brigham and Women's Hospital

So if we want to do this, this is clearly a good, a good thing, ah, and, and everyone should have, ah, have tools like this in place, so I'm, I'm okay with including it.

W

Under clinical decision support?

David Bates – Brigham and Women's Hospital

Under clinical decision support, so there are two things here, or actually really three.

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

Yeah.

David Bates – Brigham and Women's Hospital

There's decision support for appro—appropriateness of lab and radiology and then there's tracking of tests that have been done with the ability to flag important/abnormal.

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

So I think we're, here's the inter—the problem is the interpretative tests—

David Bates – Brigham and Women's Hospital

Yeah.

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

And so they're not machine readable, yet so many things are triggered, health maintenance, a bunch of things are triggered by that, so that's almost in your lab tests, ah, objective. Oh, I'm sorry, not lab tests, test results and this specifically applies to the interpretive test results versus clin/lab.

David Bates – Brigham and Women's Hospital

Well, um, so, ah, I mean it can, it can include both. It's easier for the clin/lab.

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

Right, that's what I'm saying, that's my point.

David Bates – Brigham and Women's Hospital

Yeah, yeah. It turns out that some of the interpretive tests like, like mammograms, are typically coded, and they're coded in such a way that you can just do this. The same is true for paps, not so true for chest X-rays.

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

I think it's a question of, it really is provider behavior—meaningful, meaningful provider behavior that contributes to meaningful use of EHRs.

David Bates – Brigham and Women's Hospital

Yeah, exactly.

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

You're not reliably coding mammograms and we're just not going to pick it up.

David Bates – Brigham and Women's Hospital

Right.

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

So that, that seems like it's fair game. Um, so the CDS parts are moved up to CDS and then you want to move this one up to test results, or you want to have it separate?

David Bates – Brigham and Women's Hospital

I think, I think separate maybe.

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

Okay, okay.

David Bates – Brigham and Women's Hospital

Okay?

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

Okay.

David Bates – Brigham and Women's Hospital

And the next one is, is medication at dose monitoring and dose alerts for kidney function, age and, and weight.

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

So the comment back from Standards is that it's not clear that we have, although ... picks up the drug ingredients, it's not clear that structured ... is, is widely deployed.

David Bates – Brigham and Women's Hospital

Okay, um, yeah, I mean I think we, it needs to be, it's an important statement.

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

What's the timeline here?

David Bates – Brigham and Women's Hospital

Yeah, I, I would have thought it would ready by Stage 3, but if Standards says it's not and we needed to put it in Stage 4, I guess we could.

M

There's no structured stake in, in e-prescribing.

W

Say that again.

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

No, not necessarily.

W

What standard do you believe does not exist?

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

The, the structured stake part, that's how you calculate the dose and duration, so a lot of, ah, ah, e-prescribing has its stake as a text. It makes it less useful for us there.

M

Yeah, I agree with David. We should try to work to fix that.

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

Yeah. Ah, let's see 2016 is like three development years away. It's, it's more a, it's, yeah, all the systems, the pharmacy systems have to accept this in there. Well, your call, David, do you want to try it for 2016 or for 2018 for Stage 4?

David Bates – Brigham and Women's Hospital

How about 2016?

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

Okay, let me just put it in and leave it up for discussion.

David Bates – Brigham and Women's Hospital

Yeah.

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

Okay.

David Bates – Brigham and Women's Hospital

All right and that's it.

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

Great.

David Bates – Brigham and Women's Hospital

Unless anybody else has anything else that they want to highlight.

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

Thank you, David.

David Bates – Brigham and Women's Hospital

Thank you.

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

Okay, so we're narrowly, I think, fitting in the, in the balance of it and continue to make progress in category two, Christine?

Christine Bechtel – National Partnership for Women & Families

Yes, so I'm going to go with the spreadsheet because there are some errors in the slides that I think will scare people, so don't read the slides, go to the spreadsheet.

Um, so first of all, big thank you and shout out to all the subgroup members who worked really hard on this and, and I think we've come to a good place since we got feedback from the full workgroup, ah, where we did achieve more parsimony. We did all more detailed measurement and clarifying, so we have three to four new things, um, depending on how you count, three existing. And then we've got three things that are really only for the certification rule to create the capacity, but would not be objectives, or you know, criteria.

So the first is the addition of a functionality to, actually a couple functionalities to view download, transmit, um, and the first functionality is the ability to provide patients, um, the ability to self-report information and we've listed eight different kinds of information that providers could choose from, um, depending on what's most appropriate for their practice or hospital. So the first is family health history, ah, the second is, the spreadsheet says it's ..., but I think that doesn't work anymore in the, in the research that I've done, so, um, recommendation is, is, is my recommendation is to replace that with the how's your health tool because that is risk status, it's got some patient experience. It's got some other things that are very consistent, um, with the patient family engagement Tiger Team. The third is caregiver status and role, and that's a bonus and two-fer, because that's, it's in a couple other areas of the, um, care coordination for example and other places; functional status also a two-fer. Ah, patient created health goals also a two-fer and then three from, um, medical devices, so this is again creating the capacity and we chose the three sort of most common things that we understand to be reported, which is glucose levels, ah, blood pressure and weight, so that's the first new one.

Comments on that?

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

The question would be whether the standards exist for, let's, let's pick on glucose and blood press—I mean actually I know that they don't.

Christine Bechtel – National Partnership for Women & Families

No, they do actually, the, um, for glucose, blood pressure, weight, um, what the Standards, I guess, John Halamka said was the I triple E or the quadruple E standards plus no med LOINC. And then for the others, what you asked us to do last time was think about whether there are value sets and those are the tools, so what I have next to it where, where functional status ... ten, that's a value set. Um, caregiver status and roles, detox is a value set, so you see that the standards aren't ready to go today, but we know that they could be, because there is a standardized value set.

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

Okay, so this point you have both, provide patient with the ability that what's the implication maybe, you don't have measure here, what's the implica—does, does every patient have, have to report glucose ..., so what's, what's the implication of this bullet?

Christine Bechtel – National Partnership for Women & Families

I'm sorry, you know what? It didn't translate over from our big sheet, um.

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

Is this a certification requirement?

Christine Bechtel – National Partnership for Women & Families

It's, no, it's not. It's 10% of patients are provided with the avail—the ability to do that. There's not a use requirement. You know, they don't have to actually do it, but it's to provide should have said 10% of patients, and we had that originally. I just don't know why, I must not have transferred it over to the spreadsheet.

M

... above notes.

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

Oh, wait. Ability to reconcile. Maybe that's different.

Christine Bechtel – National Partnership for Women & Families

No, no, no, that's a different piece, so it's, it's just missing from it so that's first bullet should say provide 10% of patients with the ability to self-report information and then those are the different types that you could potentially draw from.

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

Comments, questions?

Emma Potter – Office of the National Coordinator

This is Emma from ONC. Um, am I still keeping in provider can choose one or more objectives according to its appropriate ... facility?

Christine Bechtel – National Partnership for Women & Families

Yes.

Emma Potter – Office of the National Coordinator

Okay.

Christine Bechtel – National Partnership for Women & Families

I'm sending you revised slides, Emma, so don't worry.

Emma Potter – Office of the National Coordinator

Okay, thanks.

