

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
April 9, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there is time for public comment built into the agenda and the call is also being recorded so please make sure to identify yourself when speaking. I'll now go through the roll call. Paul Tang?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

George Hripcsak, MD, MS, FACMI – Columbia University

Right here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. David Bates? Christine Bechtel?

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

Good morning.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Christine. Neil Calman? Art Davidson?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Art. Marty Fattig?

Marty Fattig, MHA – Nemaha County Hospital

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marty. Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Leslie. David Lansky? Deven McGraw?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Deven. Marc Overhage? Latanya Sweeney? Charlene Underwood?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Amy Zimmerman? Tim Cromwell? Joe Francis? Yael Harris? Greg Pace? And Rob Tagalicod? And any ONC staff members on the line?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. And with that I'll turn it back over to you Paul.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

All right, thank you MacKenzie. Good morning everyone and I'm glad you're enjoying the weather out in DC and we have some 80's coming up tomorrow so we'll send that over your way as well. So, this is an interesting agenda, so what we'll do is we'll start with review of the feedback we got from the Policy Committee on our recommendation for MU3 both the consolidation and deeming and we also spoke about clinical documentation we'll go over that with you as well, and then we'll try to get the sense of this group on the direction based on those comments and feedback from the Policy Committee.

Then what I thought we'd do is go over the work plan and in fact maybe I'll just start with that now. So, the remainder of this call we'll work on some of the RFC comments, remember we had sort of tabled the RFC comments while we went through a revamping of the approach meaning the consolidation and the deeming because we want to fit the RFC comments into the new structure rather than the old.

And work on parts of the comments in this full group, meaning not in the subgroups, where the public comments were divergent. So, there were some comments really overwhelming supporting the draft that we put out for comment and some where we got more than one viewpoint and we wanted to go over those pieces.

Then we would finalize the consolidation and deeming proposals in the April 30th, our next call is April 30th we thought we would...and then have the subgroup do any adjusting and I will explain that in just a little bit, do any adjusting for the recommendations we've put forward so far and then come back and present that at the April 30th full workgroup call. We'll continue with the – you know, it's called divergent public comments in the full workgroup on the 30th and then break up into our subgroups and go through the categories 1 through 4 and take into consideration the comments we got from the public.

And then finally come back together and the proposal is give ourselves until May 28th instead of May 14th to go through all of the – reconcile the RFC comments while incorporated into the MU objectives in the full group on the 28th. Does that make any sense? And, I know that it sounds a little confusing, but let me open it up for some questions and then I can explain more if needed.

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

Paul, its Christine, so the subgroups should not break up until April 30th or after ...?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct. So, we can use the time that's been set aside on our calendars to revise the consolidation and deeming recommendations and bring that back on the 30th and then we'll break up into the subgroups after that one.

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

Okay, because I think we have a subgroup on the – oh, no, I guess that's ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

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

Okay, I'm confused – patient and family engagement subgroup or consolidation but that's just my issue, I'll figure it out later.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

No, it's not your issue, we've scheduled them as subgroup calls but we're going to revised them, we'll substitute the consolidation and deeming calls instead.

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

Oh, great.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, we'll try to work that out towards the end or MacKenzie do you just want to change that after we break up?

Michelle Consolazio Nelson – Office of the National Coordinator

I think we might need to cancel a few, for example we have one Thursday and Friday of this week, but we probably only need one for consolidation and then we might be able to – on the 15th is the patient and family engagement call, so, Christine because that's your group anyway maybe we make that into a consolidation one because that means that you're available.

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

Gotcha.

Michelle Consolazio Nelson – Office of the National Coordinator

|But we can figure that out.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so let's see where we get to at the end of this call and then we'll sort of readjust it may be clearer for us.

George Hripcsak, MD, MS, FACMI – Columbia University

So, Paul, we talked about, this is George, we talked about slowing down a lot which I think is actually a mistake because then you just kind of waste time and then end up doing it at the last minute anyway.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

So, it sounds like we're more or less going, other than a little bit of slowing down, we're pretty much going on our old schedule and I think that's the right thing to do, but what are we presenting say on June 5th?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I don't think we're presenting anything in June. So, we are going much slower actually because we originally were going to present our final recommendations at the May meeting.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

That would have been next month. So, instead we're probably going to be presenting in the July or August timeframe.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, so we don't need to present in June and we're not presenting...are we presenting anything in May?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I don't think so.

George Hripcsak, MD, MS, FACMI – Columbia University

I don't think so, okay. So, okay, that sounds fine.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

We probably need to determine how the reconciliation goes and what work we have to do in order to finish up for consolidation and deeming.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Michelle, any comments on this approach?

