

**HIT Policy Committee
Meaningful Use Workgroup and Certification & Adoption Workgroup
Transcript
February 14, 2013**

Attendance

The following Workgroup members attended this meeting:

Meaningful Use Workgroup Members

- Paul Tang
- George Hripcsak
- Marty Fattig
- Leslie Kelly Hall
- Charlene Underwood
- Amy Zimmerman
- Joe Francis

Certification Adoption Workgroup Members

- Larry Wolf
- Joseph Heyman
- George Hripcsak
- Elizabeth Johnson
- Donald Rucker
- Paul Tang
- Scott White

The following Workgroup members did not attend this meeting:

Meaningful Use Workgroup Members

- David Bates
- Christine Bechtel
- Neil Calman
- Arthur Davidson
- David Lansky
- Deven McGraw
- Latanya Sweeney
- Tim Cromwell
- Yael Harris
- Greg Pace
- Robert Tagalicod

Certification Adoption Workgroup Members

- Marc Probst
- Josh Ash
- Carl Dvorak
- Paul Egremann
- Charles Kennedy
- Micky Tripathui
- Martin Rice

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning, everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a joint, in-person and virtual meeting of the HIT Policy Committee's Meaningful Use Workgroup and Certification & Adoption workgroups. This is a public meeting, and there

will be time for public comment, prior to adjourning today at 10:30. I'll just also remind everybody for...since the meeting is being recorded, if you could please identify yourself when speaking. I'll now just go through the roll call of the two workgroups. Paul Tang.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Paul. George Hripcsak? George?

George Hripcsak, MD, MS – Columbia University

Hey.

MacKenzie Robertson – Office of the National Coordinator

George, hi. David Bates? Christine Bechtel? Neil Calman? Art Davidson? Marty Fattig? Leslie Kelly-Hall?

Leslie Kelly Hall – Senior Vice President – Healthwise

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Leslie. David Lansky? Deven McGraw? Latanya Sweeney? Charlene Underwood?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Charlene. Amy Zimmerman?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Amy. Tim Cromwell? Joe Francis? Yael Harris? Greg Pace? Robert Tagalicod? And the Certification & Adoption Workgroup. Mark Probst? Larry Wolf?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Larry. Joan Ash? Carl Dvorak? Paul Egerman? Joe Heyman?

Joe Heyman, MD – Whittier IPA

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Joe. George again, I know you're here. Liz Johnson?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Liz. Charles Kennedy? Donald Rucker?

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Don. Latanya Sweeney? Paul Tang, here. Micky Tripathi? Scott White? And Marty Rice? So with that, I'll turn the agenda over to you Paul.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay, thank you. And thanks for joining us on this follow-up of the hearing yesterday. We have two and a half hours; probably we won't need all of that time. And the goal is to sort of summarize what we heard yesterday and come up with some recommendations, in the sense I guess to the Meaningful Use Workgroup related to clinical documentation. I could start out with some of the high points. I think we learned a lot yesterday, actually, in all four panels. And again, thank you to Michelle, who arranged all of those speakers and it went very well.

It is clear that clinical documentation is really an important item in the medical record. It serves, we think of it as serving the primary care team, or the care team. More and more it's serving the patients, an example of that is OpenNotes, and their caregivers. It's a communication tool, in addition to a documentation tool. I think people would like it to be even better than it is. The communic...in the old paper record days, it was almost a communication to yourself and very few people could access it. Now, the advantage is that it can be distributed to all of the people who need to participate in a person's care, but it has to be an effective tool. And some of the things that get in the way are some of the productivity tools, I mean, it's a good intent for physicians but I think it actually crowds out a lot of information, the so-called note load. We also heard about the multiple stakeholders. It's all related to patient care, it may not be individual patient care, but it's the folks who have more than the one-on-one relationship with the patient.

So, one of the motivations for the hearing was the concern that the accuracy may not be completely there. We had Amy present their results and with the review of the literature, they could not find evidence on the accuracy of information. There's more anecdote about the risks of not having good, accurate information, but unfortunately, there hasn't been a good study that's at least been published that demonstrates the accuracy of the documentation as it is today. And in query on the HIMA representatives, she wasn't aware of any additional information about that as well. There seemed to be no clear method associated with high-quality documentation. If you remember what David Bates said, possibly the specialist to used templates were associated with higher quality care. But otherwise, whether it is unstructured, whether it's dictated, whether it's voice recognized or whether it's structured templates, not a good correlation between the documentation method and the quality of care.

People advised us not to...and consequently advised us not to prescribe any one method of doing that, and that seems good advice. We try not to be prescriptive, just in general. There were some hopeful things. George mentioned NLP, natural language processing, seems to be getting better and better and is able to extract some of the content that can be turned into structured code from unstructured text. Presumably with good oversight by the human who spoke the words. The other thing that can be used as an efficiency tool is voice recognition. That also gets better every five years, but we're also caution there that works well for some, other dictators can be taught to make it work well, and there are some it just doesn't work well for. But where it does work, it can be an efficient way to get unstructured text into computers.

So, one of the recommendations actually was the DOD said, well they played with both sides, both the extremely structured and were...basically people walked out on them or extremely unstructured where you can't get any information to do reports on. And so they came up with a hybrid, using voice recognition where you would like to have the stories in the unstructured text; NLP to get out some of the data in structured form and guidelines directed structured text and templates to make sure that you support the care process for conditions where guidelines existed. There was an interesting suggestion that sharing notes with the patients, a la OpenNotes, maybe one corrective...self-correcting way. As you know our...so, the challenge is how do you know something's accurate? Well, the two parties to that transaction are actually the provider and patient. So, we have not tapped into that other person in years past. That might be a really way to not only make sure notes are accurate, it sort of...well, it's transparency, it's the working transparency.

If we remember the...at least the HIT Policy Committee, we talked about sort of three levels of checks. First, there's the individual or individual organizations accountability and ethics to do the right thing. Failing that, you have social mores that say what...how should you behave. It's really peer pressure. And failing that, there's government regulation. So basically, elected officials and appointed officials saying, hey look, this is what society needs in the public's good. So we talked about trying to use those levels as necessary, based on the lack of information and the concern about the accuracy of the notes and effectiveness of the notes in the chart, maybe it's time to at least move to the second level. Meaning we can't count on each and every person to necessarily have the best notes, but, if we expose it to mores, people who care and relate to that note, then maybe we can use the social mores or the peer pressure to make sure that notes are accurate and readable and useful.

So, I thought that was one of the most interesting comments, and it is one of the things that could be put into the Meaningful Use Program as we go forward. Let me turn this over to others to comment on either some of the high points that I haven't covered that struck you from yesterday, and then we will turn to sort of draft recommendations and work on those things. Charlene, do you want to start, maybe we should just go around?

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

Okay, on the...one of the topics that came up, and I think something we have to grapple with is that the purpose of clinical documentation is to document that you actually did it. So that mores, that teaching, that unless you...if you don't document you didn't do it for legal purposes, for billing purposes, and even as the clinical people look at using the system to take care of patients, there is an overriding feeling...overriding requirement that they have to document what they do. So, we can't forget that. And I think there is a gap and there's a tension between, and I know this, systems we develop, we develop them to help providers take care of patients. Yet on the other hand, there are tensions because that's the same system, if it is the legal medical record, has to be used for that purpose and has...and there's a different set of requirements. I'm not sure what to do with that piece, but again, I think that's one thing that we have to struggle with.

The other piece, and again I just listened and I'd like to hear other people's reaction to it, as I think we had a very powerful third panel, when they were trying to wrestle with the balance between data that you need to capture for taking care of patients and data you need for secondary use. And we see that every day, even in stage II with tension between what we're trying to support our customers in terms of helping them advance to Stage 2, at the same time use that same data to report clinical measures. And the two don't match yet. And so sometimes you have to negative chart, and as soon as you add extra steps into the process, then it causes a lot of angst and more education and those types of things. Because if you have to tell people well you're doing this because you have to report to somebody, you don't get a lot of acceptance on the frontline. So that's the other piece. And I'm not sure what the end learning's were except it's got to be a balance between those two and how we get there, but I thought that was a powerful panel.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Thanks. Amy?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Yeah, I think what struck me, and I talked about yesterday was, I think we do need, as we move down this road, to come up with clarification around what we're defining as clinical documentation and the issue between notes and other components. Because as I said yesterday, I think that there was...people were using...some people had a narrower view and some people had a broader view and I think to me, the clinical documentation is the whole record, while the notes part presents their challenges in and of themselves. Then I would agree with Charlene, I think what really struck me is the concept that it's not just so easy to take the data in the record, and it does not automatically align with the measurement and other purposes and how to really balance that. And again, from a public health perspective, not just from a quality measurement, but sort of them being able to have providers use it for a patient panel population

measure, all the way up to a community level measure, so...and a community assessment. I mean, there's so much important information there, and it is primarily to take care of the patient. But, I'm still of the philosophy, collect once and make it easy on the provider and use as many times as possible within the constraints and understanding the data.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Leslie?

Leslie Kelly Hall – Senior Vice President – Healthwise

I too also was struck by the idea that patient notes being available and useful and I think we heard that in the patient generated health team too, from Geisinger about medication accuracy. That coupled with, we heard over and over again, it can be documented...things can be documented in new ways and not have to be re-documented, by allowing for devices to be automatically, and maybe maximizing the standards for device integration, and also maximizing the opportunity for systems to make available things like results, without having the doctor to have to reenter that information. And then also, the opportunity for patient generated health data to be another contributing factor where that is just part of the workflow and I think that we shouldn't overlook it. We heard many, many times about the burden being pushed on the physician, yet, we also heard that the only evidence you have is with the patient either says or you observe from the patient or the device or... So, I think we should encourage and perhaps maximize those alternate data entry ideas as a way to relieve some of the burden of the physician.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Good. Liz.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

I think, certainly, all of you have touched on some clinical components of what we heard yesterday. I think we need to be careful around the definition of format. It was clear to me that they want a variety of formats to be available to do their documentation. There's a discussion around is...and Amy said this and Leslie as well, are we looking for reports or are looking for actually a record and how are we going to define that? The legality part of it, from a more practical perspective of everyday managing one of the larger implementations in the United States, the points that they brought out about the legal record not being printable are absolutely correct. So, it's very, very frustrating and we need to be very careful with that. I think we really need to take into consideration the multi-contributor model, that this is bigger than just physician documentation. We heard about patients, but we didn't hear a lot about the rest of the clinicians. And yet we need to take that as part of...if we're going to talk about clinical documentation from a holistic perspective, we need to think multi-contributor. And then I think you said it Leslie and others, the workflow considerations, and I know Joe will say this, we talk about this every week on the Implementation Workgroup, is that somehow we have to capture this data without overburdening our clinicians and that is an incredible balance that we have in front of us. So, Paul, I would say the Meaningful Use Workgroup has its work cut out.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Thanks Liz. Larry?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I agree that a lot of good comments are already around the table, a really good day, very full day yesterday. I guess I was struck repeatedly at how much this is...healthcare is a team activity. And, we say that a lot, but I don't think we realized how much we're saying it now and how much we weren't saying it a few years ago. And our definition of team keeps getting bigger. So now we're...the team is the patient, the team is all the supporting clinicians, it's not just a single doc doing everything on his or her own. So, we've really shifted what's going on. And that's coupled with the technology really has changed a lot. And, that really struck me during the legal discussion of, once upon a time, the EHRs were pretty simple. The log it provided of what went in the record when, wasn't all that different from what the user saw on the screen and it was a pretty reasonable approximation to a paper record. And, you know, it didn't look particularly pretty when it got printed, but it was legible and it was a step-up from paper records. And now we have very complex systems.

I was sort of struck by the handout that's really more about physician activity as a summary sheet dashboard, but we see these for patients as well. And if this is what you're seeing on the screen, that doesn't translate very well to what you see as a narrative log of all of the individual updates in the chart. So in my mind, we have two shifting paradigms happening. And especially coupled with the comments of, there doesn't seem to be singular best practice out there. That we're at a time of we need to be learning, this is an innovative time. We probably need to acknowledge how much is in flux, I'm thinking a little bit back to some of the safety discussions. That because things are in flux, people have to really be on their toes and where can we bring technology in to help with that, both help with clarifying the documentation, helping people stay on track and follow good procedures.

In terms of the data side of things, I thought this tension between wanting to reuse information and also preserving the original context, that both of those are important and showed up a little bit in some of the discussions of patient generated data. Now we have a data feed that people in the past haven't considered very much and now it's in the record and how do we track it in the same way we track information from a lab or information from a specialist? So, we don't lose the source. And as information moves across settings, that we don't lose the context or even moves across specialties we don't lose the context, because that might tell us a lot about what was actually recorded. And finally, in terms of the documentation process, as the record becomes more interactive, I think some of the tools we're seeing in other parts of our lives, that let us flag what's important to us. And that the vendors of those technologies are making it less and less intrusive for us to do that. So, some things they track just because we did a search and it knows, well we like to search for these things. Other times, we get...there's a little tiny plus or a thumbs up or something or a thumbs down, you know, next to the thing we are seeing and we click on it and it doesn't review the screen, right, we stay in context, but it's captured something about what we thought was important. And I think tools like that give us opportunities on the clinical side, but we need to figure out how to use them well. And, we run the risk that, so if Amazon tries something and it doesn't work all that well, maybe they lost a few orders. But if we try something that doesn't work well, it's not as glib to say we lost a few lives. So I think the concern here about doing experiments in a way that we can learn that's still safe is really important.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

George?