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

What does that mean one or more objectives, what, what's the—

Christine Bechtel – National Partnership for Women & Families

This was the feedback that you gave us last time, so they can choose one or more, it's, it's the type, it should probably say types of, um, you know, data sets I guess, one or more of the eight things listed below based on what's available or what's appropriate for their practice and facility.

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

Okay, so you sort of created a menu within this objective, is that it?

Christine Bechtel – National Partnership for Women & Families

Yes.

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

So from the vendor's point of view, they need to be able to accommodate each of these eight things where there's—

Christine Bechtel – National Partnership for Women & Families

Well, I think what we need to understand in the RFC process is what's the most efficient way to do it—

M

Yeah.

Christine Bechtel – National Partnership for Women & Families

Because you could, I mean, you know, you could have, um, I think it's probably, um, you could ask, it's easier to have the people who do all eight or you could say that for the first five, which are really survey instruments, so what it has is a questionnaire capability and it's a lit—it's more plug and play and it's adaptable. And then for the last three, I, I, I don't, those aren't questionnaires. Those are direct feeds from like home monitoring devices, so it only would have two types of capabilities. We don't know. We're policy; not standards, so that's what we're wanting input from vendors, um, and others about what's the most efficient way to create this capacity.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie. Also some new information I received this week, the Rhode Island Health Institute has been us-, taking patient-generated medical device information inbound through direct as the mechanism, so, ah, there's, there's already work being done on this and, and Christine is right. The first, the first all are types of questionnaires, um, and getting response back in meaningful structured as part of the consolidated PDA work, ah, that we're looking at in the HL7

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

So that's a very helpful clarification, Christine, and Leslie, you can put on the, in our to-dos when we put out the RFC, we can explain that and I'm sure that will help people understand this and how they would fulfill these requirements better.

Christine Bechtel – National Partnership for Women & Families

Yeah, and Paul, I have a more detailed, um, document and a couple versions that I can, um—

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

Great.

Christine Bechtel – National Partnership for Women & Families

—that, that actually detail a lot of things to ask about in the RFC that won't be reflected in the spreadsheet necessarily.

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

That sounds good.

M

What should I put here for now?

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

Right, um, um, it's just a little clearer that the provide—the provider chooses the relevant obj—the relevant one of these eight to, to ... and then we're clarifying that one through five are basically questionnaires, ah, and, and, that could probably come up in discussion in Policy Committee.

Christine Bechtel – National Partnership for Women & Families

Yeah, and the other thing you're, so it should say provider can choose one or more, you know, data types or whatever according to what's most appropriate and then it should also say in the bullet provide 10% of patients with the ability.

Emma Potter – Office of the National Coordinator

Okay.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

All right, so the next is, um, provide 50% of patients the ability to designate who and when a summary care document is sent, um, and the ability, um, of providers to review and accept them. So this is something that the care coor—it builds off of the Care Coordination Committee and the care coordination group, um, ah, wanted to include over there, but it was getting too, um, complex, so we have it here. And this is really basically very much like, um, patients today, um, under Stage 2 would potentially be able to designate their communication preferences. This is simply being able to say on an ongoing basis, if, you know, if anything changes in my care, please send a care summary to my primary care provider, or for them to go in and just request that summary of care, we sent one time to, let's say, an endocrinologist. So it's this auto blue button, um, notion, so it sounds, um, you know, fabulous, but it's actually very simple.

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

Ah, comments on that?

M

What, when you say when, what does when mean?

Christine Bechtel – National Partnership for Women & Families

Like when meaning, um—

M

Is it every week or do you mean today or—

Christine Bechtel – National Partnership for Women & Families

No, I mean like a triggering event, right, Leslie?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes, this was a set, you know, set and forget it. I, I would like to receive all of my updates as they come, ah, so some sort of auto step and then the other is on demand.

Christine Bechtel – National Partnership for Women & Families

Right, so it's like a triggering event, when something changes that my cardiologist and my care or medication changes or whatever, I would like a new summary sent to my primary care provider, so it's not a time frequency.

M

So then we would need to define some feasible list of triggers, like we don't want—I mean the patient might in his or her mind here's a kind of trigger I'd want, but it may not be implementable in an EHR.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So for instance a lab changes and maybe that indicates a new summary of care document is sent. So it's really trying to have that summary of care document still be the instrument, but know that people might any time there's updates to receive that information.

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

This is describing the transmitting side. There's a receiver side to this, does the, does the recipient get a chance to say I want this and then I want it to be automatically updated all the time, because they, they're going to wonder about and then do I have to respond and review and what are the obligations there. I, I think that needs to be worked out.

Christine Bechtel – National Partnership for Women & Families

Right, right, that, Paul, that's a, that's a big part and you would see this in the detailed notes in another document, but that's a big part of the, um, what we need to understand in the RFC and that's the last part of that sentence where it says ability of providers to review/accept updates because for exactly the reasons you talked about, so we want to make sure that we can figure out a way to do that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And Paul?

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

Yeah.

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

I, I think the other thing to think through as I, as I think about this, you know, is like if there's a standard, I mean, I can kind of see it like when you, you know, sign up for a credit card or for your bank, again, you determine your preferences and where you want them to send your statements—

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

Right.

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

—and those kind of things, but again, in this particular scenario, do we need a consistent definition across every single venue, so they can do that in a common way, um, and ultimately evolve to this communication platform where you might be able to do it once rather than multiple times. So, you know, it's like, um, it's, you know, it could, just like today, you've got to, you know, do that face sheet umpteen thousand times. You know, we don't want to create a sit—situation where it's a lot of redundancy in this space either, I don't think, so that's the other question to kind of think through.

Christine Bechtel – National Partnership for Women & Families

Well, I also think that the ability to the providers to review and accept updates would feed into that and we need to have some answers around that, because it applies not just to this, but to the care plan updates that you'll hear about later in care coordination and there's, you know, other transmittal, you know, sort of information exchanged based criteria where the, there needs to be an ability to review and accept updates or not.

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

Well, the other thing that goes with this, ah, Christine, is, is when I get something out of the blue, I, I need to know wait, what I am getting this for and what, what's changed. It's almost like track changes.

Christine Bechtel – National Partnership for Women & Families

Right, and actually, um, it builds off of the care coordination, um, recommendation that has a, um, free text narrative that is essentially like why am I getting this and what is it about. I, I'm trying to dig out the exactly language, but Charlene, you would know. I mean it's like the first thing on the list.

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

Yep.

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

The, the trouble is when, when it's done automatically, you, you, your, you, you, um, anticipate ... referral request. When you're getting it out of the blue, you don't know what's the context.

Christine Bechtel – National Partnership for Women & Families

Right, but it's, it's a, it's the care summary and the care summary according to the new care coordination recommendation. It starts with a concise narrative in support of whatever the transmission is, so I assume that it would be able to have that.

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

But, but you said it's going to update, every time, it's going to auto transmit and, so there's no human saying, oh, here's, here I want to tell you, say, what to look for now in this next one.

M

So let's say for example—

Christine Bechtel – National Partnership for Women & Families

No.