Michelle Consolazio Nelson – Office of the National Coordinator

No, I think it makes sense. So, we will be addressing some of the meetings, but otherwise ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

I think we're on a good path.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, any other comments? We'll review it at the end of this call just to make sure we're all in sync.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Paul, its Neil, just to let you know I'm on.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Oh, hey, hi, Neil, right?

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Yes, Neil, thanks.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, yeah, we got voices by now. All right let's go to the next slide then. Now, I believe, I think everybody in this call either was at the meeting or probably listened in, is that correct, so we don't have to go into the details of the slides?

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Why don't we skip over to the comments we got back and I think that's on page 25. Okay, so we'll just go over these fairly quickly and we'll hit the ones that are directional and ask, and pause, and see what the workgroup members think.

So, Farzad liked the approach, he really did like both the consolidation and the deeming, and the goal really is to move more towards outcomes and to reduce the burden, and streamline the work that's needed on the part of the providers, so that was a good approach.

But, since we're short on true outcome measures his question was whether there are ways to deem functional measures even for non-outcome measures and the other – and so one of his pleas was to be even bolder in terms of consolidation, to make the administrative overhead of complying with this program easier, because the thought is that we've already had four-to-five years of Stages 1 and Stage 2, and we know from the past history that people one blow pass the thresholds and two keep going and the reason is because these are useful functions.

So, let's reduce the amount of work it takes to qualify for the program and point everybody in the direction of outcomes or things that are surrogate outcomes. What do people think about that? So, I think this is mainly directed towards consolidation at this point.

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

That's funny, Paul, this is Christine, I thought it was mainly directed towards deeming. So, I think, is the issue or is the question, you know, we took a very purely consolidate kind of approach, so should we go back and kind of go with a deeming lens and think about, oh, well if we did this we could deem for that and try to add some of the deeming approach instead in, is that what we're thinking?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah, so, yeah, I think, it's a little bit of both in the sense of consolidation and deeming. I think, if you let's say use a process measure well that probably can...you could call it deeming but it probably means that you did use a function.

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

I think, what's confusing me – I agree, what's confusing to me is we didn't look at the quality measures at all.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

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

So, are we saying the consolidation group should go and look at the quality section or do we need to engage the Quality Measures Workgroup on that? I'm happy to do whatever I just want to make sure I understand it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle, I'm sorry, go ahead, Paul?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
No, go ahead Michelle.

Michelle Consolazio Nelson – Office of the National Coordinator

So, my understanding was that so there's some functional measures like closing the referral loop, which we actually talked about in the Workgroup, but, you know, using that as an example that could possibly be a way to consolidate as well.

So, the example that Farzad mentioned were patient safety related items that you could possibly use for some of the medication items or patient experience in closing the referral loop. So, those are all CQMs but there might be functional measures that we could consolidate by requiring that people do those quality measures for example.

So, when we did the consolidation we didn't really look at quality measures, when he was – my understanding was that he was pushing to, why not use a quality measure that might push – while may not be an outcome measure itself it pushes a little bit further than some of the functional measures that we currently have.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah, so it's in the gray area.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think, you're right, Christine, it's a bit of both, so closing the loop is a good example. People would hardly think of closing the loop as an outcome measure yet it would certainly take care of the referral, the functional objective that we have.

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

Right and I mean that actually is a function.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

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

As well as a quality measure that was already proposed, so, but anyway, I get the point. I think, the question, and I agree, so it makes a lot of sense for the consolidation view to kind of look at, well are, you know, I think, what we're saying is are there two or three process measures that because they're process and not condition specific outcomes might apply to every eligible provider and hospital that if we went back to almost the approach we used in Stage 1 where there were three measures that everybody had to report, but these are more process measures and more related to the functions of an EHR then could you remove some of the functional requirements, although I don't know.

I mean, so we should look at it, because you may just be swapping in three for swapping out three and what's the point there, but maybe we can find some, you know, patient experience would be something that would be, you know, more synergistic. So, as long as that's in our scope and you don't think that we need to enlist the quality measures or maybe we should, you know, invite a couple of quality measures folks to be part of that, whatever you guys think is fine.

George Hripcsak, MD, MS, FACMI – Columbia University

Paul?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think it's in scope in the sense that if you pick the measures that are, you know, fit for process...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And this is Leslie, so for instance would it be a high value area for the process to look at where do we get the most critical mass as a result of it? Whereas the quality measures goes to a very, very specific disease or condition, or treatment, is that a way to slice it differently?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, I'm not sure exactly what that meant, but here's an example, if you're posting a report...so, you're trying to help somebody a patient, a consumer pick a provider or a hospital and you're going, gosh, you're probably not going to say, gosh I wonder how many times they closed the referral loop, that's just sort of not on your radar. So, it's sort of a dividing line of is this something that measures good performance from a provider point-of-view versus some process thing that reflects, that could be a reflection of using some EHR function.