George Hripcsak, MD, MS – Columbia University

Just to comment on scope. So, I think the scope of yesterday, if you look at who invited and what we were thinking of, it wasn't the entire EHR. So we say documentation, we don't mean "The EHR." I think what it means is the provider's input on what he or she saw, did, thought and planned to do. So, that's what we mean by documentation, which is usually done in notes. As we go forward, we may break that up into other pieces of the EHR. But it's not the lab display that affects documentation, but it's not what we were looking for yesterday. It's also not the summary that we give the patient which is assembled from things that includes the documentation that we me...the clinician documentation that we talked about yesterday, plus maybe some lab results, plus some orders and plus some other things. So, these summaries that we generate automatically are not the same thing as what we were discussing yesterday.

The thing that surprised me, same as Larry, was Chad's comment about the different views. I think that was a very important thing. So it seems that one version of what some people mean by the document is what happened to the patient. And that's CMS knowing whether they should pay the bill or not, or all the insurers, all the payers saying whether they should pay the bill or not. And added onto that is what was the person thinking? That's what goes into the courtroom when you're trying to defend your decisions, so it's beyond what happened, it's not just what happened, but when you knew it and what you were thinking at the time, so that's bigger. And then the third one, which is what I was breaking out yesterday is, whatever is necessary to improve care for the patient. If incomplete information helps the patient, then we want incomplete information, you know, I mean it's like you would think that it complete information is best. I'm just saying that whatever it takes to improve care of the patient, which in that case, being terse might be better than being voluminous. It's TC3 medical student note versus the attending note. So, I think those are three different lines going on. It's a different way of saying we've got to be clear about our scope, not just the breadth of the thing, but what kind of what it is we're trying to document.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...and Paul, wonderful moderation, too. We should thank you for that. I guess on the fascination part, the patient interaction stuff I thought was, just like what they were doing at the break, I thought that was just a very, very interesting experiment. And as you think about it, we just need to do just way more there. On policy for ONC, it struck me there were sort of three things to think about. One was, I had a little bit of a nagging thought when I heard Larry Garber talking about all of the other data fields they needed for transmission to actually have that sort of broader connection of care. And I wonder whether, sort of that whole CCD, CCR and CDA, that whole argument whether that needs to be just subtly re- thought in terms of what the payload is of what we're sharing. And make sure that we're not boxing ourselves in if these folks who are on the frontlines find they actually need either somewhat different or a further set of information that we should be supportive there. I didn't have a good sense of what Don Mon talked about in terms of whether that was fully ready for federal policy. But, I think the...I share everybody else's comment that the eye-opener on some of the legal issues, you know that's sort of a Wild West and ONC would be the logical body, I think, to give guidance there. Maybe even a statement, maybe it's not even a policy, per se, in terms of MU3 but I think it sort of looked like there was a call for something there.

The third thing, I think, is sort of what I sort of see as the elephant in the parlor, which is, large chunks of the note. I think the reason that most docs have a residual distaste for EMRs, so I'm not talking about the folks who are fans and have built EMRs and trained in informatics, because they look at these notes and there's so is so much sort of data that I think is perceived to be billing boilerplate, right. We have these long review of systems; we have these sort of long physical exams. So, I think in most settings, and I do emergency medicine as well, I would say half of the note is of no value, it's just camouflage for billing. I think that's actually something that ONC can do something about. And in particular, all of that comes really to sort of the definition of two CPT codes. I mean, when you sort it and net it all out, it's the X4 and X5 CPT codes, which is, I think, a CMS controlled thing when you get right down to it. I know there's a whole rec process.

So, I think the recommendations we can make is to have ONC think about the definition of those two CPT codes, to potentially enter into discussions with CMS on the unintended consequences of those codes. And I think that would also be a great research topic for the Center for Medicare innovation, to sort of say, can we sort of look at what we've done and distorted with these codes? Because I think if we get that out, there will be sort of, instead of the clouds over EMR and notes, there will be sunshine. So I think, again, that's sort of a very on the street having to read these things, you literally cannot read the notes of many of my colleagues because there is so much stuff there. So, that, I think is probably the single biggest thing we could do to advance EMRs.

Joe Heyman, MD – Whittier IPA

Well, I hope I'm never audited because when I do my review of systems, all I write is completely either a GYN ROS is normal, or I write complete general review of systems is normal. And if somebody asked me what a complete general review of systems is, I would recite for them what I asked the patient over the 40 years, it's the same thing, every single patient. So, my notes are relatively brief. And I guess what I would say is, first of all Paul, I thought you did a great job of summarizing what happened yesterday. I thought that was terrific. I've had an EMR since 2001, it's the same one that I've had from the very beginning, and I love that EMR. And I've always loved it; I love it less since Meaningful Use.

The care I provide hasn't changed one drop because of Meaningful Use, but the burden on me, because of Meaningful Use, has increased substantially. And, that burden, I've decided to ignore some of it, and I haven't tr...and I did Meaningful Use last year, and this year I'm thinking of not doing it. And the reason for that is, predominantly, in order to count how many patients I've done a blood pressure and other vital signs on, I have to give up the ability to say, with one template, that this was a well-developed, well-nourished patient, which is in one of my templates. If I want to count the fact that I have done her vital signs, I have to separately say how well developed she is, how well-nourished she is, and that I did vital signs on her. So, it's a separate thing. Now I understand that's not a requirement of Meaningful Use, but it's and EMR vendors attempts to make it possible to count how many times I have done vital signs on the patient. And that's just one example.

Another example is there's a new field for tobacco use. So, I used to have all the patients already with information about their tobacco use, but in order to be counted, I have to use a new field. So I have to ask that information all over again on every patient. It's those kinds of things that drive me crazy. So, I wanted to...what I learned from yesterday, or at least what I think from what I heard yesterday is, the most important thing about documentation is that it has to be comfortable, in the workflow, for the particular entity that is entering the documentation. So, if it's a social worker, that person needs a special way of documenting things. And if it is a physician, that person needs a special way of documenting things. And they're not the same way, and they don't use the same records and they may be part of the same team, but that does not mean that they have to use the same medical record. So as I said yesterday, I think there should be technology that calls all of the different documents and produces whatever is necessary for the secondary use, without making everybody change their workflows. And without making everybody change the way they want to read a document. They ought to be able to read a document the way they are accustomed to reading it, instead of having to read my document.

The other thing is, I don't think it's fair to put the burden on the vendors to prevent fraud on the part of the providers. I think if providers are intentionally doing something that's illegal, that's a terrible thing, but I'm worried about the unintended consequences of changing the ability to be flexible in medical documentation. I use cut and paste. I use cut and paste for example, I see a patient on Monday and I do a workup on her, and then on Wednesday, we decide that she needs surgery. So, on Wednesday, I write another note, but I don't want to subject that patient to another pelvic examination. So, what I do is I copy the previous pelvic examination into the note that I'm submitting to the hospital for her preoperative workup. And I don't imply that I did that pelvic examination on the same day, it's quite obvious that it's copied from another place, but still, it's something that saves me maybe only 5 seconds, I don't know how much time it saves me. But, it saves me enough time so that I want to do that. I don't want somebody to interfere with my ability to do that.

Also, some people, you know, we use templates for a lot of things. Some people use a template that is the entire normal physical examination, because 70% of the patients that they see have an entirely normal physical examination. And it's...and for some of the patients that don't have an entirely normal physical examination, there is only one thing that's different. So, they take that entire normal template and put it in the note, and then they change the one thing that's different. That's an incredible efficiency timesaver that it would be a shame to lose for those docs who like to use that. I don't use that, but a lot of people I know do use that.

Let me just see...yesterday Paul, you referred to the medical record as "this document." And once again, I think it may be several different documents. And that we don't necessarily have to make it into a single document. So, I'm really interested in trying to find some secondary software that's able to cull all of these different things and pull the stuff out that everybody needs, and maybe that's a health information exchange, I don't know. But, it seems to me that's what the HIE does, it pulls in information from a whole bunch of different places and then allows people to pull whatever information from that that they want to see, and it seems to me that that is a potential answer for this problem.

As far as sharing the notes with patients, I think it's great; I've done it since the very beginning of my EMR. And, in my EMR, it won't count that though, it'll only count if I give a summary. So, because of that now, I print out a copy of the entire note to send to the patient's primary care physician, but I give the patient only a paper summary. And, I've been doing this for a long time, and not a single patient has asked me for an electronic summary, yet. I'm still waiting for some patient to ask me for an electronic summary. I think when there are health information exchanges and patients can just go there and pull a summary, then that's great. But, this idea that meaningful use is going to cause patients to ask for an electronic summary, I think is absurd, and you're forcing physicians into forcing patients to take electronic summaries when they don't want them.

The other thing I'm concerned about is, if you see something in a clinical document and you are a physician, you are responsible for what you just saw. Even if you see it for just a fraction of a second, that will come back to haunt you five, six, twelve years later. And if we are going to give a fire hose of information to physicians from this huge care team, we have to have the ability to somehow give the physician the ability to avoid seeing things that they can't act on. And I don't know how to do that, but, I think it's very, very important because if I have to look at every laboratory document that every other person on the care team has ordered for one particular patient, and I haven't seen that patient for two years, it puts me in a very difficult position. So, I don't know how to handle that part, either. So, that's my contribution to this discussion.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

No, all good, Joe. I'm tempted to react to some of the things about meaningful use, because it's educational clarifying, but I won't right now. Michelle, do you want to add anything.

Michelle Consolazio Nelson- Office of the National Coordinator

No, I think you summed everything up, thank you.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yeah, Charlene?

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

One of the challenges, again, and I don't even want to contemplate being able to do this. But, sometimes for a vendor, it's a lot easier to automate things if there is a standard behind it and if there's a standard of practice behind it. So for instance, especially in the notes field, like are you going to use...and again, we've tried to automate. Each physician kind of has their own nuance of how they want to capture family history, and so it's really hard if there's not a standard of practice out there. So are we going to use SOAP notes, or are we going to use those kinds...I mean, this has been Larry Weed's mantra for how many years, so many years. So anyway, a challenge in the field is that there is not a standard practice in terms of how notes are captured. And when I...when we were doing that notes piece, again I looked at all of the different formats that notes could be captured in, and it is all over the place. So, we will get back comments that...well, tell us explicitly what you mean by a note, right, and I'll look at them and say, okay, for what practice for what discipline, so, I think that's a challenge.

So again, if we would say, okay you're going to document using a SOAP note format, vendors know how to get a hold of that and we could do that. Not that I am suggesting that, because I know the pushback that we would get on that, but that's another element here, as we try to look at how we move forward in this area.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

True.

Leslie Kelly Hall – Senior Vice President – Healthwise

I wanted to comment on what Don said. I think that Don Mon did talk about the RNs ES standard, and I think it's in the CCHIT certification as a "may" instead of a "should." So I think it's worth investigation to see about creating that and maybe taking it a step further so that a standard not only defines the function of the EHR, perhaps a standard viewer on top of the RMES, would then say, hey, if you've met a standard to create a viewer on that, it's good as gold, we're done. Because I think that getting down into the specificity of what that medical record is or is not or who captures notes in what way, is a rat hole that's intractable, but perhaps using the work that Don mentioned in the CCHIT certification and coming up with a standard viewer might help us with legal requirements, so, it's something to consider.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Now, I think...this was really...I think we covered a lot of the highlights from yesterday and it was a really good summary. Now, if we could move towards sort of draft recommendations. I think...and one of the goals is to, one, not be burdensome, two, not be prescriptive, three, the sum total to have a parsimonious set of things that would address the issues that are before us, hopefully advance the utility, the usefulness of the medical record and allow for innovation. And it's really hard to do those things all at once, but it's good when we do. So one of the examples that I did bring up in terms of this transparency...so one example you said, Joe, is you would like to bring forward...the thing...people talk about...I think what Chad said about, you cannot represent the dynamic review, either the record or it's review, on a printout. And remember he mentioned this example of, and one physician said, this is not what I saw, when in court they were looking at the printout from the EHR. And I could very well imagine that because in theory, what you're tried to do is spit out everything out that is knowable, but that's actually not what's necessarily viewed by an that individual at the time. And that's just discontinuity.

So...but when you...but it's very helpful for the physician who's making the decision, even on that patient that day, and the future people who review that to see everything in one place. That's why we copy things into the record, but it's not in a format that's usable. When you say you copy the pelvic, if you say something like, and the result from my pelvic from 2...okay, so that's essentially data and time stamped and everybody knows exactly what you are doing, saying because now this person is in hospital, I just want to let you know, and it can be in place, what the pelvic was when I examined her a few days ago. That's very useful. And you would not object if everybody knew you copied that thing from the previous...because you say that. So, here's an idea is if we could, and I think it showed up in somebody's written testimony, if we could just like Word documents, track changes, if you could color code, well, when you bring that forward, it turns...it's in red or whatever, which is your same intent, it just makes it very clear. The other thing that makes it clear that is if you -- pardon me.

Joe Heyman, MD – Whittier IPA

There's a problem with that. When you print it out, it's not color-coded.