M

I say I want my daily glucose measurements to go my doctor and my diabetologist, so now your subspecialist is getting daily or several times daily messages from the other doctor and doesn't know why. I mean if you have a panel of 1,500 patients, I think you can multiple pretty quickly to a large number of transfers because it's automated—

Christine Bechtel – National Partnership for Women & Families

No, it's not automated in that way. It's, it's would be auto is more set, so the patient can say when there's a change in my care plan, then, you know, or, or treatment at that point please send. The sending is not necessarily automated. It's that it, it's more that the patient has set their preference and then it would trigger, for example, like a reminder to the provider to say this care plan has changed and the communication preference said send to primary care provider, and then they would be able to do that. But I think it does take some human intervention.

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

So, Christine, may I suggest with this one, it sounds a bit more like we have a lot of, of questions to ask rather than jumping to proposing something and getting reaction. Would it be acceptable to make this, um, a, you know how in the ... had, we're kind of playing this kind of thing. How do you think we should best do and here's some questions, would you, would you ...

Christine Bechtel – National Partnership for Women & Families

I thought that was purpose of the entire RFC was.

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

Well, I don't think, I, I think there's a couple things to do. One is here's, here's how, we're proposing the following, what's your reaction, versus we're exploring this kind, we're exploring this need. Can you help us figure out whether this is possible and what would be the most efficient and effective way to do this? That seems like a different kind and they had those two different kinds in the RFI as well.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So this is Leslie, just a little bit more background on this, this was at the White House meeting. It was done, I viewed download and transmit and trying to get to a narrow scope on transmit that allowed for a patient to say, for instance, auto, any time my summary of care changes or there's a new summary of care, that needs to be automatically sent to me or to the following, ah, physicians in my team. And then to be able to say, um, on demand please transmit this summary of care document now to this new cardiologist I'm going to see. So we were trying to very much narrow that auto blue button idea to those things and narrow it to information that's already collected, like the summary of care, under perhaps the, um, the auspices of a brand of the blue button. So there could be, ah, it could be as simple as the direct message with that document inside of it. Um, so it's, there is work being done and this is all around that transmit idea that something is either, ah, auto, auto set or on demand and trying to limit it, ah, so it's doable using things that are already being worked upon.

Christine Bechtel – National Partnership for Women & Families

So Paul, I guess, um, I mean I, I mean I agree we need, you know, I, I, I approached this, ah, most of these sections as this is what we want and let's get feedback on it, so I think this is definitely something we want to get feedback on, um, and I think that Leslie and I can do some work to give ONC some more detailed language and we'll go from there.

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

So I think that I understand how the, um, ah, the interest was derived. There's a lot having to do with the receiving end and how to make that effective and efficient and that's I think what needs to, that there needs to be a great deal of, um, attention, ah, centered on that, so that we understand what the issues are. That's why I'm putting in the category of let's, let's, ah, put out the problem we're trying to solve and ask for help in, you know, ideas on how to solve that, which is I think there's a different, um, category than here's what we're proposing. I, I think we're pretty much in the same plane. It's just more open. It's a bit more, um, exploratory in this area, because there's a lot more we don't know, um.

Christine Bechtel – National Partnership for Women & Families

Right, I just want to make sure, I mean, I, I, I don't see a big distinction, but I, I understand what you're saying, but I just want to make sure that anything that goes in we need to explore this category, still have the ability to come back with a proposal if, we have to figure out how, because we have a long process to go to get even more public input after this, so.

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

Right, I understand—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And there's actively work being done on this.

Christine Bechtel – National Partnership for Women & Families

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And probably an SNI framework being launched in the next I'd say 30 days. Direct project is already working on this.

Christine Bechtel – National Partnership for Women & Families

Okay. I'm okay with that approach, Paul.

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

We're talking about the receiving end, Leslie, so yeah, so that's just like the RFI, um, it's, it's just a different state of, of, of or knowledge and, and it doesn't mean that it won't be incorporated if we can find a, you know, efficient way to do that.

Okay, we've got to move on, pretty much.

Christine Bechtel – National Partnership for Women & Families

Yeah, so the next one is, um, is a, is a capacity only, no user ... it's really for the certification rule, um, and it's the ability to accept pre-visit ...into the EHR, so the ability to consent to treatment, view administrative forms, um, and, and whether or not we could send those, save and send to other EHRs, for example. I might add, I, I was just reading the patient generated health data paper yesterday from RTI and I might add a patient agenda, pre-visit agenda, um, to that. That was one of the simpler things, so this is again something that we want to get feedback on, but it's, it's really a capacity building piece that's designed to create administrative efficiencies and cost savings for providers.

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

Uh, huh.

Christine Bechtel – National Partnership for Women & Families

Okay?

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

Okay. Any other comments? Okay.

Christine Bechtel – National Partnership for Women & Families

So then the next is, um, offer 10% the ability to, 10% of patients the ability to reconcile information in their record, so there's no requirement for the number of people who have to do anything, you know, the patients who have to use it, ah, but being able to now reconcile information in an environment where we're getting hopefully a lot of data flowing between view and download and direct and transition of care summaries and all these kinds of things that there will be problems that the patient will, will need to be able to flag, so that's what this is.

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

That sounds great.

Christine Bechtel – National Partnership for Women & Families

Okay?

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

That sounds great.

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

This is Charlene, just do we want to use the word reconcile or provide updates, I mean, the same intent, reconcile, you know, is more like as you start to get it operationally like you got two lists you got to compare them to each other and you have to have this proc—

Christine Bechtel – National Partnership for Women & Families

Well, why don't we say, um, so George, maybe we could say the operability to reconcile, update or correct information in their medical record.

M

Well, don't want to say or, because then we have to define all three of them.

W

Right.

M

But, um, is it correct, are we correct or are we annotative?

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

I think update/correct, so you may be giving additional information, or you may be actually changing something, you know, correcting some information.

W

Yeah.

W

And then we add it the systems we add the appendums in there, right, and we document that.

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

Correct, correct.

M

But what we mean by correct is that it's still an audit trail, so it's really an annotation, but it's—

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

That's true, maybe the word is append, that's the official word on the, on the EHR site.

Christine Bechtel – National Partnership for Women & Families

Okay, ah, all right, so that, that's it for the new pieces and the download. Um, we can skip the next one because it's an existing piece, um. Number six is, um, the access should be I think, so this is patient specific education ... it was 10% in Stage 1 and 2, um, with a slight change in the denominator. I would suggest that this actually should be 15% here, just a small increase. The new piece, though, is that for patients who, um, yeah, I'm sorry, there's a couple typos here, so for patients who speak one of the top five languages spoken nationally, then 80% of the materials would be provided in those primary language.

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

Ah, I think that's tough.

Christine Bechtel – National Partnership for Women & Families

Why?

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

Just most of if we're going need some kind of commercially available solution.

Christine Bechtel – National Partnership for Women & Families

Right, and that's why we focused on the, um, um, top five, because English, Spanish, etc., those materials are available in the public domain.

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

Top five?

David Bates – Brigham and Women's Hospital

There are for English and Spanish. I don't about the

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah, this is Leslie and the top five set as a national, ah, scope is, is doable, um, if we went to something that said the top five in every state or region would be not doable. Ah, so I think it, it is a realistic. Ah, it could be so that you need to confine it to a, I think we already did, it's a certain percentage, ah, information available, but um, five languages seem much more realistic.

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

So one is I, I'd look towards publicly available let's say like, ah, med line plus, and, and as David said I think English and Spanish are, are pretty well covered; 80% also creates another kind of a barrier, so I'm, I'm nervous about both top five. So one of the ways to characterize is publicly available 'cause I don't know that we want to create ... things.

Christine Bechtel – National Partnership for Women & Families

We tried to do that, Paul and it got real complicated real fast, so the reason, so top five would include English, right, so that's why you had the 80% threshold being high, because you, you have a, a large number of English and Spanish speaking people and so, and, and let me come back and correct myself, because I, I think that the spreadsheet is correct in the leaving the threshold, the base threshold at 10%, um, as it, as it has been; provide patient specific resources for 10% of patients. If we, we left that threshold very low and then said, you know, where, where, um, where they speak one of the top five languages, that was how we got there. We originally had the publicly available thing in there and they got so complicated, but we could add that back in here, um, and get comment on whether should it be top three or four; I don't know.

W

The other aspect of this one that we talked through, and Christine, I don't know where we, um, left that one, what's in many cases because caregivers, even though the patient's language may be in one, the caregiver may be another, so it came down to the language of preference, too, Did we lose that? I forget what we decided on that point.

Christine Bechtel – National Partnership for Women & Families

Um, let me see.

W

It became more difficult to manage and that's why we stated the top five nationally I think.

Christine Bechtel – National Partnership for Women & Families

Okay, that was more like at the 80%, because again, you know, there's going to be variability. I mean it should be their preference in the language.

W

Right.

Christine Bechtel – National Partnership for Women & Families

It does seem pretty high then in that case.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

So does this, this is Amy, and maybe you said this and I, I had to, ah, turn my attention to one other thing, but so if you're saying, um, top five languages spoken nationally, is that other than English or including English, because everyone could read it with just 80% of English.

Christine Bechtel – National Partnership for Women & Families

Right, it's including English. That's why we didn't, you know, go crazy here, but yes, that that is correct.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

So if 80% of you patients were English speaking and you gave them the materials in English, you've met this. It doesn't—

Christine Bechtel – National Partnership for Women & Families

Yes.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

I mean my concern with that is, is it doesn't really help drive the, I think the intent here about helping to, those that are not English speaking as a primary language.

Christine Bechtel – National Partnership for Women & Families

That is, that is the downside of the way that it was structured. Um, I think we were trying to ease people into the requirement and have it get beefier in out years.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

Um hmm.

Christine Bechtel – National Partnership for Women & Families

But you are pointing out a—that is absolutely correct.

George Hripcsak – Columbia University

Could you put the publicly available, ah, I mean, um, the nonpropri—the, you know, basically the free stuff back in.

Christine Bechtel – National Partnership for Women & Families

Yeah, so George, maybe you could say provide 70% of education materials in ... we can say preferred language where publicly available.

W

You know just remember a lot of state and local and county health departments have multi-lingual materials.

Christine Bechtel – National Partnership for Women & Families

Yeah.

W

And they often provide them at no charge or minimal charge.

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

And that's—we want to take advantage of that.

W

Exactly.

W

I'm actually wondering, and maybe this has been discussed, so if we don't have time, I'm actually wondering if you want to lower from the top five and just say one other language that some of your patients speak, like to still help drive the cultural competence here.

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

That has a lot of appeal to me anyway.

Christine Bechtel – National Partnership for Women & Families

Well, yeah, so, and, and maybe we can propose two methodologies and get comments on it. What, where we started was that people would essentially use the, you know, they're already collecting information about preferred language starting back in Stage 1. And so where we actually started with this was that you, of the, um, you would say that for any patient population, non-English speaking population that comprised more than 10% or 15%, you would have to provide materials in that language as well and that where publicly avail—and it just got, it got real cumbersome, but we can certainly ask for comment on which approach or other approaches might be best.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

Well, and it we want ease into it, it may, you know, if you have, if you're in practice that has multiple different, lots of individuals with multiple different languages, then what you're saying may be harder to achieve. What I'm suggesting is maybe one additional language spoken by, you know, a reasonable amount of your population or however we want to word it, so just requirements to have materials in at least one other language, 'cause that would at least allow, sort of help drive at least getting materials in one other language of their patients versus saying I've met this with all 80% of my English speaking population.

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

Yeah, so if this—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, then, then it should be Spanish, but other than that, if you say just one, then it's all. So if I'm in Wisconsin, it's Mung, and if I'm in Florida, it might be Haitian, so it's best to be either a national ... number, or a stated singular.

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

So now, we need to move on, because we can have each discussion for every objective, but it sounds like Christine was willing to look at, um, feedback on two versus one is top X number and then other is one other—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

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

And with the goal of really, we're just moving the dial here—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

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

That's why we ...

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

Yeah, I think that's great. Thank you for hearing me out on that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Thank you.

Christine Bechtel – National Partnership for Women & Families

So hopefully, Emma, you've got that.

Emma Potter – Office of the National Coordinator

Yeah, I apologize, um, for having a couple of typos in there, um, because patient preference was supposed to be, you know, whatever.

Christine Bechtel – National Partnership for Women & Families

Oh no, that's

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

Let's move on.

Christine Bechtel – National Partnership for Women & Families

So, um, the next one is really secure messaging, so, but, but there is a suggestion that I think we need more in the exploratory section, which is, um, for creating a capacity for electronic episodes of care and the ability for e-referrals and e-consults. And I think that is at more of an exploratory piece, okay?

W

And that's great, 'cause that feeds into the self-referrals and all, we could get some information on that.

Christine Bechtel – National Partnership for Women & Families

Right. So in terms of number eight, I now understand what the referral was and I think what we want to do is retain, um, what was in Stage 2 and come back to it if we need to, so no change; we don't; need to talk about it, but just Emma for the spreadsheet, if you could make that change that'd be great.

Okay, last thing – it's another just certification only piece, which is, um, creating the capacity for the EHR to query research enrollment systems, ah, using the HL7 info button standard and Leslie had, this was actually an adaptation and a, and a huge simplification of something we had before that I think is really good and it was Leslie's idea, so you can weigh in. But, you know, the idea being that the EHR itself has the capacity to look out into the research community and figure out what, what, you know, trials there are that this patient might fit. And it's simply creating that capacity as a sig—now as a signal for the research community, so that they are able to sync up with that standard also.

Leslie, did I get that right?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

You got it right. It could be EHR has the capacity after meaningful use, too, but the, now it just signals to the research community, hey guys, there's a way people can check, and thought it would really help to move the needle on enrollment.

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

I think there's more than meets the eye here. Most of the research requirements have exclusions, the majority of which have to read by humans in the medical record, so it's, it's not that easy, ah—

W

No doubt, Paul, this is just about, okay, I've got a patient. I think they might be well suited, ah, using the info button standard to the research community to say what trials meet these, meet these criteria in this particular context.

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

No, that's what I'm saying. It's not easy to do that. There's a huge, um, ah, attrition when you either talk to the patient or read their chart when you, ah because they fall out by other exclusions or actually don't meet the inclusion.