Paul Tang, MD, MS – VP & CMIO – Pal Alto Medical Foundation

Well, we will get to the details later. Because you can actually have the bar and there are black and white counterparts there actually that do show up. And it can be underlined and all kinds of things, but, if it's heritage could be there, then all the good things done for it would be there. And also, if you do have this "normal physical," and you see the green that is the one you changed, that's also visible. Because the big problem with copy everything is that you can't find what's changed, if anything. Another piece that's a little bit of a side tan...but it's one thing to copy the same way you write the physical every time, you'll know what to change and where to look. It's another thing to take systems, you know, some standard somewhere, this comprehensive exam and say, that's what I do and att...because it's probably not true. So, there are ways. But, that's in a practice...

Joe Heyman, MD – Whittier IPA

...solo practice.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yeah. Well, anyway, the idea is to make notes transparent and make your actions transparent. So, the whole track change in terms of when you copy forward or you're copy and paste, it is known, whether it's color or sidebar or whenever. And that it's shared with people who were party to the discussion and have a vested interest. And that's why there patient sharing is so useful. Not only will you correct errors you actually made and would like to have corrected, but then there's a bit of...so it seems like that's something that is one, useful to the care, useful to the party with vested interest, the patients, and self-correcting in terms of errors and incomplete notes. And the legacy helps make it very clear to everybody what tools you have used and people can judge whether it's appropriate. So I'll just put that as one draft on...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

This is Liz Johnson. As you talk about that...did you want to say something George? Go ahead.

George Hripcsak, MD, MS – Columbia University

About that particularly. So you know we have that. I think ECLIPSE has that. So, it took a lot of work to get that out of the system so we didn't have to use it anymore. So they use RTF as the format and I forget...I could call someone at a break and ask what went wrong...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay.

George Hripcsak, MD, MS – Columbia University

But, there was...the details of how it actually came out to the...I forget what went wrong with it, but we moved away from using the RTF and from allowing the...I don't know if there...it's not that there were bugs, but odd things happened when you copied it. I forget what went wrong exactly.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So it's possible that something technical went wrong, but the concept was not necessarily...

George Hripcsak, MD, MS – Columbia University

You know, having a log of what changed for special viewing I guess is possible. Like in other words, just a fancy form of tracking changes. But, what you want to see is not that. I think the main thing was people couldn't tell...people couldn't...I think one of the problems, they couldn't read the record anymore, because they couldn't...I know that in theory...like have you ever tried to read a very marked up document and try to interpret what's going on clinically? It's just is distracting. But there are other things wrong, too.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

But, Microsoft fixed that too, because you can accept...

W

...it turns off and on, right.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...it turns off and on.

George Hripcsak, MD, MS – Columbia University

...show final only...

W

That's another step.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

But anyway, Liz.

George Hripcsak, MD, MS – Columbia University

I'm not sure I'm ready to put that on any vendors.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

So, there's two or three things, and I really like where Paul is going with this, but... First of all, the functionality does exist. If you have a Microsoft-based product, you can copy forward today. We don't tell people that because the legal ramifications, I'm just going to be completely blunt. But they can do it today we watch them do it. So what we want is to do exactly what you said which is identify that you did copy...be transparent about it. Say you copy forward for the right reasons, you don't want track changes on, because that does interfere with your ability, what George was talking about, to read the content, so we want to do that. I can tell you where we're getting push back in the field. We're getting push back at the academic sites because they're concerned that the residents and interns, this is again candid, will copy forward and not do the assessment. So, we have to work with that internally and not regulate that. We need to work on the process, so when those concerns come up, what I say is, let's talk about the intent of caring for the patient, not about an intern or a resident that didn't do particular work.

The second piece that we haven't talked about yet that comes up along with this, which is patient readability. One of the things we've got to deal with somehow is that translation factor, because many of you are physicians and as a nurse, I have been reading those notes for close to forty years and I understand the intent or where you are going or even if you leave parts out, I've got it. A patient does not. So somehow as we talk about this, and whether it's a separate topic or part of copy forward, because if you're changing, like Joe you said, the assessment you've done has not changed, I've had the same OB/GYN assessment for 15 years. I want you to reaffirm that and then I want to be able to validate it, not as a nurse, different hat, but as a patient. So we've got to deal with both, and I like your idea. I was very pleased yesterday, Paul, when you were...counter to the panel to say, does everybody want no copying forward or is that a universal truth or one that we want to debate? And I think you're there.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

The other thing I think we need to think about is, if you're making it transparent what's been copied in forward or what's been changed, is sort of under the whole feedback from the patient. I mean, if there's an error, the patient claims there's an error that is different. I mean, under HIPAA and other, there is a whole patient amendment to a record process that I think we haven't really talked about and I didn't...I forgot to ask them on the OpenNotes, how they're dealing with that. So if you're hearing someone dictate in the room and you have a discussion with them, that's one thing. But if you get your record later, you look at it, and then you want to make a formal change, I'm sure there are different processes all over the place, other than general guidance. So, I don't know how the systems handle that now, but I think that that's a different category, and we need to remember that, especially as we're moving to more patient transparency and a way to make that obvious. I mean, you know, in the old days you'd cross the line through and initial and rewrite and whatever. But, I just think we need to separate and think through as we have the conversation, chunk this down into smaller bits.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Of course in the, I hate to...I mean, it's just the product I use, Microsoft Word, each annotation is date, time and owner stamped, so, it could be a patient correction, date, time and it's by the patient.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

I mean, we don't need to get into it now, but there are times where patients will want to make a correction, the provider may or may not agree, providers don't have to or have to accept. I mean, there are formal processes in larger institutions anyway on how to submit a change. So, it's not a simple...if we're talking about, okay, once that whole process and policy has been done and then the change is made, I just...I think that there's a difference between knowing that it was a...or even documenting a patient request to make a change, whether it was or wasn't changed.

Leslie Kelly Hall – Senior Vice President – Healthwise

The whole process has to be considered and I think the work that Larry Garber and Holly Miller and crew have been doing has been with that in mind, that all of the providence is recorded as associated with the record of the patient.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Don.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Two quick technical comments. So one, I think it's not...we have to make sure, it's not really Microsoft Word, it's the operating system, right, independent of the application, that through the clipboard supports cut and paste. I mean, you can disable operating system functions, but I think in terms of an MU spec, I mean, I agree, I think it's an entirely reasonable thing to have a time stamp as being part of an MU spec, that that's an option. But in any language that would be written, I think making the distinction between the operating system and the application just has to be there. On the patient feedback thing, I mean, patients already have, in Meaningful Use, they have multiple options for getting their note and their chart and their summary and every morsel of information. So I think again, the technical point there is what we're really talking about is simultaneous to the generation of the note, getting this information, I think.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Nope.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corp

No? Well the OpenNotes stuff is a little bit different. But, what I heard was part of that was, you know, I show the patient the note as I'm generating it.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

I think OpenNotes is basically it's after-the-fact, you just have access to it. What it can generate is amendments or corrections and that goes...there is a process and actually it's online for us.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

(Indiscernible)...people have always had the legal right to look at their notes, so this is maybe more of a formalization of making it more accessible...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...far more accessible.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Right, but they've always...and Meaningful Use 1 and 2, I think, both have provisions on capturing that data, so I think...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...not notes. It did not specify notes, we never have.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

But there was some discussion yesterday about dictating while the patient's in the room and it going in right away, I mean...and I've actually been in a personal situation where at the end of the visit, the provider's dictated and it's gone right into the computer. And I've been there so if I wanted to change something I could have. But...so I think, we did hear that yesterday, I think that's different than OpenNotes.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Right. Okay, Joe.

Joe Heyman, MD – Whittier IPA

Well, two things now. My EMR allows me to use templates and also to use free text, but I don't dictate. So, the history of the present illness, a lot of times instead of using a template, I actually type. And I think that's important, so that's why I'm worried about flexibility, let's not say that it has to be one way. The other thing I'm a little concerned about is if we start to move down the road of documenting that something came from some other place, that's fine with me. The transparency part is not a problem for me. What is a problem for me is that every other move that we have made with meaningful use has meant some extra work for me. And if this is going to be a recommendation, then right at the very beginning of the recommendation should be, there has to be no change in the way the physician actually does this without...I mean without. You understand where I'm coming from; I'm worried that something that took me only 5 seconds to do will now take me 20 seconds to do.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay, so you are opening the, I think I need to respond to that, because, it's an educational opportunity. The things you've been describing sound like they're vendor induced. Let me give you an example, so...

Joe Heyman, MD – Whittier IPA

No, the things...I understand that.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

And they didn't have to be, that's the issue. So to fulfill meaningful use, and probably the biggest issue is the clinical summary after the visit. Many vendors code it so that you literally have to get a print out. That was never in meaningful use; it was only that this capability be available to all your patients or "X" percent of your patients. And the fact that they forced people to print things out and then had to litter the parking lot, is a vendor-induced burden.

Joe Heyman, MD – Whittier IPA

Isn't there a requirement that...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

No.

Joe Heyman, MD – Whittier IPA

...a certain percentage of your patients?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Be provided. So if you have a patient portal, for example, and it's available to everybody, in our case for example, it's available to everybody except for the adolescents, because of state laws. Then it is the percent of our patients who can take advantage of this and we make it available to all of those folks, is what the ratio is. So, it has been some vendor's interpretation that you must force the doc to print out, that was never true... never true in meaningful...it was never true anywhere, and that was, you know what I'm calling a vendor induced burden that was placed on many, many, many providers.

M

I think it's a little more subtle as well. I'm hearing Joe say, he is used to give them his note. But, the note isn't the summary, and so he now gives them the summary because that summary is the thing that's being counted and giving them the note isn't being counted.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Now, did you also...do you have a portal in your EHR?

Joe Heyman, MD – Whittier IPA

I have not a portal in my EHR; I have a separate website that I share information with individual patients.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

And does it have the elements, which are very basic in Stage 1, problems, meds, allergies, that kind of stuff? Does it have that information in there?

Joe Heyman, MD – Whittier IPA

No.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Well, then you didn't meet it. So what you have to do, in that case, and I don't want to get to honed in on this, but I did want to, for public educational purposes, say that a lot of the burden, and accept a lot...there is burden to meeting the objectives to get the incentive money, but much of the burden that has been complained about is actually induced by vendor misinterpretation...

Joe Heyman, MD – Whittier IPA

Let me just say this...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...not maliciously.

Joe Heyman, MD – Whittier IPA

Paul, I don't want to get into a debate over it. But, regardless of whether it is a vendor misinterpreting something or a physician misunderstanding the thing, the fact of the matter is, the burden has increased. It may be somebody else's fault, but it all goes back to the meaningful use requirements. So I think for whatever reason...I was at a big eHealth initiative...I don't want to do this. Never mind.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yeah, I just wanted to help clarify and to the extent that we can make recommendations about the program and more education, that may be useful. Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So I want to pick up on an earlier comment that George made about the rich text format that was being used and that they had to back off from that. So, Kindred was in a position of interfacing with a system that was using markup stuff in their notes to do cross-outs...to do a cross out. So, you could edit...you could go in and you could put a line through something as a way to update a note to say, that was wrong, like a transcribed note that you are editing, you could put a line through it. And in their system, that was terrific. When they generated an HL7 version 2 message to send that note, as a MDM I think, just a narrative blob of text, the note...the markup disappeared, and so the cross out was now the pre-cross out was what was transmitted. And so it required that they update their system, that when they generated that MDM, they had to take it out of the note and you would lose the information that there was a prior note that had been edited. But, at least you didn't have the wrong information in that note. And so I think that secondary uses, in this case, sending somebody a copy...an electronic copy of the note is a pretty important use, was being messed up, because there wasn't a standard for the markup language to communicate this and when it got shipped out, the markups disappeared.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Presumably, that's how...that's what RTF would fix, so, again...

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well if everyone was using rich text, it would fix that.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

And that is a standard. So we can't...

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

No, it's not a standard.

W

It's an option...

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, it's something for our standards folks to come back on. We could not get agreement with vendor on their markup language.

Leslie Kelly Hall – Senior Vice President – Healthwise

Rich text issues...rich text issues as well as more other complex media inside an EHR will only compound. And so, getting something addressed early on, before that confusion is increased, is important. So whether it is a line out or an insert of a video clip or a fetal monitor strip or it's a particular iPhone app that you've recorded the patient, multimedia of any kind, enriched rich text, we do have to allow for the evolving nature and not be based on our legacy green screen and old models of Windows, which are still in place.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

George.

George Hripcsak, MD, MS – Columbia University

...testimony from people, because people have already done this. If we wanted to put this as a requirement, we would need testimony to say what goes right, what goes wrong, what would it cost for everyone to do it. Is it feasible, are the standards there. So it would be a larger process. I mean the recommendation...the objective would be more general, that you have to have a...you have to track where things came from. I don't know what it would be exactly, but something like that and then the implementation might be something like RTF or something. But I think that from our experience, I think it's at the point where we're trying to figure out how to do it, so I don't think it's something we can really mandate yet. But if we wanted to go ahead with it, we would certainly need the people who have done it to come in and tell us about it.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Right. Okay, other draft recommendations? Parsimonious, non-prescriptive, addresses the key problem without introducing burden on the doctors, except where vendors...

M

I think, too...yesterday David, I mean, one is continue Stage 2, yes, we should have clinical documentation in meaningful use. So that's the first affirmation that we should keep clinical documentation in meaningful use. So, that's one thing that came out, I think. Two, pushing, sharing, perhaps of the actual notes, not just a summary, to actually have doctor's notes available...provider notes...eligible professional notes to patients, which is different than saying the clinical notes. I mean, different than saying the summary has to be available. So that's something we could recommend. It doesn't add any burden, it just makes them available to patients, it doesn't change what you do other than if you want your notes to look better to your patients. So that's the second.