W

But would it give, the question I think I'm hearing is would it give a starting point to say here's some possible options to further explore, like not an absolute, but it might give an initial list for the provider to talk to the patients and say here's some options that we need, that, you know, can be explored.

Christine Bechtel – National Partnership for Women & Families

That was the intent.

W

Exactly, I was at the Academy of Health meeting and they just, the researchers just want to know how do we get our information available? Give us a standard; we'll follow it.

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

It almost sounds like—

M

Maybe this is another problem to be solved rather than a concrete proposal.

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

Yeah, I, I almost think this is, um, a Stage 4 signal that we need to work on rather than that you have all the answers and go ahead and make a certification rule. I don't know that you have the ability to make a certification rule yet.

Christine Bechtel – National Partnership for Women & Families

Well, what do you mean? We've got a bunch of capacity creating things that could, would be put into the certification rule, but there isn't a corresponding policy—

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

No, what I meant is—you have to know how to specify the certification criteria to say whether the EHR meets this yet, because, because we don't have I think it's premature, I think we need to do work on it and that's like a Stage 4 placeholder versus, oh, we already know what we want. We just are waiting for the, the—

M

We just got an RO1 from NIH to do this exact problem from an EHR automatically, so in three years that RO1 will be published and a paper on that.

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

Right, so that that's the issue.

Christine Bechtel – National Partnership for Women & Families

So could we, could we rather than just put in the Stage 2 because I think the appeal was getting the capacity beginning to be built and, and more on the research side, could we leave it in the sort of explore and get people's reaction to this, um, and if they come up with alternatives, then great; and if they don't it goes to Stage 4, would you be all right with that?

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

That'd be, that would be better.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

I mean George's point is germane. I mean it's literally ... want to do this.

Christine Bechtel – National Partnership for Women & Families

All right.

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

Okay?

Christine Bechtel – National Partnership for Women & Families

Yep.

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

Are we done with two then?

Christine Bechtel – National Partnership for Women & Families

Yep.

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

Great, thank you so much. Um, Art, when did you have to leave?

Art Davidson – Denver Public Health Department

Um, I have to get off about ten of the end of the hour.

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

Okay, it looks like you've got a lot. Um, why don't we get through three then and we'll, um, try to hurry the—

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

So do you want to do, Art, I have to be off by two Paul, that's all. This is Charlene. Did you, we really scrubbed on the call this morning. You and George were both on that call.

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

Yeah, I think we scrubbed it pretty well. Do you want to—

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

Just highlight them quick.

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

Yeah, and let's see if we can get—

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

All right, we in care coordination again with input from a lot of the other groups, we've narrowed, um, to four key objectives and I'll, I'll and I need to use the spreadsheet or the PowerPoint rather than the spreadsheet because they're not updated in the spreadsheet. So the first one that I'll touch on is 302, which is the reconciliation function. Um, as I mentioned before, you guys had asked us to look at how we can consolidate, ah, the recommendation. So what we did for, um, our recommendation for Stage 3 is look at building a more robust reconciliation, um process, and this aligns with what's currently being certified in the system. Um, we would like to again continue with the reconciliation process around medications. We did not change the threshold, because we're just waiting for the definition of what happens in Stage 2, but we did add into this capability the ability to do reconciliation around, um, medication, allergies and problems as they are two of the elements that are being looked at through the certification process, as well as we felt that it was important to start to work through and we recognize some of the challenges in reconciling problems, some of those issues, so that they can, um, be worked through and in position for Stage 3 and is a key element of advancing care coordination.

To that end we set our measure to be, um, you know, 50% for med req and again, we can move that up according to what happens to Stage 2, and then, um, 10% for allergies and for problems, so we do expect that, um, to be in use. We looked at the issues of intolerances and, um, contraindications and agree with the direction that David's taking that in, we need to send a signal that we need to start to capture, so we can reconcile them and, um, those need to be elements that are looked at relative to data capture and then we'll put those on the table to reconcile those at a later stage, so, um, and I think you see the comments on the standards.

Any questions on that? Again, we expect a lot of feedback relative to the reconciliation process.

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

What's the difference between the 50% and the 10%?

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

Fifty percent was med req, maintaining the current 50% from med req—

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

And then what's the 10%?

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

For allergies and for, um, problems.

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

So it looks like you also have meds again—

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

And we'll point it out, okay.

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

Okay.

W

....

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

Okay. And again, we'll move it to 65, depending on where the current bar is.

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

Any other comments on this one? Okay.

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

All right. Um, the next one, um, this is we're trying to put on two and saying—I mean this is, um, and we spent a lot of time on this one, um. This is, um, we're trying to work toward and this also relates to what David, um, was talking about in his to a more immediate, um, transition of care summary that's available when the transition occurs. Um, what we did is we spent a lot of time talking about, um, making that information available when the transition occurs, whatever information is available and then providing an update in a second phase. Um, we would like some, we would like to see that second phase the update would essentially be either a signal for Stage 4 and/or potentially, um, a certification objective in Stage 3. Again, we would like some input on that. We had a lot of debate on our call that we might be able to do that and we just felt we needed some feedback in that particular area, because again for closing the loop in terms of when additional data becomes available and how that, important that is to the process, um, that's the intent of this.

So for the purposes of, um, the recommendation again, um, you know, we pretty much, you know, left the objective as is, if you will, um, and then we added in, and then a lot of debate about this, um, the other change we made on this one is, um, there are fields that are relevant to, um, the transition of care record that were defined for Stage 2 and what we said was for Stage 3, um, we would like that concise narrative to definitely be contained on the care record summary, so we're sending a signal that we would like the standard to accommodate that. And then there's three data fields that are critical to transition of care, so when there's a transition of care from site, we want to, um, require that those fields be populated and again, this would be from, you know, a hospital to a nursing home, a hospital to home care. And those fields are, um, setting specific goals the instructions for care and the care team members. And again, they correspond to those data elements that we were referencing in patient engagement. So it's revising this objective, um, with the intent to make it stronger over time.

Comments on this one?

Emma Potter – Office of the National Coordinator

This is Emma. Um, did I capture what we talked about this morning with this objective?

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

I'm looking at this, at the PowerPoint. I think you did.

Emma Potter – Office of the National Coordinator

Okay, great.

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

So it's, um, it's adding a 30% electronically to the, to the transition, the transmission of the summary of care and it's adding these, ah, four new fields, um, that are mandatory at least for transitions of, site transitions of care.

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

Site transitions, and I think the question is in terms of the referral, um, the reason for referral might end up, ah, if there's a referral order, so we just have to, I think, wait till standards sorts out some of these different places where we might be able to do this, but clearly on the transition care summ—we want that concise narrative.

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

Um, and Emma, that's a site transition.

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

Site transition.

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

Um, so one of the questions we had in the, the small group is should the goals, the instruction for care transition, um, for 48 hours and the care team members be a requirement for, for all transitions, and then support clinically relevant referrals.

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

And again, Paul, I would wonder if, and this is kind of go to the rest of my group, you know, if we made, um, the other one for the hospital, you know, what the one that David was talking about, would then that be appropriate to make this the hospital transition? Again, I don't want to exclude other kinds of transitions, either.

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

Wait, hospital transitions is included here.

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

Yeah, yeah, yeah, but it should just be, um, an eligible hospital requirement.

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

So I don't know what the question is because it is here.