Joe Heyman, MD – Whittier IPA

You know, I'm a physician; I have no problem sharing my note. But I don't know what social workers put in their notes about patients, and that's going to be part of the clinical documentation and I just think that we need to think about all of those other members of the team before we go suggesting that the entire thing be transparent.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Well, and I know this is an issue in behavioral health, with behavioral health providers, concerned about sharing notes and for certain patients it may induce...that patient may take it and it may induce harm to the patient, more harm than good.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Well as you know, there's...one, the rights were there for HIPAA anyway, and two, the exclusion for mental health had been there even predating HIPAA. So, I mean, their portion of this is covered, so we have to accommodate the existing law.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

And even though it's covered, they're still going to...there will still be push back is my point, particularly possibly from that community.

M

Maybe we could refer back to the law, actually and say, in accordance with HIPAA, these things should be made available.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Right. Leslie.

Leslie Kelly Hall – Senior Vice President – Healthwise

The other thing we talked about or heard a lot about was this idea that what shouldn't be in the record but is material to care, like the collaboration platforms or communication platform that is not necessarily an institutionally centered electronic health record, but a collaborative care platform that can communicate with it. So in other words, I'm a recipient of this shared care plan, I'm a participant in a shared care plan, but that does not necessarily have to be housed in entirety in every single EHR. How do we think about that? So if I have a collaborative record and I'm in a different app, I can send it to the EHR so it's there, it's posted and noted. But to have that idea of a collaborative care record only being housed in a single institution with a small team, I don't know how that could be done. I didn't hear a lot of solutions that were EHR centric, did you guys. So, I've got my mom and me and the whole care team involved in this documentation or in this creation.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

It's a great point. I think as I look at Meaningful Use 3 and 2 frankly, and we talk about the care plan...the care team, if you think about the measure around summary of care and the disposition of information, that issue's coming up anyways, because we're already trying to figure out the definition of care plan. You guys, you know I am talking about again, my day job, when I'm trying to make this work at fifty places. And when you talk about that, I guess I want it, I want it for all the principles we all understand clearly. I am struggling though, with the how do you manage that...how do you take care of the patient first, you know meet the true meaningful care piece of this, but then how you, from a legal perspective, protect this.

So, I think about Joe, I think about a lot of our places, you guys, many ladies in this room, we practice. So, if that stuffs out there and we are not acting on it, I think about what Joe said is, now it's part of the record. Sorry, I don't want to squelch the enthusiasm, but I think we better be realistic, let's say the Meaningful Use group comes out with a set of recommendations that say that say that's our goal, depending on how much leeway you give us and how ONC interprets it, then we're now facing a requirement. Vendors in the room, you need to think about this, too. Now we're facing a requirement to try and somehow encapsulate that or connect it and manage it. So, I don't think we are talking about anything anybody in this room doesn't already understand, but the dilemma that we are creating is pretty phenomenal. Sorry.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yeah, no...let me see if I can...Joe brings up a...it came up yesterday and Joe brought it up again in terms of...there's been a lot of good intent to think of the clinical documentation holistically, and we're all part of the same team and it should be altogether and it just sounds so good. But then when it was mentioned yesterday, and Joe repeated it, it's not like the social worker necessarily wants to read all the other stuff or that cardiology wants to read...so on and so forth. Because actually there's an efficient mechanism of getting the information relevant to that particular profession and perspective, so that it gets communicated.

Leslie Kelly Hall – Senior Vice President – Healthwise

But the patient wants it all.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

I understand, but that point is interesting. And then Joe's comment about, gosh, should we be regulating what the social worker's share what they write, because that could potentially be a lot more sensitive and a lot more disclosing.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Definitely.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

I guess one of the outs we have is that they're not an EP, correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

That's right.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Correct, that they're not an EP. So in some sense, we don't have to touch that part. So this would really be regulating the EP's notes.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Which would be much smaller...?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Which would be much smaller, but it's one of those things, you know, let's not throw out everything...not do anything...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

That's right...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...before we do something. We do understand how important the provider's note is, and let's move, but I think we have to look at all the unintended consequences as we move in that direction.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

So we don't get....

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Is what you are suggesting, Paul, that the EP notes be available to the patient through the portal or like...I'm trying to...or, must be available to the exchange electronically to another EP? I mean, I think we need to sort of hone this in a little bit to where we think the value will be.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Right now, the thought is the OpenNotes concept, which is making the progress notes of providers, clinicians, available to the patient.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

So that would...that could...and we wouldn't say how. It could be through the portal, it could be through...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

However, they...right...the...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

(Indiscernible)

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Right.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...outpatient. Just...right, so if I'm in the ICU on a ventilator and I have 3 inches of notes, because of all the sort of the complications and stuff...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Well, you're...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...it seems like it's more of an outpatient thing, or, maybe not.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

I think it is more useful in the outpatient, but that doesn't mean it's not useful...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Right.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...in a...so where...the place where this would fit in, I think, is what we call clinical summaries, which is what patients get after an encounter. An admission is an encounter, an outpatient visit is an encounter, but they have a clinical summary, including what the doctor or the nurse practitioner or whatever the provider writes.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

And I agree with Paul. I think the reality is, today the patient has the right to see the notes you're talking about. They may not understand then, but if an inpatient...and in fact, so, I'll put on that sort of real life hat, I frequently get called on by my family, just like each of you does, to go in and read all their notes to try and translate to English what the heck's going on. We've all been there. So I think that Paul is right, where we need to focus first is that we make motion forward is, on the summary piece of it, recognizing that the part you're talking about is in place. It may not be perfect, but today, you can see anything in your inpatient record you want to see.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...got a requirement already or not, a discharge summary requirement...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Yeah, it's been a requirement for years.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...obviously not...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

...yeah, for years it has...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...of great interest to most people.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

People don't know how to access it and they...and clinicians frankly are often resistant to allowing it to happen out of fear, not out of really wanting to prevent the patient from being engaged. We're working on that every day, have been for years.

Joe Heyman, MD – Whittier IPA

But I do think, Don, I understand where you're coming from. I'm sort of amused about where you're coming from. But, I do think that without bringing it up as a possib...I mean I think you're going to get a lot of resistance, is what I'm starting to say.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

In the inpatient specifically or are you talking about OpenNotes ...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

I think...you know, I don't know. I mean coming from the AMA point of view, which I'm no longer representing, it just seems to me that there'll be some resistance to the idea of just opening up notes. And I can tell you that I don't use the word obesity in my notes anymore, because I give them away. So, I may say the patient is heavy or very heavy, but I don't want to offend. So, I mean...and maybe that's not even appropriate, but that's what I do. So there are things that I have changed in my notes because I give those notes away.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So I think...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

...that came up yesterday, none of us jumped on it, but I think we all heard it. One of the comments from the panelists was about the fact, will this impact what clinician's document? I think there's a reality that you're right Joe, but on the other hand again, I want to see us go forward. So hopefully...what they're modifying is only that they're still being transparent in putting everything in, they may not...and we have this today, the side note that says, patient's husband is extremely difficult, blah, blah, blah, blah. We don't put that in the document anymore. We need it to care for the patient, so that we know how to manage that person effectively and protect the patient, but it may not show up because of the le...it's reality.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...are already pretty careful about what they put in. I don't...I mean, I'm very reluctant on obesity, frankly, because I'm looking at the jurors, if I'm ever sued...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Absolutely.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...right, in Philadelphia. I mean, I'd have to be nuts to put in anything that a juror would find objectionable, right, on the get go. I think you...that didn't come up in secondary uses, but you've got to be...I mean, you want to be pretty heads up about what the bigger world is for these things. But I still think there's something we could do about making it easier or facilitating the transparency, because that may be...just the clarity is probably good for many, many reasons. I don't know what that language would be...as I'm listening to this, I'm not sure what the regulatory language would be so that they'd...I guess maybe to also provide that note as a feature, would that be the thing? Or...I don't know how to put in, looking at the same screen simultaneously, but maybe just having the note in toto as a...

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

I just want to...as we talk about notes, George said something yesterday and there was some discussion yesterday about new ways of doing things. And if it's possible, and I'm not saying that we want to drive toward this likelihood, but if it's possible that the Wikipedia Google Docs, shared document could be done, right. Let's just say somebody does it. Because payment models might change...somebody...and the note, as we think of it, SOAP, goes away. Let's say some facility does that and everybody makes their entry, and I'm picking a word instead of note. I'd want whatever the recommendation that comes out of this group to be compatible with that and not prevent it, right. So, this is the unintended consequence of saying "the note" must be shared. Well what if there is no "the note?" So just...let's be thoughtful about that, so that we don't prevent the innovation that we'd like to allow for.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Well that was going to be one of my questions. It would be helpful to distinguish between...I mean, I understand what a note is and whatever. But, wouldn't a clinical summary be very close to what...No.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...it doesn't have...progress note.

Joe Heyman, MD – Whittier IPA

There's absolutely almost minimal...the only thing that's in my clinical summary that's the same as the note is the history of the present illness and the plan at the end. Those two things appear in both my note and clinical summary. And, I don't know what somebody else's clinical summary looks like, I only know from my own EMR. But, everything else in the note is different. The physical exam doesn't even appear in the summary.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

And so now, I'm going to just be a little...

Joe Heyman, MD – Whittier IPA

So if I said there's a lump in...

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

...provocative and say why don't we try to merge the...

Joe Heyman, MD – Whittier IPA

Amy, if I say there's a lump in her right breast and lump was in the left breast, the patient wouldn't notice unless it's in my plan.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

And that wouldn't be in a clinical summary?

Joe Heyman, MD – Whittier IPA

It would not, it would not be in a clinical summary, it's part of the physical exam.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Okay.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So, it sounds like we are fairly uniformly behind this. Let me try to draft an objective and then we still can, at the end we'll reconsider all of the things we come up with and just do a reality check. So, the objective would be that, it's twofold. One that notes...that documents of the clinical encounter, however it may be, today or tomorrow...

M

(Indiscernible)

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...documentation...

Joe Heyman, MD – Whittier IPA

...of the clinical encounter...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...documentation of the clinical encounter, that's between a patient and the healthcare teams, as part of certification criteria, the vendors would produce, would make visible the providence of the data. An example of that is the Microsoft track changes, and, that can be called so the view...the thing that's viewed is the current version of that document. At the click of a switch, you can see the providence of things. So, this deals with the readability, just like in Microsoft Word, you can turn off all the comments so you can...so, everyone has an unobstructed view of the most current documentation of that encounter. But, the providence is viewable by the touch of a button. So, that helps with the transparency for people who want to know, even if you're looking at, did they really have a murmur, I know exactly how that physical got there, and then I can adjust my probability of that being accurate. And then, to address the interface, the interface is the clean document.

So, that means that the vendor controls everything, however they want to do it, inside of their system, and from the outside world, they spit it out like they do now. So, the same standards they use now to get this clinical documentation to go from their system to another is used. And so that should avoid this problem of creating not agreeing on the edits. The second component of the recommendation, it's a different meaningful use objective, would be that patients have the ability to view the documentation of clinical encounters. And, we haven't talked about menu and that kind of thing. But, that's just something to put on the table.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

When you say ability to view, Paul, are you talking sort of the universal ability in the inpatient, in the ambulatory? And, what are you thinking on that?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So, the same way that they have the view, download, transmit; this is just another component, another section of things they are able to view.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

So, I'm just going to try and translate. So that would mean that I would be able to do what Don was talking about earlier which was, I can go and look at my ICU notes.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

And more importantly, probably in that situation, your family members, your personal representatives, could see that too, and can be much more involved in the care. That's the direct consequence.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

And the clinical notes then potentially could be defined as, and this is where we get into that EP sort of definition, because that would be NP, PA, doc, versus social work nurse, not EPs.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So right now, we're only covering the EP, because in a sense that's the only thing we have jurisdiction over anyway.

Joe Heyman, MD – Whittier IPA

...hospital...right.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Well no,...it actually does...

Joe Heyman, MD – Whittier IPA

I think also Paul, you used the word clinical encounter, which I think that clinical part is important, because there might be other encounters that are not clinical.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Be specific, Joe, what do you mean?

Joe Heyman, MD – Whittier IPA

Well, I was thinking in terms of, say the social worker calls me and tells me they're worried about a patient of mine being a pedophile. That would not be a clinical encounter.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

And that would or would not be included?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Would not be included because it's not...

Joe Heyman, MD – Whittier IPA

I would have to record it.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

That's what I...

Jodi Daniel – Office of the National Coordinator – Director of Policy & Research

This is Jodi Daniel. There...I mean there are other laws that protect that information, so you probably just need to be able to have ways of putting something not on view, selecting things that are not to be disclosed, and that might be a capability that you'd have to build in, both for other legal...for legal reasons as well as for...some of...kind of circumstantial reasons.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

But Jodi, you're talking about protected information categories. I think what you're referring to is protected infor...so to make it real simple, think about HIV status. We've all dealt with that one, it's a real universal understanding and there many other things I think Jodi's referring to that fall into that category. Fair...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Paul, the providence section of your statement, how do you know where it came from? Like, if you have a thick client system then maybe the operating system can say okay, they've cut from there and pasted to there, and the clipboard will hold some context so you could figure that out. But if you have a thin client system, let's say, using an EHR that's a web browser, I think it's just like...it's as if you typed into the...the paste is as if you typed into the keyboard.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So, maybe this is a good example of we should turf some of the implementation to the standard skies.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Absolutely, I think there's a zillion ways to get right...it's by definition, computationally fungible right, that's what computer science is about. But, I think you could have a thing that there is an option to put in a specific providence note, right, that would be your sort of like absolute lowest...least common denominator thing. I was thinking about the same thing George was thinking about and I'm thinking, so if I'm sort of a doc who wants to get around this. I mean, it's not my personal style, just because I'm confused enough with what the patient's telling me right now, without trying to bring in stuff from before, but, so what do you do with templates, right, because a template is, in essence, a cut and paste, right. But yes, it's the guideline, it's the standard of care.