M

I think that should be only hospital.

M

I think it's, no, I think it's supposed to be ET.

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

Okay, that's fine.

M

It should be appropriate, it should be feasible, but it was supposed to be for ET.

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

Okay.

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

Okay, any other questions on this? Okay, and Charlene, I think I made a mistake in, if we're, if, ah, if, ah, Art is leaving in 20 minutes, we probab—or less than that, we ... yeah—

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

That's fine. We just—I got two more, go ahead.

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

Yeah, Art, you want to go ahead then?

Art Davidson – Denver Public Health Department

Okay, so, ah, we have in the, we're up to slide 31 in the slide set. I guess I'll use this one. So this is the, the first one there is the, ah, immunization registry and there's a slight modification. It goes back to the discussion we had with David and I think also with Charlene just now about contraindication to vaccines for reasons for refusal. That's a slight modification that rather than just sending vaccines you would send also contraindications. There is a method to do that to the registries or immunization systems, information systems.

Ah, the next, the next one on that same slide is of a, ah, capability to access and review of patient's history and, um, there are methods for that already established. I believe that in the, um, Standards Committee brief comments those were identified and there's a way for us to now receive information and I know that's happening in several states, my own included, ah, where you can receive, ah, information and get it incorporated or at least it gets to the EHR. How it's incorporated or not is probably an issue about the EHR, but it's at least surfaced to the user.

Is that okay? Should I go on?

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

Any comments? Okay.

Art Davidson – Denver Public Health Department

Okay, great. So we'll move on to the next slide, which is, ah, 401D, that's slide 32. Um, the, this one is the ability to receive recommendations and there are again, ah, recommendations, ah, being sent out by immunization information systems around the country, and they are as, ah, we have listed here based on age, gender, and immunization history, the, it's called forecasting and, um, they're, they're exactly how this happens, um, is it coming from the immunization registry? Is it coming from the EHR? I don't think we want to, um, um, stipulate with that needs to happen, but the, one of the things that could happen, and this gets back again to David's earlier presentation, is that this is a clinical decision support system, and it could be that there's a way to access the information for, ah, ah, immunization schedules from a, ah, ah, a registry or a, ah, actually, ah, a knowledge base that sits out on the web. I, I don't know whether this is an item that we as a policy committee would like to promote, the idea that you can go somewhere and get knowledge and use it in the HER; that valuable not only to population health, but to others, to other areas, especially to the work that David Lansky, ah, might be presenting around clinical, ah, quality metrics, so just, ah, something about clinical decision support and I receive knowledge and this, this is one, ah, example of that.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

So Art, this is Amy. Is this the, I, I thought earlier when we had the clinical decision support discussion, this was the one you were talking about could get moved up there.

Art Davidson – Denver Public Health Department

That's correct. That's correct. I'm just going through this, ah, as quickly as I can and yes indeed that might have been a faster way to get there.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

And the one other thing that the group, um, that we spoke a lot about here was, you know, um, the importance of, ah, getting the recommend—where to get the recommendations from. I don't want to get bogged in and down on that conversation now, but state registries may have algorithms based on how they're purchasing and distributing vaccine that may be a little bit different from something else. So, so this is the area that we had a lot of discussion and it was not easy to, ah, to sort of, ah, work through specifically.

Art Davidson – Denver Public Health Department

Right and then, I, I did capture that I hope in it says allows for local and state variations.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children’s Preventative Services

Yes.

Art Davidson – Denver Public Health Department

And then also accounts for contraindications.

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

I, I think there’s a lot in this measure, I mean, do we know when an immunization recommendation system is, and do these things exist that has the baseline recommendation and, and allows the local and state—that means they would have to understand what states it’s in and accounts for contraindications. That’s a lot to ask.

Art Davidson – Denver Public Health Department

Well, I, I think that, ah, there are systems out there that are geared to the immunization recommendations, just as Amy just said for the state ...

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

But are they, this is has to be in the EHR.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children’s Preventative Services

Or the EHR has to go out and make a call and pull the data back in.

Art Davidson – Denver Public Health Department

That’s correct.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children’s Preventative Services

Like through a web services type of thing, it’s doesn’t have to—so one of the challenges is my understanding is, and Charlene, maybe you can help me, there are EHRs that, that you can plug in and build and put in like ACIP immunization recommendations in. The challenge, David, does that align with sort of what’s in your state or local region, and that’s part of the challenge.

Art Davidson – Denver Public Health Department

And Paul, we’re only saying here that you, you need to be able to receive. You could also generate it. It could be in the EHR, but you could receive that from a web service.

Bruce Gellin – National Vaccine Program Office – Director

This is Bruce Gellin from National Vaccine Program Office. There’s really not that much variation and, and just to remember that while ACIP makes these recommendations as you’ve been suggesting, they are ultimately up the states to implement. But at the same time, there’s been a great effort with the professional societies, particularly the American Academy of Pediatrics, the American Academy of Family Physicians to harmonize these, so these recommendations are not that variables across. And, and I think that given the existing, you know, registries/immunization information systems, they probably already worked out where there are some of these variations.

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

So the, the question is not what exists in the immunization registry system. It is what, what exists in the EHR that can communicate with it and can do what this measure says. It has to be able to account for local and state. It has to be able to account for contraindications, which we actually don’t even have in the EHR until Stage 4.

W

Right.

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

So there's a lot of, I, I think this is ahead of—

Art Davidson – Denver Public Health Department

Well, let, let me just clarify something, Paul. There is a HL7 message that allows you to enter contraindications that would go to the registry in Stage 3. That's the modification to the previous, ah, slide.

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

No, I understand, but we don't have the notion of contraindications in EHRs today and we just went through the discussion that we thought that it would be too premature to, to even make a recommendation for Stage 3, so we actually put that in Stage 4. So, this, it seems like this kind of thing could be accompany that in Stage 4 once we've defined what contraindications are, and we might even take advantage of vaccine contraindications as, as the exemplar, but we just got done with the discussion saying this does not exist today. And part of the reason is we haven't actually defined it well, so I don't know how you can implement this.

Art Davidson – Denver Public Health Department

So, so then I could, I, one thing we could suggest here is that we drop this number three and just say, this is as Bruce Gellin – National Vaccine Program Office – Director suggested. There's relatively little variation and we should be able to establish what is the standard in a community and, ah, leave it that. That's what's going to come back from an immunization registry is the what's recommended at that time, and that's what's happening around the country now. This is not something we need to necessarily wait to implement. It's happening.

W

I agree. I mean I think this is an important component of clinical decision support.

W

And I think it will reduce sort of a lot of catch-up vaccines, you know, especially with, you know, um, it's just easy with all the vaccinations to miss stuff, and then someone's, you know, kids going off to college here, there, whatever and you're trying to play catch-up. I, I think it's important.

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

So, so, just remember. A lot of things are important. What can be done through the EHR in the timeframe we're suggesting, so if you want to put a lot of emphasis on this, then we've got to make sure we prune a lot of the additional things that you may have coming up. Does that make sense?

So immunization, you may decide immunization and we have in the past said that's one of our important things we want to focus on, so let's line up all the things dealing with immunization, but I think we have to take away some of the stuff. We can't force too much on folks at the same time.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

I don't, I mean from my perspective, this is Amy, I, I think since there's already so much focus on immunization, this is an extension of what we're doing, so I think it's logical, even if we have to cut some other ... or more brand new items.