So, how do you know...right, because the logical correlate of that is, I want to flag what was in the template and go from there, because that's a cut and paste. And I think that's sort of part of the problem that we had talked about earlier, which is that the sour taste of EMRs I think in a lot of practicing doc's mind is just because already today, skip what we call cut and paste, there's all of this non-content from the level 4 and 5 codes. And I think for ONC, if they could talk to CMS, get that out to either to the coding process or maybe at least even through the CMMI, study the implications of these review of systems and ten-organ physical exams, that would be a great, great advance...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Which is, I think, another recommendation we should talk about? But, let's first talk about the providence. So, I think if you do pull in the template or any other phrases, that should be audited somewhere so I could know, this note was constructed with the use of template 235. That's a good thing to know. Now again, it does not cloud what everybody views, we just know what happened and providers would know, we know that's the part...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Well, just to give you a concrete, some people have templates separate for each part of the body...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

It's in this log...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...so it would just...so, we built a system 25 years ago, that besides automatically coding CPT, had 20,000 lines of code, so you could dynamically put in pieces of physical exams that were all done, based on age, sex, chief complaint, you could sort of knock out the normals and the abnormal. You can...the nature of the data that you can, sort of, like half template, right. And again, all of those things were user selections, so they were conscious user selections, because we were very sensitive to this cut and paste issue. I think it is just a soft...if I select grade 2/6 heart murmur as a phrase, is that a template or not?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

It's something that was pulled in that you did not type and if it's accurate, there is nothing...there's no concern.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

I mean, what does the...of text, right. You have AutoCorrect...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

But when you read...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...is that a template?

Joe Heyman, MD – Whittier IPA

Paul, when you read it, even if it's very small, you're going to have a document that has little numbers all over...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

No, but I am saying the document looks just like it looks now. It's when you want to know how it got...

Joe Heyman, MD – Whittier IPA

Oh, okay.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...there, you click a button and it does show up. So that...and again, it's actually, this question of mem...so, my biggest challenge is what's changed and can I rely on that last note? If I knew the providence of that stuff, I have a better chance of knowing how much I can rely on that last note, that's one of our major challenges.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Right, but if you have a complex system templating system that's not just a bolus, but has essentially sort of sits as a programming language, if you will, that has hundreds of implicit choices that would be logged...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

That's fine, it doesn't interfere with...it only...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Okay. All right.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...you only know when you need to know the accuracy of that data, that's when you'd...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

And again, it's at least granularity...it's all these type and correct things...

W

...and there's how do I...solve is...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...because there are templates, too.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

I think that's...I mean, I think ultimately that's fine, that these are all the details, and you rarely use that. But, when you need to use it, you're wanting to know because of clinical reasons. And that's when you would take the time to do that.

Joe Heyman, MD – Whittier IPA

And Paul, I also want to have the ability...I mean, we're talking about this, I want to make sure I don't lose the ability to copy something electronically, you know, copy...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Right.

Joe Heyman, MD – Whittier IPA

...and be able to paste it to a document that has nothing to do with my EMR, and I also want to have the ability to copy something from a document that has nothing to do with my EMR, and put it in my EMR. I want to make sure I don't lose either of those abilities.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

And as George pointed out, that's actually in the OS, or as Don pointed out, it's actually in the operating system, so...we haven't turned off anything, we're just giving you the ability to understand the reliability of the previous notes better.

Leslie Kelly Hall – Senior Vice President – Healthwise

Paul, I think we can build on some of the work that, I think, Larry...talked about, the providence work that's been done on standards for CCD...consolidated CDA, how that could perhaps fit into this idea of providence for cut and paste, so that the vendors aren't doing multiple...maybe you could get a "twofer" out of this.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I guess I'd like to add a comment about what is or isn't in the interface. I don't want to constrain the interfaces to not have a way to capture some of this richness. So, I would want to look to, can we actually get in place some standards that allow that richness to be provided, and maybe with the flavor of some of the CDA documents that have...there's a human readable part, there's an XML structured part, and maybe we're now saying there's now a hypertext marked up apart, so that there may be a way to accommodate the variety of things.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay, so we'll ask Standards Committee on that one. Are we close enough for this particular one?

George Hripcsak, MD, MS – Columbia University

One of our workflows, for example, is we have our...many residents will author their notes in a separate, secure area and only when they're done with a note at the end of the day do they enter the EHR and actually insert the note. So what you'll get is entire notes inserted, so you won't know where the pieces came from, it'll just be one blob of text being pasted. They're not trying to avoid this, because this doesn't exist yet, I'm just saying that...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

I hope they have a vendor who can...

George Hripcsak, MD, MS – Columbia University

...well, just different workflows, it depends on where you want to access the system and they don't want it in the EHR yet, because they're still...I think part of it is that they're not ready to put it in the EHR yet.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So I think there's something to be said about that though, this creation of PHI outside the EHR, I mean, it's not...knowing that is not unreasonable. At any rate...so, as you said, it would come in as an insert, which is what it was. Charlene, did you say something?

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

I just wanted to just reinforce...I don't...because we did the Care Coordination Committee work, one of the...and the whole panel on that, again, a key purpose of notes is again, communications. I don't want to lose that, so again, it was not only the ability to enter the note, but to be able to read the note was a requirement that seemed to come out yesterday. And a sensitivity to where that note is going, and maybe as part of the process, again, there were however many data elements that Larry is working on and there's a huge sensitivity to the burden of that cost of capture, and I get that. But, maybe we can make some progress on advancing some of those data elements that could be part of a note or relevant to a note. I mean, patient goals seem to pop out of the...as I read the testimony, patient goals tended to pop out as one of those things we should be looking at. So maybe there's no pertinence note, but it sure seemed to have pertinence to the hearing. So again, I would want to just not let us forget that end game that we're trying to get to. It'll be a key piece, I mean, however that gets communicated, that patient story is so important to the communication of taking care of a patient.

Leslie Kelly Hall – Senior Vice President – Healthwise

Um hmm.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. So let's try to move on to another recommendation, other proposals. I could pick on Don...I think it was Don's recommendation about can we say something about what's driving the pollution of our current notes and is that something that's remediable and I think...well, I mean, the dream is when we're paid more on outcome, we should...that should take away the need to document activities, i.e. fee for services. That seems like something that could be a true win/win, in the sense of return to the old days, before fee for service, when the notes were notes to self about clinical care.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

So somehow you're trying to push to the fee for value really, instead of this...wow, yeah. I mean, that would be nice.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...the way to encapsulate it is, it really...I think we sort of forget it's just these two classes of CPT codes that are driving this...I guess pollution, you know, however you describe it. I would just say it's...I look at it more as camouflage of information or hiding of information and the CPT coding system is under the control of HHS and CMS. And I think it would be the single best thing they could do for EMR adoption and since increasingly this stuff is sort of boilerplate, I mean, almost you could just say have the doctor certify and have some are audit, right? Because this stuff is already audited in many other ways, right, so there are other constraints in the...I think the whole constraint of those codes made sense in the paper world, right, because the level four and five codes, I mean they came in in the mid-90s, they were sort of in an almost purely paper world. I mean, there were some early EMRs, but they were certainly the exception. And at a minimum, at least get the processes of CMS, like CMMI or somebody or AHRQ or some combination I think we could recommend, or maybe that's...I don't think ONC has research funds, I don't believe, but Jacob's wanted some...

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

...for health care quality and research, might be the tree to bark up on that one, Don.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Right, so I think we can put in a recommendation for...

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

Research and quality, I said it backwards. Sorry Don.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...yeah for AHRQ, too, to look at this and get this formally on the radar, because I think it's central to clinical documentation, everything else we do.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

Joking aside, AHRQ just three days ago they put out a notice about their intent to fund projects that look at proposed MU 3 elements. So this is actually right up the alley. So, call your academic friends to respond to this because AHRQ actually does want to fund ideas for MU 3, before MU 3. So they want to do a rapid cycle on this, to learn more about what works and what doesn't work in a way that might actually inform Stage 3 Meaningful Use recommendations policy.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

The corollary maybe is can we do something that Joe likes, which is without burdening the doc, and some of it was raised in the panels in the sense of, well you can tell that I've hooked at the CT scan for 60 seconds, you can tell that I reviewed the lab, you can tell that I wrote orders...med orders, you can tell that I reviewed allergies. So there are some things, again, it would be in this magical audit trail, and so if you are audited, then this is what you say to document my fee for activities, yet my note remains clinically relevant. So that's the one possibility.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

I'm looking to Don and Charlene perhaps. Why couldn't the record, in some very concise manner, actually document those things? So it might be like the bibliography, at the very end you just say did this, did this, did this, did this, so you don't have to go fishing in the audit trail for that kind of stuff, in the case of an audit.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

What we could do, except it would be the polar opposite of concise, because it could be a log file, and then you'd have to go in with some scripting language and get out data realistically. But I don't think it would be a...I think it might be a very interesting thing Jacob that you have a requirement that there is some logging function of screen access or screen use, right? And that would not be, I think hugely burdensome as a programming thing, right, if you just had it at that level and then that might be a tool down the road. And everybody has some kind of logging function and that might be a great tool down the road, as we get the NLP things and all the other data mining things that George talked about yesterday, to substitute out for the effort part of the codes, in case we don't get to outcomes by MU3. So I think that might be an interesting proxy, and would certainly provide an audit track in this world with...I mean, if you're a provider and you're coming to a staff meeting, maybe that's just in a little practice, but for any of us who are employed docs, I mean it's constant haranguing about RAC this and that and all the audits we're going through.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So maybe the...in response to the AHRQ RFA, a vendor can work together and actually state, how much of this can we automate.

Joe Heyman, MD – Whittier IPA

What I'm worried about Paul...what I'm worried about is not logging that I looked at something, what I'm worried about is being presented with something and not looking at it. I'm worried that because I'm now part of this huge care team, that there will be a fire hose of information that comes through and I want to be able to ask for the information I need, rather than somebody forcing down my throat some information that I then am responsible for looking at, when actually it doesn't change anything. That's what I'm worrying about, I'm worried about the legal implications of having a lot of information given to me

because with physicians...and I don't know how it works with anybody else, but with physicians, if any data of any kind was presented to you about any patient, you are responsible for that data even if you didn't order it, even if you had nothing to do with it. You're still responsible for it five years after the thing happened. So that's what I'm worried about.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President – Tenet Healthcare Corporation

So I have a question, Paul.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yeah.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

When you talk...this is Liz Johnson. When you talk about the clinical documentation today, where we are and where the measurements are, primarily related to EP, is the plan for it to be EH? Because if it's EH, we've got to talk about some other stuff like ICD 9 and 10, and the fact that while you all talk about this, we're very reliant on clinical documentation for ensuring medical necessity. And so when we talk about that sort of translation and so on, if we're going to the EH side, we've also got to talk about that part of it. So sort of, not to disrupt the flow of conversation, but more to say, if we're going there for Meaningful Use 3, then we've to get to the EH side of it as well.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Well, and I was going to ask, and this is a question, because I don't know. How much of this extra pollution and coding actually then goes to...through billing systems? Like does that documentation go along with the codes? Because one of my concerns is, in just real pure practicality, if you start having to think about changing all the Medicaid management information systems or...insurer systems, I mean, I think there's a trickle effect. So I'm not opposed to the concept, but I think we have to be practical that there are, at least on the Medicaid side, the states have, you know, big potentially being redone, but clunky, at times, systems and it's not just that quick and easy to sort of change those systems. So I just thing we have to think about what's the down flow of the change and allow for some thinking in time and put that in our concept. Not to say we shouldn't do the right thing on the EHR side, but we have to understand what it means downstream.

Leslie Kelly Hall – Senior Vice President – Healthwise

I think it goes as an attachment to the claim, if requested, and so we're just talking about the content inside it changing, not the structure of the data that gets attached to the claim.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

It would essentially be no different...

Leslie Kelly Hall – Senior Vice President – Healthwise

Right.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...it would go as a claims attachment. Charlene.

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

...go back to the system capability to be able to do some auditing. I want to preclude actually putting it in the audit trail and at a minimum, because then you could mine that, and people do that now, they watch for things. And so that could become rather than an after the fact process, more of a dashboard kind of thing. A tool to kind of help you assure quality and assure notes...so think about it a little proactively. And then the other piece of it, even if that couldn't be, just the fact that when you're done with...we don't do this now, but when you're done with an order, you sign it. So there's a...there are some steps that you could go that would actually perhaps at least show, here's the decision point, you can start to audit some of those things where you actually do that. You actually formalize and say this is what I'm ordering. You sign your order and you can capture those kind of things. And again, systems I think vary, in terms of their degree of capture that. I mean HIPPA required us to put those audit trails in place, so I don't know what the span of that is, but it starts to take steps toward the legal record as well as perhaps monitoring. It doesn't monitor you looking at the data, but it certainly takes some steps in that direction.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So I think I heard two recommendations out of this concept. One is to propose to HHS/CMS, AHRQ, that there be some reexamination of the documentation and requirements associated with billing in the new payment paradigm. And two, that we also potentially through this AHRQ RFA, look at what use can we make of the audit logs of current EHR vendors products, to assemble things that can be captured automatically without having to be restated in the clinical documentation done by physicians and providers.