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

That makes sense.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

It would be my bias.

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

And that's consistent with what we've said in the past, so I would cut out the number three at least, because we don't have that in Stage 3.

M

Yes.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

And you know, Paul and again, one of the sources from the vendors is keeping like, you know, this kind of knowledge and keeping track of it and embedding it in the system, you know, there's just, so if there's this source that you can go to enable this knowledge would be helpful, so, you know, and we could choose one area to start to learn it and I, I think that would be—

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

Yes, I think, yeah, that's the goal.

Amy Zimmerman – Rhode Island Department of Health – Chief, Children's Preventative Services

That's the goal.

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

Okay, so that's the caveat with, we're trying to work with immunization and we're focusing in on this. And I think it's more mature in the public ... area.

Emma Potter – Office of the National Coordinator

Um, this is Emma. Just to be clear, we eliminated the third sort of part of the measure that does account for contraindications and patient preferences.

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

Correct.

Emma Potter – Office of the National Coordinator

Okay, thanks.

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

And number two, that's implying that we, there's a query that could be formatted, so that the state system would know to return back a, a state or local variance. Does that already exist? Is that true?

Art Davidson – Denver Public Health Department

Yes.

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

Okay. Okay.

Art Davidson – Denver Public Health Department

Is it okay to move forward?

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

Yeah, we might want, so what you got here in the measure is 20% review, that's a check off measure and we're trying to avoid those kinds of things. You might just say that they've received that, but that, that's a fine tuning, but you may want to do that.

Art Davidson – Denver Public Health Department

Um, okay.

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

Review is a check off thing and we're just trying to avoid that, the fact that they've downloaded this; that may be okay.

Art Davidson – Denver Public Health Department

Okay.

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

All right?

Art Davidson – Denver Public Health Department

Yes, um, the next item is, um, the ELR, ah, electronic, ah, laboratory reporting. ... is, um, is unchanged for the, for the fir—for the eligible hospitals. We're adding a new one here for the providers, ah, to, um, receive, again the same sort of consumption of knowledge. I, you know, I don't know whether there's, how are we promoting the idea of health information exchange and how does the EHR benefit from that change to do things, exchange, to do things better. I think that's what we're proposing here again, giving knowledge to the EHR that it would know which are the reportable diseases based on lab tests that, ah, are, um, identified, ah, ah, by CSTE, the Council of State and Territorial Epidemiologists and CDC in a knowledge management system. And they are working to create that knowledge management system for meaningful use. That's where they're at now. It's not currently available, but that's where they're at and we're saying that we would like for the EHR and the hospitals to be able to receive that in, in some format that they could then incorporate into the EHR. It's a similar concept to, um, receiving knowledge for immunizations and I presume similar knowledge for clinical decision support, or quality metrics.

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

So is this, um, it sounds like the vaccines were, immunization was more further along. Would be, would this be something you could put in a Stage 4?

Art Davidson – Denver Public Health Department

Ah, potentially, you know, we could, we could, we could see where, um, where the, um, the work of CSD and CDC is in a, in a short time and try to get information back to the approach that Christine had was can we ask for more information about this.

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

Okay, that's ... instead of proposing, we can explore this and we can certainly if it turns out to be far, far along, then we can incorporate it in our proposal of what was

Art Davidson – Denver Public Health Department

Right.

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

Right.

Art Davidson – Denver Public Health Department

We'll move to the next, unless there's more comment, I'll move to the next slide, ah, 402B, um, is, ah, the it's used externally accessed or receive knowledge to determine when a case report should be reported and then submit the initial case report. So this is where using the knowledge that was just received in the previous, ah, we would then, ah, use that to generate a message and a message we were proposing the message be the, ah, consolidated TDA, ah, structure that, um, we heard earlier would be a solution potentially for the transitions of care. So I think we're hoping that that would be a document that would be leveraged again for this activity.

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

It sounds like this is the ... arm for the one we just reviewed, right?

Art Davidson – Denver Public Health Department

That's correct. That is correct. The ... arm and this is where, you know, you, you would, um, um, attestation is really the method here for 20% of the reportable users or conditions.

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

So maybe it's part of the same exploration; it's—

Art Davidson – Denver Public Health Department

Yes, this is all one use case, but the ... aren't arms separated.

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

Correct, it's a wonderful functionality if, if we can figure out whether it's, um, mature.

Art Davidson – Denver Public Health Department

If it's feasible.

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

If it's feasible, right.

Art Davidson – Denver Public Health Department

Right, right. Um, I'm going to quickly run to the next one, if there's no comment about that, and this was, um, the, the next two are about registries, and, um, trying to address—they're broken into two. They could be lumped the idea is that you would participate in two registries. One of them hopefully is, is one that is mandated in your jurisdiction, and that registry would then be willing to receive a standardized message that, that we would ask all registries to receive, again, a concept that has not been proven, but we believe that it is possible for us to begin populating registries with the initial data, maybe not the complete data. And there may be other systems that other sort of follow-up for the, the arrival of an initial record, but I think we would be happy to see initial records arriving incompletely at this moment. It would be much more complete in reporting the number of cases for individuals who meet certain criteria or our ability to track large populations through this method rather than saying I'm getting 100% of all the data and working more toward larger numbers of patients knowing that I will not get all the data. That will take time and will grow as we get better at this.

The example is the cancer registry if it was able to, to send messages to, um, from EHRs to cancer registries, but here we talk about in this one mandated ones that, that, that may be cancer, may be children with special needs, early hearing detection, um, ah, so those, those are just some examples of mandated. And the following one, just to kind of follow on the same theme, is you have to do another one. It could be one of those mandated ones, but it, it also could be something that's really germane to your profession, you know, your specialty, ah, or germane to your jurisdiction, ah, for instance, as I mentioned earlier, we're trying to build this for hypertensives in Denver or for a smoking status in Denver, or for BMI in Denver. And you know, there, there could be, and there are, there are many other cities around the country that are working on this and have made progress in terms of registries for population based analysis across healthcare institutions. So that's the second one here.

Um, and we could again, Paul, just, you know, as, as we receive from the Standards Committee, there's little standards in this area yet, ah, something we could ask for, ah, advice about and information and see whether we are ready.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This, this is Leslie, Art. I had a question.

Art Davidson – Denver Public Health Department

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So in this syndromic surveillance, um, reporting standards that I think came out in ... there were 17 criteria, ah, in there. So are you suggesting that the mandatory use those existing named standard and then anything beyond that mandatory that would be unique to the practice or unique to a particular disease would be optional, is that what you're—

Art Davidson – Denver Public Health Department

No, no, the syndromic surveillance specifications are different than we're basically starting out with cancer has a CDA that it wants to use, let's say, or, ah, another one, ah, would be, um, the health care associated infections.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay.

Art Davidson – Denver Public Health Department

There are CDAs out there, we're trying to actually not, um, ah, use that ISDS standard, but rather one of these, um, ah, CDAs probably trying to just tuck in right behind the transitions of care document, it has a lot of information of value to public health, which is different than the ISDS, ah, elements for syndromic surveillance.

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

I know you have to go.

Art Davidson – Denver Public Health Department

Right.

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

Um, so is this one you're proposing for the explore?

Art Davidson – Denver Public Health Department

Yeah, I think we can, I, I think a lot of these are going to be explore. You know, we, we don't have, when, when Standards Committee says there's nothing really there yet, we need to explore.

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

Yeah.

Art Davidson – Denver Public Health Department

Don't you agree?

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

Yep.

Art Davidson – Denver Public Health Department

Okay. So, um, then the next one is, ah, um, healthcare associated infections. That one, I don't think there's a lot of exploration that's needed. This one fits well with our patient safety mission in the first priority area. It's a population based one, but it allows us, ah, to then, ah, understand the rates of, ah, HAI in, in healthcare institutions and that would be only in, in hospitals. Ah, that's new. Ah, then this one to, ah, do adverse event reporting and, um, there's some question about standards in this and I actually was looking online and found a couple of articles out of Germany where they use ICD-10 codes and they're apparently 505 different adverse event codes in ICD-10, if I read the articles correctly, that have been used to track adverse events in hospitals, um, and several other institutions in Germany. So just, um, I think there may be more of a standard there once we get to ICD-10, which we should be at by 2016.

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

Ah, okay. So what, where would you put that in an explore or a Stage 4 or Stage 3?

Art Davidson – Denver Public Health Department

I think, I think this is likely to be something available in Stage 3, just off of a, an ICD-10 code.

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

Okay, other people's comments?

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

I don't know if Marty, this is Charlene, if Marty still on, but again, if there's a provision, they have to, the hospitals have to report this one, there's a provision to do that, they'll definitely do the reporting. It would seem like this should definitely be considered a higher candidate for Stage 3, again—

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Yes, Charlene, this is Marty. Yeah, and I, I would agree, the ... hospitals have to report this now, so, you know, they're doing it manually. Um, they, they'd relish the idea of having to be done electronically, but—

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

Are you referring to HAI or adverse events?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

HAI.

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

Okay. What do people feel about adverse events?

Art Davidson – Denver Public Health Department

So that, that indeed, Paul, probably needs more exploration.

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

Okay.

Art Davidson – Denver Public Health Department

Yeah, I, I, I was not trying to suggest that it's ready for prime time in the U.S.

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

Okay, or actually, yeah, okay, yeah. Is that it?

Art Davidson – Denver Public Health Department

Um, I think so, you know, I think I've skipped over the syndromic surveillance, which remains the same, so I, I believe I've—did I miss any? I think I've covered them all.

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

Great, thank you.

Art Davidson – Denver Public Health Department

Thank you, Paul, for letting me go. I'm sorry I have to leave.

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

All right, ah, Charlene, any, can we quickly go through the remaining ones you have?

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

Um, so we have, we have four in all, so we did the care transition—I'm sorry. We did the care transition one, feedback from the group was to look to see if we could consolidate, um, the care plan information into the, um, the summary of care. We chose actually we wanted to establish a separate objective and so if you look at the objectives for, um, establishing a care plan, let me see if I can get the right number, um, 305, ... 304. Um, again, this is, um, for site transitions of care only, the ability to for 10% of the population provide a care plan. We're starting to emerge the care plan as a core in Stage 3 with the data that's listed.

Um, we got this data from work that both Eva and Leslie did on working with the transition of care community. Again, we're serving this up right now as the content that's to be provided. We're positioning it mostly as three text for Stage 3, but do expect that there would be a lot of work between now and then relative to these data fields and refinement of these data fields. For a referral, if the care plan is available, we suggest that it's passed, but again, the focus is for, um, the transitions of care.

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

Uh, site transition of care.

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

Transitions.

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

Emma, that should be site transition of care.

Emma Potter – Office of the National Coordinator

Okay, and do I need to change the objectives where it says transition their patient to another setting of care? Do I need to change that to site?

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

That, that's what we mean by site transition.

Emma Potter – Office of the National Coordinator

Okay, all right.

M

....

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

Any comments on this list? Okay.

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

All right, and this for the last one I'm, I'm not sure it's reflected exactly correctly on, ah, the—let me just talk you through, on the spreadsheet. Again, what this is is closing the loop on the referral requests that we talked about, David talked about, and so we narrowed this one down to substantially for Stage 3, so it was the ability, um, to be able to acknowledge the receipt of, um, ah, this is going to be different. Um, this is, and I'm going to have to step back and revise this one I think a little, Paul, but let me walk the group through it. Again, what we ended up with at the end of the day was the ability to be able for a provider who received the referral to be able to send back, um, the referral results and then, ah, the measure was going to be that that provider for those providers who have received, ah, a patient has been referred, that they could, um, send back the information from their EHR, um, to the requester for 10% of the patients. So the intent of this objective, and we really scoped it back for Stage 3 was to close the loop on the referral. And we kept the threshold low. We made it core, um, and we focused on that particular area, that particular requirement.

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

Questions ... about this? Okay. So I see another new one, the up-to-date interdisciplinary ...we didn't talk about that this morning. Is that supposed to be there?

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

Um, no, I don't think so, Paul, this was the one where I think we had to, we chose that we were going to defer discussion on that to, till we see what's in the, um, in the final proposed rule.

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

Okay.

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

So we, we put that on hold.

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

Okay.

M

... problem list is getting, is not actually, I mean we're still figuring out if we can do problem list reconciliation in Stage 3 so this would naturally follow that.

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

Yes.

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

Okay, so it's

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

We're trying to get the problem placed in Stage 3.

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

Yeah.

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

Or the problem.

M

I think same for the PBM in the next one.

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

Yep.

M

One twenty five.

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

Those are potential Stage 4 candidates.

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

Okay.

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

Okay?

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

Good, thank you.

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

You're welcome.

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

We just narrowly made it. Any final comments and then we've got to go to public comment, so this will, so with the, with the, ah, ... we've discussed today and it's very helpful, thank you, everyone, one for getting much more parsimonious. Two, for dividing between, um, what we're proposing for Stage 3, where we're asking, ah, we're, we're asking for more comments to "explore" and what we're, um, putting I think for Stage 4 I think that's very helpful. Thank you.

Um, can we open for public comment, please?

Mackenzie Robertson – Office of the National Coordinator

Sure, operator, can you please open the lines for 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.

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

And Christine and David, I'll follow up with you about any questions that I have on yours, and George may want to follow up for three and four. That's how we usually present back

Christine Bechtel – National Partnership for Women & Families

Okay.

Operator

And we have no comment at this time.

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

Well, thank you so much for all of the effort that's gone in in these past, ah, few months to getting to this point. Let's see what we can get, the feedback we get from the Policy Committee and then we'll do another rev before we go up for RFC.

Thanks so much and see you very soon.

W

Thank you.

Mackenzie Robertson – Office of the National Coordinator

Thank you, everyone.

M

Thank you.

Public Comment Received During the Meeting

1. Terminology and functionality differences between care plans and plans of care. Discharge - can the discharge instructions meet the requirements for patients? Patient confusion, discharge notes for healthcare professionals - Can the committee incorporate current practices and requirements rather than adding more redundant documentation? For example, Medicare required MEPS for LTC and OASIS for home health care?