George Hripcsak, MD, MS – Columbia University

...the first one of the findings in the AMIA policy meeting that we heard about yesterday was that they felt, and we don't have hard evidence, but it that was commented during the meeting and ended up in the recommendations that institutions are over-interpreting the law and that greater clarity from CMS on what you actually need to do, as opposed to...the overboard people are doing, would be helpful. So you don't even need to change anything, you've just got to educate people on what you need. So that was one thing that we could put in our recommendation.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

That's what I tried to do George.

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

Being on the interpretation side of that, and I want to just kind of support Joe a little bit in what he said. Interpretation made us crazy. So that is a huge one in terms of understanding what the intent was and how to execute on it, especially towards...I mean, I think everyone did their best, but interpretation was really a challenge.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

If we do that though, I think we have to say exactly what areas we think there's this...because I'm not...I mean, I appreciate what's been said here, but I'm still not, other than the summary business, I'm not clear what's being misinterpreted. Because I've looked at the underlying CPT codes and I think we're sort of doing what those code counts are. I mean, some of it, medical decision making, some of the components are innately a little bit under defined, but I think people are pretty much doing what the language is right now, so I'm not sure what's being misinterpreted.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Are you talking about Charle...George's comment?

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

Yeah.

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

I don't think...can easily use Joe's piece, so that's where I was.

Joe Heyman, MD – Whittier IPA

I have to say, I was just going to bring up that Liz, on our conference calls, we're constantly struggling with the interpretation. Constantly struggling.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

That's fair. So one of the recommendations can be to reinforce the education about some of the misunderstanding with meaningful use compliance.

George Hripcsak, MD, MS – Columbia University

Audit trails are a good...the other topic, audit trails are a good idea, but we've tried to create documentation automatically from our audit trails. In other words, don't have the doctor do this...but it doesn't work well because as you try to get to more sophisticated displays, they summarize a lot of stuff, so the audit trail is not telling you where your eyes are looking on the screen. And so we don't really know, so we still have the manual click on which things you were actually focused on. So it's not fully automated, but we do know it was in front of you, but then you get to Joe's comment that, well, but if it was in front of me, then I'm responsible for it or whatever...yeah.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...trail just in a very increased...not for saccadic eye and cognition. This was like sub-cognition, which is just like, were you like in the building the day you're billing and is there some plausible thing to say that this was a complicated patient. Or did you see there's all the electronic evidence suggested every patient you're billing 5 for, you saw in 10 seconds, right. And I think the veracity of a pile of billing codes, I think to a high degree of precision, can be motivated...right, certainly the fraud out liars and the context from log functions. So a really, really dumb use of it, but to get out some of this sort of documentation overload.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, I'll join with the comment that Charles Kennedy might have made if he were here. We have multiple data streams. And so if some of this is what did you do, and you ordered some labs, there are orders for the labs and maybe they don't need to be redundantly entered in multiple places and then eventually there will be results for the labs. And so if there's billing for the labs, there's a lot of evidence in the data streams that labs happened and there were orders and then there were notes and they all sort of redundantly state that the same thing happened. So, I don't think Charles has ever said this is like a done deal. Like we can unequivocally say what went on, because of the multiple data streams, but I think some of George's comments about there's a long history of NLP. That there may be areas where there actually is good information in the multiple data streams that could be pulled together. But it needs to be pulled together and it may not be that EHR is the place where it gets pulled together, so it sort of creates a would you do this technical magic. But, I think we should look broadly at this rather than kind of overloading the tool that we have with everything we want to get done.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. So, I want to move to another area, but I don't really know how we would do this is clearly the way that's increasing amount of data is being presented to users and clinicians is overwhelming and not very illuminating. It goes to usability and I don't have a recommendation for how we improve on at that, but that was one of the issues.

Leslie Kelly Hall – Senior Vice President – Healthwise

There is a science to usability and...that...I don't know how you would potentially go to functionality except as a certification requirement that some usability, science user testing, navigability, there's a science around that and I don't have all the right words; but there is some consideration in that. I mean, they're difficult to use is the best way to describe it today, and I think as we get more involved...I'm not sure if in Meaningful Use 3 there was anything on usability in the recommendations that we had from other work groups. But, to get to that more explicit certification that shows that it's demonstrated usability testing. I don't...

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

...talked about...

Leslie Kelly Hall – Senior Vice President – Healthwise

...sort of like AHRQ.

Joe Heyman, MD – Whittier IPA

...a hearing on usability?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

(Indiscernible)...talked about this...Paul's group asked, and I think it was the certification group that responded on this concept with our vendors who that do have...meet all of the regulatory kinds of things around usability. That's a long way from a patient being able to read...I mean...(Indiscernible)..., we...looked at it, and we did a full exploration on it, because we really believe what's being said here is critical. But Paul pointed out the complexities of it. You know, it's like...when you start talking about testing a certification, because that's what we do every Monday, and we have gotten very, I don't know what the word is, certainly engrossed in it. And we've come to realize how difficult that is, not that we don't want it and we're willing to do a lot of fairly innovative things to try and get there Paul. But I'm telling you, you start talking about trying to get it to a readability...and we use kind of the cardinal rule 6th grade level, I don't care what rule you use, we're not there.

Leslie Kelly Hall – Senior Vice President – Healthwise

Right. So I'm got referring to comprehension...I'm not referring to necessarily plain language concepts which is...but that is, plain language concepts for actual readability, understandable patient by patient is one thing. I was referring to the usability of the EHR in general to try to accommodate the innovation that Larry talks about, about how is our screen interfaces, how do we interact with it, what does it...we don't want to constrain that by having so much nitty gritty. With regard to the usability of patients...or understandability, I think plain language, there are organizations that can certify that a plain language process is being used. We just totally shy away from grade level, it makes no sense. As soon as you say fever and then you say Tylenol, you're up or acetaminophen, you're now at the 11th grade. So, it's not...it's plain language concepts are better.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...usability hearing, you could probably quickly summarize it as, there were some people who were adamant that they could measure it precisely and there were some people who were adamant that, in fact, there's no inter-rate or reliability validity there and the processes are still to be determined. And there was some polar testimony on that. But to the point of what Joe was saying, I think one challenge is, you can't actually humanly get all this information, right. So you sit there and now that we have gotten pretty successful in a lot of places with EMRs, and you have sick patients, they have tons of visits and tons of labs and tons of imagines and tops of hospital summaries and op notes and stuff. So, you purely have to do this on a statistical basis. You have to take a guess for this patient, the one thing that if I click on their note from this person, I'm going to get information I need to act on its...there's information overload already today for many patients and many sites. And it's beyond human cognition and there sort of is an old AI guy, you know...graduate, I don't think...I don't believe there's any technology out there today that solves that or certainly that we could do. So I think any things that we have on that, needs to be...needs to recognize whether it's the UI level or at the MR level or at the display level.

George Hripcsak, MD, MS – Columbia University

There's a...just...because you just mentioned that...is someone who created this...because that is active research, because of this problem. So I agree with Don, it is very hard and we're about to go live with it for our campus, so I'll tell you whether it worked or not or whether anyone found that it improved their understanding. This is just for providers to understand the mess of information, not even patients.

(Indiscernible)

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

I think it would be helpful if the committee had thoughts on the scope of usability expectations. So as you recall from Stage 2, the standard certification criteria require that EHR vendors use user-centered design and submit the results of their summative usability testing. That was the action that was taken in response to the hearing and a lot of research that we are did. So if the scope needs to be broadened, so there were eight certification criteria that did not include, for example, notes, not that there will be notes, necessarily, right. That would be of interest. How about that?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Those things formally known as notes.

M

Now it's informally...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Which are menu, which are optional at this point? Okay, other draft recommendations.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

So are you saying, Jacob, that we take those...criteria and apply it to this now known as notes category?

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

Well, I'm not suggesting anything, I'm as...truly, I'm asking. So there were eight things, you folks have talked about usability is not what this needs to be and this is a conversation about usability in the context of documentation. And I think the question is, would you like to stick your necks out and say, in the scope of documentation there should...that should be added to the eight. And if there are any others that you think should be added to the eight, it would be of interest.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So specifically saying you want, that we want to put a spotlight on the design issues around clinical documentation, both the generation of the documentation and the readability...usability of the documentation.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Yeah, and then come back to...and say...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Joe.

Joe Heyman, MD – Whittier IPA

You know, usability is...one of the things I got out of the hearing was that usability is in the eye of the...

M

...beholder...

Joe Heyman, MD – Whittier IPA

...user, right. And one of my concerns about proscribing, prescribing, any specific usability thing is that it can confine us so that innovation doesn't happen. And you would think that physicians, at least those of us who are not in huge institutions but in smaller groups, we would choose our EMRs partially on the basis of usability so that there would be some competition based on which is more usable and which isn't.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

...institutions, too, right? I mean large institutions...have exhaustive evaluation of what users like and don't like. So...and folks can look in our Stage 2 documents for...or the 2014 standard certification criteria, usability actually has a very clear, scientific, as Leslie was describing, definition. And although some did testify that usability is in the eye of the beholder that is not how we've treated it. We actually leveraged the scientific definition and notice that in Stage 2 we didn't have criteria, this is usable, this is not, because it's not either the criteria or our relief that usability...there's a wide spectrum of what is more or less usable; it has to do with efficiency and meeting user expectations. So our criteria really were just that user-centered design is fairly well established as being highly correlated with more usable products. So companies that incorporate user-centered design make more usable products and therefore our expectation was that organizations developing electronic health records incorporate user-centered design into the development of those eight specific certification criteria, which in Stage 2 had to do with medication life cycle. So just to be explicit about that. So, I heard that also Joe, but that doesn't cause it to be so.

Leslie Kelly Hall – Senior Vice President – Healthwise

It's the how, not the what.

Joe Heyman, MD – Whittier IPA

I see what you're saying. Yeah, I have no objection to that, I mean, I think that's great.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

Another thing as we think about these things, I was at the Health 2.0 conference, and it's interesting, there's an entire virtual world of medical, clinical, non-FDA., non-ONC software being developed. All right, there's sort of a parallel universe with hundreds of developers actively working on things that have as one of their defining characteristics, they have nothing to do with meaningful use, or the FDA or maybe any number of other things. And, I think any suggestions we put at least needs to have in the back of the mind, there's a whole alternate universe that's saying, I don't want to have anything to do with this and, they're sort of trying to gingerly avoid core EMR, but those things are going to collide, right. I mean, if you're using your Fitbit now and you're 23, one of these days you're probably get sicker, right? Happens to everybody. And so I don't know when that is all going to happen, but I think any of the suggestions we put out in MU in general should that have that Health 2.0 thought test applied to them. Just...does this make sense in the sort of brave new world of devices. Just as a general observation, because I think we're making ourselves a little bit like the railroad industry in the 1920s.

M

So actually, that was one of the challenges and it did very well, right. It was summarizing data for patient viewing and it was a very good challenge and they came up with some good solutions, now that you mention it.

Leslie Kelly Hall – Senior Vice President – Healthwise

So an example might be, this collaborative care record that we want to do, not being so prescriptive that we inhibit collaboration that can be done with other systems. So what is the nexus point where EHR data and collaborative care need to intersect and can we define that intersection? So, an example might be an EHR standard that would allow for the ability to get to an expert system and share common context, we do that very minimally today, but we do that with patient education in JAMA and it's in meaningful use and the Infobutton. But this idea of saying, how can I share a context with patient permission across a larger ecosystem? And then how do I share the creation of this collaborative Wiki and what are those nexus points. So really taking the standards group and asking to define where those nexus points, so that we encourage collaborative interoperability between the new generation systems and the legacy systems could be something that would be very interesting. Because I do believe we heard a lot about integration and the patient, we heard a lot about collaborative care, we heard a lot about patient generated data, but then our sort of...I've described it our aversion to interlopers of software coming out that are not from our known domain, our caution goes up. So what can we do to be proactive and just ask for recommendations that define these nexus points so that we actually advance innovation in a meaningful way.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Charlene.

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

It's that recommendation that...based on what Jacob said, this is an area that we spent a lot of time on in trying to think through what that future state of collaboration software would be, without us really having a lot of knowledge. So that may be an area that you want to actually do a little bit more research into, at least bring that information to the table in terms of this. Because there are...I've been out and there are, not vendors, but in the research area they're starting to do some work, you know, let's bring up...you can imagine having an HIE of all the patient encounters out there and then you're operating in your own system and you can bring that window up and you can loo...so those kinds of systems are emerging now, they're rudimentary, but again, they're the basis of some of this collaborative work. And that future state, I think, is a little vague to us right now.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

But would you want to at all stifle innovation that's going on in that area?

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

No, no. I would just put this on the research agenda, because that was one of our topics. We got a lot of pushback, do care plans in Stage 3 rather than Stage 4 and those of us on the committee are saying, we don't even know what the standards are yet. So, I think some more insight into that area might help us advance our understanding and how to actually create a better road map to get there.

Leslie Kelly Hall – Senior Vice President – Healthwise

Without harming that future in recommendations today, which was Jacob's point.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So the research would be about...

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

Either the...the advance in the use of collaborative care models in the context of meaningful use. That's probably too prescriptive, but basically that's what our discussion has been around and we've been...and people will say, okay fine, I'll feed whatever that thing is to share it, but what is it that I need to share. And when we say well, it's got to be bidirectional in communication, you've got to have that and I know there's an emergence of collaborative software out there, but the road map between those two is, at least us, trying to figure it out, it's pretty murky...and they understand. So the work that Larry's doing and how that fits in, and should it be integrated, should it be apart, and there's a couple of different models out there.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So I want to pick up on a couple of threads that just got brought up. So certainly in the discussions about how to do better collaboration, there were some pretty robust speculations about possible models that really created a shared environment in which activity happened, which is very different from the typical interfaces we have now, which keep all the systems at a distance. And it was like, well, we're going down this road, but none of this exists. So we really can't regulate it, because it doesn't exist, but we need to start discovering it as it begins to emerge, and point to it and go, this is really valuable. And maybe it needs to be integrated into regulation or maybe it becomes community practice and we don't need to regulate it, but we certainly need to spotlight it, that because is a place we think it's important to go.

I'm reminded of two things, one which is out there in the world in a big way, which is health information exchanges are dealing with this problem of how do you make sense out of a fire hose of information. There are vendors who say, our sole job is to make sense of this big pile and we'll show you useful pieces and let you drill in and find stuff. And they're not electronic health records, they're tools for viewing questions of information. The other piece is, there were some side discussions yesterday, a little bit related to what George was referencing this morning of residents have tools that they use, they're outside the medical record, to do their hand-offs. And that there's a lot of really valuable information in there and, in fact, clinical decisions are being made based on that information, and that may or may not make it into the EMR, because it is a separate system and depending on what people think to document, the decision may not even be seen as a decision, right? It points like, well it's obvious we're going to do this and then you realize two days later when someone says why did you do that, that there was no documentation in the record to say why you did it. And so we do have an ecosystem of other things going on there.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

...intentionally don't want it in the record. I mean, as I think back to my residency we had 3 x 5 cards that on call, that we would just hand to the person and in an era when how to determine code status was ill-defined, and teaching environments had very little attending support. Basically it was left to the house staff to sort out...obviously I think, always with sort of family and I mean I think we never did the wrong thing, but we were left to our own devices to sort out code status and provide humane care to patients and some of that can't be documented in the record, because there's no legal basis for what you did, right...if you did less than full CPR on everybody.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. As you know, we adjourn at 10:30. Let me try to go over the recommendations we have so far and see if we have agreement. So one, just wasn't implicit, but it was something that George mentioned, I think everybody in the room yesterday agreed that clinical documentation is important. It does need to be in the medical record for all the stakeholders. And so it is currently in stage 2 a menu requirement and would this group suggest it be a core requirement in stage 3? I mean, it's something MU will take up, but I mean, I just thought I'd get the sentiment of this group, too. That the current menu requirement for clinical documentation be part of certification requirement be a core instead of just menu.

M

The existence of it...a tool.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yes, that's all it has to say right now, it's in Stage 2.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Yeah, EP and EH?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yes. That was a hard fought battle actually and so we're just progressing. Okay. Second was...

W

(Indiscernible)...progress notes...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

We're just making that word suggesting it be core in Stage 3. Okay, first recommendation we come

Across is, I'll try to read what I summarized, that documentation of clinical encounters have the equivalence of track changes within the vendors EHR, which can be viewed at the click of a button. The default views of the clinical documentation is a clean copy, what's transmitted is a clean copy, what's different is when you're viewing it within this vendor's EHR, you have access to the providence, essentially is the equivalent of the track changes.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

So the only thing you need to do there Paul is just make sure at that it's the old white out, line out kind of issue? I think the audit will suffice that....

(Indiscernible)

M

Paul, on this one...

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

...EHR provided by a vendor, right?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

It's a vendor EHR...

Joe Heyman, MD – Whittier IPA

What will happen...

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

But it's the use model you're talking about as opposed to, you know, vendors have to provide...Christine was just clarifying it. It's the provider's context that they can see.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I asked a question. I hadn't heard the term vendors EHR and I was trying to figure out is that different from the providers EHR.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

(Indiscernible)

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So if it's not, I don't want to introduce a new term that people are going to go, well we don't understand that.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. Can I just...

Joe Heyman, MD – Whittier IPA

I'm worried about this...can I just...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay, Joe.

Joe Heyman, MD – Whittier IPA

I'm worried because if it's...if the only place it appears is within the EHR, then when a physician gets sued, the lawyer is going to want to come to the physician's office and actually examine the EHR itself. The electronic...I mean, maybe that's going to happen anyway, I don't know, but right now you produce documents that you hand to the attorneys, what's going to happen if the only place where the audit is visible is within the EHR, are they going to want to come and look at your EHR.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Well, I mean, presumably you could print out the marked up version of it, yeah.

Joe Heyman, MD – Whittier IPA

I thought they precluded that when you...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

No, I was trying to get around the interface problem. So...

Joe Heyman, MD – Whittier IPA

Also, right now my understanding is that there's a whole industry around looking at Metadata for lawsuits for...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Probably there is. Probably there is.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

There's a huge amount of stuff. There's a huge amount of stuff on forensics. I think what Paul is getting at is something beyond the current timestamp...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Yeah.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

...and I think it's a way to respond to the issue of widespread cut and paste that really sort of...the process as opposed to sort of quality cut and paste. And the challenge, of course, is that's a very narrow line.

Joe Heyman, MD – Whittier IPA

But I thought Paul that you wanted to be able to...that you wanted for...if I'm transferring my record to the hospital, you wanted it to be possible for the hospital readers to be able to tell that I took something from someplace else. And the way you're describing it here, I don't think that's what is happening.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. So...the follow up, it was in response to anecdote that Larry presented. But if RTF is standard enough and can transmit the mark up, then that would be a good thing, but we're not going to rely on that. Right now, we just want the people...the people who are usually reading the record inside the organization, to be able to see that.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

This is Larry, and I guess my concern is that we broadly ask standards to comment on ways in which this might be communicated well. Not assume RTF is the right vehicle and also not necessarily exclude it from the interface, because I think this is actually very valuable to make electronic.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

My interpretation of what you just said is document editing. So if I write a note and temporarily store it, sign it or not, if I make changes, that'll be marked up. That's different than authoring a note and taking pieces from everywhere and putting it together in this document that'll look like the original note without any red lining. So what you're...just think about your goal was to do the cut and pasting, but when you're first writing your note in most of these systems...like you're writing in Microsoft Word, when you first write the document, that's the original.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Not if I copy into...

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It'll show.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

I guess...I guess so.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

That's a good point...

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

I mean what'll happen is...what you'll know is that this character came in one at a time and these characters came in as a group. You don't have to display that, but that's what the...that's what your EHR notes, that these came in one at a time and this came as a group. So you could tell that...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Actually, I think Microsoft knows because it came off the clipboard and similarly, you can imagine the EHR would know this too.

Donald W. Rucker, MD, MS, MBA – Vice President and Chief Medical Officer, Siemens Corporation

Okay...(indiscernible)

Leslie Kelly Hall – Senior Vice President – Healthwise

...the problem we're trying to solve...

Multiple speakers (indiscernible)

Leslie Kelly Hall – Senior Vice President – Healthwise

What's the problem we're trying to solve specifically?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. So I think we've got that...we spent the most time on that anyway. The next recommendation, draft recommendation was that we would endorse the certification criteria for having open notes functionality in EHRs. And that is basically the electronic access to clinical documentation by EPs on the part of the patient.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I want to get to Liz's point, which is, it's important to capture the source of the information. If you're editing stuff that's within your context and no one else knows it, it's very different than if you're assembling stuff.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

That's correct.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Yeah. I'm just trying to get to George's comment, which is I'm sort of out there in Word, I'm putting together my document. I haven't posted it anywhere. I don't want all those iterations coming into my record in the hospital. When he gets there and then he decides, wait a minute, I've seen the patient now and there's an amendment, I want that. And I just need to be...because when I heard you say that George, my head went off and thought, if we...kind of what we said earlier, I could get 15 versions of which it's a wordsmith or a misspell or...great point. So I don't know how you capture that, Paul. I know you know what I mean, I just...because people read this stuff so black and white, and then people interpret our...the vendors then force us...and it's not them, they're trying to meet the specifications we set up. Please just keep it in mind when you get to that more final step.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

No, that's correct.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Also, I don't want to lose an important thought, which was Joe's..., and hopefully I'm not mis-describing this, that when Joe was describing, you take a template and then you edit the thing that...take the normal, edit the thing that's not normal. If that was something that could be flagged as well, that's very helpful. That helps someone out, quickly scan this, oh, this jumped out, and I need to pay attention here. So something that allows that to happen, encourage that to happen and doesn't make it disappear. It's almost like there's a dial that you want to be able to adjust of how much of the process do I want visible to me as the viewer.

Joe Heyman, MD – Whittier IPA

...in my EMR, I just realized what I was just thinking that...there are...it's not throughout the entire EMR, but if I pick an abnormal spot on the GYN exam, that portion is in bold. So if I choose an abnormal from the template, then that portion will be in bold as opposed to the rest of the visit. So it's obviously doable.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. It's actually...to George's point, it is all things that come in without using keyboard would be logged...providence would be logged. That's one way to state it, okay. And then the next one was open notes, where...the last one, I'm sorry. George's point was as you construct the note, you may use certain productivity tools and the question is does that count and it would count. So when it's not entered by keyboard, when you pull in phrases, when you pull in templates, those would show up as having a source...

George Hripcsak, MD, MS – Columbia University

...as what?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...as having a providence, a source.

George Hripcsak, MD, MS – Columbia University

Oh, okay. Yeah, that's fine. I thought...I'm sorry I thought you said that would be in bold.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

(Indiscernible)

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. Pardon me?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Will you repeat your...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay, open notes...that vendors would...the vendor's EHRs or EHRs created by ven...commercial EHR...no, I can't even say that. Certified EHRs would be capable of sharing clinical documentation by providers with patients.

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

So that's to say that the EHR has to have the capability, it's not saying the provider has to enable the capability.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

We'll have to...

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

I'm just asking for clarification.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

No, no, you're right. I think we're saying one way or another, and the reason I say that is we don't know whether it's menu and we don't know what the measure is, but, one way or another that has to be made available to patients.

Joe Heyman, MD – Whittier IPA

Maybe I misunderstood, but I thought we had mentioned the possibility of using that instead of the clinical summary and having it counted. Did we not?

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

I think...what I heard was making it...I heard one thing and then I had an idea. So one thing that I heard was making it part of the after visit summary. Now, I think where the after visit summary goes in Stage 3 is a big question mark in my mind, because we've heard loud and clear that the visit summary is not as useful as the original intent. And when we ask the Standards Committee to help us figure out how to condense it so that it's really about what just happened, in a specific temporal moment and what needs to happen next, what does the provider need to do, what does the patient need to do, we were told that data isn't, I think, metatagged in that way and it's very difficult to come up with that. So I think, the after visit summary notion may change. I think view, download though would be the other way to do it...would view, download, transmit has a set of requirements, these data elements are part of it. So if you simply make this...make notes part of it, you also have to think about, the percent of notes that are documented and the threshold, which isn't a separate requirement. So I think Paul's probably right that we should be clear that the recommendation is notes should be available to patients, they should be provided to patients. It's clear, I think Amy's question is right. So to be a little more clear about it, but how we do that, I think we still have to work through.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

...there's a difference between available and provided and I want to be real clear.

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

Yeah.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

I don't know where you land, but there is certainly a difference from our responsibility perspective.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. The next piece was on raising the issue about coding documentation requirements for billing. And one request is that HHS, e.g. CMMI, AHRQ, look at...re-look at the coding requirements in the face of new payment models. Another area is that there's a recommendation to HHS that there be education or more resources made available to clarify some of the, I'll just call them myths in informal language, surrounding both meaningful use and E/M coding requirements. Because both of those are causing excess work, effort, and cost, and so even without changing anything in the statute of either the billing requirements or MU, we probably can reduce...make the world a simpler place.

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

...Paul, one of the things that I thought that AMIA policy conference paper was actually very good and so their related recommendation was similar, but a little bit different. And what they said was that the federal government should lead a public/private sector initiative to transform and shift away from the longstanding emphasis on payment focus data capture and documentation, toward one that focuses on quality, safety and good outcomes. So, it's federal leadership, but there's definitely a private sector component and I think that's strategically probably right, because these are individuals who use and are part of the system every day.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...and the private sector is adopting the public sector's...

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

Exactly, that's what I mean.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...so, that's...I mean, that's good language...

M

I think Paul, even your part could be more...

Joe Heyman, MD – Whittier IPA

I'm sorry. I just...I want to say CPT coding, in spite of all the stuff about ACOs, I mean, I still remember HMOs. We don't know that ACOs are not going to go the same way that HMOs went, but one thing we can be certain about, CPT coding is going to be around for a while. So, I don't think we should...I think the recommendation should specifically address CPT coding, because so that's what the problem is.

M

So here's...I was just about to say, let's make it stronger, because if you just say on new models, and they say, all right, well, we'll worry about if we ever get to a new model. I think that you can...I mean, they want to go to documentation because they want to catch fraud. But you can only document the wrong thing also, but what they found empirically, I suspect, that if you document it, you get viewer people committing fraud than if you have them set the bill. But what they're not accounting for is that the process is hurting the clinical care of patients.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Right.

M

So there's a big cost. It's not just the time of doctors, it's the care of the patients. So even if they reduce fraud a little bit by forcing on the documentation, they're having a severe unintended consequence and I think they need to find another way to do it. Earlier suggested was looking at the audit trail and things like that, so I think you should push further and say even with the current payment model, we need to look towards not using documentation as the support of billing.

Jacob Reider, MD – Acting Chief Medical Officer – The Office of the National Coordinator for Health Information Technology

I think you could use documentation for that. I think you have to...I think it's a very narrow problem, it's the level 4 and 5 evaluation and management CPT codes. It's not anything else, it's not like your op note or any other thing. It's those two specific families of codes, right, so they have various implementations. That's the entirety of where I believe the toxicity lies.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Good addition. The next point we made is for vendors to look the...look at mining audit logs for some documentation efficiency to meet the E/M coding requirements. And that may or may not be productive.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Maybe you can rephrase that as, looking at logs as proxies for work effort to substitute it...if we're going to take out the work effort and CPT codes, looking at other proxies for work effort to the extent that fee for service...I mean, that's sort of what...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay.

M

Yeah, that's...now I have to pay someone to type on the computer all day long and make it look like I was working on those patients, but all right. There's always a way around...

M

Inventing the EEG substitute for intense brilliant thoughts. So...he's the,

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

What's it called, the white hat hackers? The white hat gamers. Okay. We had mentioned, and I don't know whether we want this to be a recommendation, to have certification adoption look at usability of clinical documentation?

W

Um hmm.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. And I don't know how to phrase this one about the collaborative care mo...so the way I wrote it was, research technology and interoperability support for collaborative care model.

W

Indiscernible

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

...we have...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

What is it?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

...more notion of a shared record that is shared across the care team and across...I mean, collaborative care is too big of a concept.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay, care coordination.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

No, I think it's...it's coming back to the shared care plan, which involves care coordination. But remember, we wanted to think more broadly about care coordination in terms of like a platform for collaboration issues, the going back and forth. Not just are we all on the same page, but bidirectional communication and things like that. So, actually I think Amy had a recommendation on this that might be useful.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So can you send that to me.

M

Yeah. I mean the recommendation is kind of...this recommendation is just that as we move forward on care coordination, which is another group, it should take into account what we're doing in documentation. So those two things know what they're doing is kind of the recommendation.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I actually thought it was the reverse from what you just said...

M

Oh, okay.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

That we need to take into account where care coordination and shared care plans are going, and we're doing for meaningful use verses them driving from us. We need to drive from them, not them from us.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yes.

(Indiscernible)

Joe Heyman, MD – Whittier IPA

Well, I just want to re-emphasize what I said at the very beginning then.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...makes work...

Joe Heyman, MD – Whittier IPA

And that is, that I don't want...I want my medical record to still be my medical record. I want the social worker record to still be the social worker's record and I would like something else to cull make it possible so that the social worker can view what she needs or he needs from my medical record and I can view what I need from the social worker's records. But I don't want to see the social worker's record and I don't think the social worker wants to see my record. I think what they want to see is what they need from my record and what they can understand from my record. I don't want a single record.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right, I mean, I think part of what's underlying this notion is the diff...is really shifting our paradigm around how we think of an electronic health record. So I want to be pretty specific about that because if we have agreement, I mean, the law is tied to something called an electronic health record. But it doesn't say what that is, it doesn't say it's provider owned, it doesn't say that it lives in silos, right. So I think that the recommendation is probably more focused on acknowledging and in fact fostering a changing paradigm for what an electronic record is and moving toward one that serves as more of a platform for collaboration across the care team. The care team of course including patients and families, or something like that.

Joe Heyman, MD – Whittier IPA

...is something different, which is there's a second piece of software called a health information exchange or something else that accomplishes the ability for a care team to work, rather than change what an EHR is, especially since as what was pointed out earlier, meaningful use only addresses EPs and doesn't address social workers, etcetera.

W

Right, so...

Leslie Kelly Hall – Senior Vice President – Healthwise

But the EHR is defined very broadly under meaningful use guys, the EHR is all technologies that our electronic health records composed. So for instance, we could work on DICOM standards in radiology under meaningful use. So it's a very broad term and so I think what Christine just said would apply, the lever we have is electronic health records, but it's very broadly defined under ONC.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

But Joe, to your point, there's noth...I think that I'm trying to suggest and see if there's agreement on the idea that, if we move away from the term that we...and how we associate it. It could include interfaces for multiple different individuals who play roles on the care team in connection to information exchange and we can still call it an electronic health record, but that the idea is fundamentally evolving in a way that is different than how we think of it today. So it's maybe multiple software interfaces connected to information exchange, the social worker has a view in those things, but that it's...

Leslie Kelly Hall – Senior Vice President – Healthwise

...more dynamic...

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

...the record notion becomes more of a platform built on the same idea though, because we can hav...we have the ability to foster those or that technology through meaningful use. Does that make sense?

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So we are at the...huh?

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

(Indiscernible)...is to help gain a better understanding of what a team means in healthcare. For example, clarifying who is a member and defining their roles and responsibilities with respect to data capture and Documentation, and the extent to which technology can be leveraged to support team-based care. So that's a pretty concrete recommendation for AHRQ, which is similar, I think, to the discussion that we just had without necessarily saying where it lives and where it resides and that kind of thing.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay. So, can we...can you just pass that around electronically and this group can say, do we agree with that, and then we can include that...

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

So do you want me to keep it from the context of what was recommended?

Leslie Kelly Hall – Senior Vice President – Healthwise

...AHRQ...to the context of meaningful use, so...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So at any rate, if you can put a draft around and then we'll try to look at it electronically. And the other big point we didn't finish is, how does this relate to hospitals. I don't know whether there's a group that can help us...

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

Oh, in terms of documentation.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

I mean, you can...I can't do this without talking to John and John, but we could give you some feedback from the Implementation Workgroup, because we have hospital and doctors there. I don't know...nobody's...Oh sorry, I'm sorry. Well, the question was, how does it relate to hospitals? The sidebar which now is public is, we were trying to figure out from an EH perspective, how do we get that interest in those comments incorporated to this. I certainly can feedback into the discussion when you send this around with your recommendations and then your group can take a look at it. I'm glad to do that, Paul.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So is the issue we're trying to address that fundamentally hospitals are somehow different in their needs, was...I don't understand the problem at hand.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

...what I was about to ask.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

It's multifold and I'm happy to...again I think we're out of time and I can respond and then you can ask questions as a group. How about that? So when we talk about it ICD 10 different from CPT, when we talk about documentation and the interchange, there are multiple places where we're focused on EP. We need to expand to EH and I'll just comment those for your consideration.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

...the recommendations that you were talking about before the first two were specific for EP and not for hospitals. That's what I think I'm trying to understand...I'm trying to understand what fundamentally...where in this conversation this morning have we drawn the line between what applies...I didn't know we were drawing a line between EP and hospitals.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Liz, is there something it doesn't apply to?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

Well I don't think...I think the first two look pretty good. I think what I was concerned about was all the conversation around CPT and nothing around ICD. So that's...so we have to be careful there because I am like you are, I would like nothing better than for us to focus on documentation and not coding mechanisms. But the differences that we talked about were strictly related to CPT. We need to get that interest evolved.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Is it limited to the E/M coding?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

...billing...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

That's where the con...

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

E/M...yeah, right and...yeah.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Let me just say that everything applies except that which we talked about for E/M coding, unless you bring up a few others.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President –Tenet Healthcare Corporation

And the other thing I want to look at is the exact recommendation around exchange of documentation and tagging. So that as documentation...because George made some good points about what would come across. Again, not just exchange between EP to EP, but EP to EH and EH to EP. How can I look at that? Again, I will give you public comment.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

So if we can't settle it by electronic means, then we'll just have a call...to finish this off.

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

Paul, I'm going to ask a question before we leave the recommendations, do we have one around patient contribution to the documentation process? I don't think we do. We have sort of patients can view the notes, but I think we heard some really compelling testimony that contribution could actually help both the patient and the provider. So, I would again say there's a nice AMIA recommendation that says individuals and their designees should be able to view, recommend changes to and contribute directly to the health record with the provenance of the data clearly noted...

(Indiscernible)

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

...health team...and is it in our recommendations from this hearing, that's what I asked.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

...3 recommendations.

Leslie Kelly Hall – Senior Vice President – Healthwise

Yeah, it's in MU 3 right now.

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

Well, it's in a draft of a comment...I mean, of a...I would feel better if it was also here, at least it's consistent if there's no objections. Since we don't know how that will change, right, these aren't...specific only to meaningful...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Next meeting we're going to be talking about this.

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

I can't hear you, I'm sorry.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

In our next meeting, we're going to be talking about this, which is Meaningful Use Workgroup.

Leslie Kelly Hall – Senior Vice President – Healthwise

So I think we're just saying there's consistency in....

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

Why wouldn't it be in both places is what I'm saying. We're already saying patients should be able to view the notes, we're saying that providers should document, those are in these recommendations, and meaningful use.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let me just say from a vendor point of view, that potentially is a huge development cost, right. If you're changing the nature, you're putting a different UI...and you have to...there's potentially a lot of issues. I'm not saying it isn't a great thing, I'm just saying there are potentially a lot of issues because you're redesigning a whole bunch of products, you're redesigning the entry platforms potentially, the workflows the data entry tools. There's a lot of...

Leslie Kelly Hall – Senior Vice President – Healthwise

...documentation in the EHR, we're talking about patient contributed data...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

Okay, so we have to end this section. We can have a call scheduled to pick this up if you'd like.

Joe Heyman, MD – Whittier IPA

Are you talking about the EMR or the EHR now. The EHR she was talking about earlier or the EMR?

MacKenzie Robertson – Office of the National Coordinator

Sorry, this is MacKenzie. We actually do need to have the hard stop, because we have to adjust the webinar and do the platform change behind. So I'll suggest that we schedule another call. We can also wrap up anything over e-mail. And if there's something that we need to do, we can just schedule another call, because we also do have to go to public comment. So, Paul...

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

We'll go to public comment now.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

So operator, can you please open the lines for public comment? And while we're waiting for anybody on the phone, we do have a public comment in the room and I'll just note that the public comments will be limited to three minutes, so if you can please identify yourself.

Alan Merritt – Altarum Institute

Also, if you'd like to make a public comment and you're listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you're listening via your telephone, you may press *1 at this time to be entered into the queue. Thanks.

MacKenzie Robertson – Office of the National Coordinator

Go ahead.

Dan Rode, MBA, FHFMA – Vice President, American Health Information Management Association

Okay. Good morning, I'm Dan Rode, I'm with the American Health Information Management Association. You've given me a lot to think about and now I have to go back and talk to our governance team. I just wanted to comment on a few things and maybe you can deal with this in your next call. Charlene brought up standards and as she talked this morning, I think there's not been enough emphasis on standards, including Metadata. We don't have a single Metadata standard. We're working on some things in HL7, but as we start to integrate data in an electronic health record, or whatever you want to call it, a collaborative record, we've got to know where the data comes from and some of the time stamps things you've talked about. And if the vendors don't have that information, then we don't have interoperability of data; we have to be able to use that, and you heard the legal reasons yesterday.

We ought to be looking at, and I've been pushing on ONC to look at innovation for CDI. We talk about innovation on how we present the data at the end of the system, how do we capture the data? We heard some great ideas yesterday, but I think a little more innovation would be very helpful. We have to look at the integration of software. It was brought up later in the conversation this morning, but, the use of various software outside of what we consider healthcare standards is rapidly growing, and we've heard in some of our security and privacy meetings, just trying to integrate Apple iPads with Microsoft-based software is creating significant problems. And we've heard about problems this morning about integrating data and how it changes when you move it across; we can't ignore that. So we've got to look at the standards that have to be across the platform so that as consumers, as physicians want to interact, we have to do that.

And then finally I'd ask you to re-examine the recommendations yesterday on the RM-ES piece of this. We have some crucial needs right now, outside of meaningful use. One of those crucial needs is the RAC audits and the second one is just the fraud. And while we want to ignore that and not talk about it, looking at some basic information that could be put in the certification process, even if it's voluntary, would allow our providers who don't have a lot of knowledge about buying systems and what's in the system and not system, be able to produce some data so that when they are audited, whether it's from the Inspector General or the local Medicare RAC, that they can actually produce the information that's needed. It's costing a lot of money and it's costing a lot of people to question whether they want to be part of meaningful use or should they direct their effort and their money to dealing with these audits, because if they don't pass the audit, they don't get paid. I think I made it in your three minutes, thank you.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Are there any public comments on the phone?

Alan Merritt – Altarum Institute

We have not comments at this time.

MacKenzie Robertson – Office of the National Coordinator

And there are no more public comments in the room, so I think we're free to adjourn until 11.

Paul Tang, MD, MS – VP & CMIO – Palo Alto Medical Foundation

We'll thank you very much and we'll schedule another meeting and we'll circulate some additional information electronically. Thanks everyone. And Meaningful Use Workgroup will reconvene at 11. Thanks.