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

So, I think, the ideal is if we have a measure that actually, you know, was a single measure where then it covered two or three functions.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

And broadly applicable that would be the way to go, because if it's just one measure that covers one function then I don't see the point.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

That's what I was trying to get at Christine; you said it better than I did.

George Hripcsak, MD, MS, FACMI – Columbia University

Paul, was Farzad asking us to change the way we're doing this when he said ...?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I don't think so.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, because when he says tie deeming measures to the function measures well we're doing a panel of deeming to a panel of functional, so one interpretation is we just have to draw the mappings so we know why we put these in the list. Another is that we actually should do the deeming like we're doing consolidation for each quality measure say which things come under that and it really becomes kind of one list of things that get eliminated because they're under some other thing.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think we – okay, so, first I think he isn't – he doesn't want to – it's not necessary to do one to one and have the mapping just...I think, what he's looking for is a rationale to why you would deem or why you would consolidate and not specifically something that would remain forever, you know, there is a one to one mapping.

The way we did deeming was – we did take a look at a quality measure and figure out what functions would be covered. The way we presented it was, okay if you did these things, you know, pick two from here, pick two from here, you would get deemed for this whole list, but in the interim along the way we did do some sort of one to one.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, I don't think we need one – it could be one too many or whatever or many to one is fine but you think that consolidation and deeming should stay two separate processes?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think so because consolidation applies to everyone deeming is an option, is an alternative pathway.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Well, consolidation really just explains change in our requirements, right? Consolidation is not really an option.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Consolidation is just basically, I mean, in a sense the way I think we're going to confuse everybody by talking about consolidation, consolidation is just something, it's an internal discussion we're having now about simplifying the requirements period.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

That's correct. So, it will be presented as a streamline version of the Meaningful Use functional objective.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

But it's not an option?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

It's not an option.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

And there will be an optional alternate pathway where high performers can deem satisfaction of a subset of questions, simplified.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

...

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

Yeah.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Yeah, so I think, the reason it seems confusing is because we're really talking about two totally different things.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

One is just talking about a change in the requirements for Stage 3 and the other is talking about an alternative pathway.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

And the other thing that I think is confusing is, you know, the way we presented the deeming the last time it was really all about outcome measures.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

And is the question that we're trying to consider whether or not we would consider deeming for some process measures as well?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Um.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

In other words for people that are high performers in relationship to the use of the electronic health

record, you know, they're using it for creative stuff for doing, you know, I mean, or we're just looking at it as – see, because I think what's confusing about the deeming, and I think it's going to confuse a lot of people, is it stops being about the EHR.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yes.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

And from the beginning we've been saying you might be the best provider in America but if you're not using the electronic health record to achieve that we're not giving you credit for it. Now, we're reversing that basic position, we're saying if you're the best provider in America we're going to relieve you of some electronic health record requirements and I assume that the second part of that sentence that we're not saying is because we don't think you can be the best provider in America if you weren't using the EHR to achieve these things.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
So, I think, all we do is switch the order.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health
Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Saying, because at this point in 2016 to be amongst the top 30 percent of the providers you probably can't be doing that without effective use of an EHR and that's the motivation for us to not focus so much on the process of using an EHR where you had to do that initially in Stage 1 and Stage 2, but by Stage 3 and 2016 it's just not possible to be in the top 30th percentile and not be using an EHR, that's our assumption and that's why we're deeming. So, it's not to say that we've given up on the EHR and so that's why I'm just changing the order of what you're saying.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health
Right.

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

Hey, Paul, this is Charlene. I had a clarifying question on this topic in the more objectives. Robert had indicated or I was not there, but I read in your notes that he had indicated alignment across other programs.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yes.

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

And I know that's part of the map process and that type of thing but is there any opportunity to align across programs as we're doing this? Because, again I think that would just be, you know, start to link together what we're doing in health reform with, you know, our program and make a clear path.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yes, we are constantly looking for that alignment.

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

What he pointed out was that PQRS, in fact our quality measures or 2014 measures is already aligned with PQRS.

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

And I believe, and correct me if I'm wrong Michelle, but if you satisfy PQRS there's already a deeming for the CQM part of meaningful use. Did I get that right?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes, you got it right. There is a slide – I took the language from the Stage 2 rule; it's in the back of the deck if people want to look at it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

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

And for ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, it already had alignment so that's why he was saying that's the starting point.

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

Okay.

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

And then Paul for hospitals I think the alignment comes in the list of measures that you presented at the Policy Committee which are in alignment with an assortment of hospital reporting programs.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Though I don't think at this point you get deemed yet, right? They're aligned but not deemed.

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

Right, but it's still – correct, but, yes. I'll just say "yes."

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

The fact that we're aligned gives CMS the option to consider deeming.

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

Yeah and so that would be an interesting slide to have in our trajectory though, you know? We kind of talk about it but, you know, you've got some other powerful content there, but it's just a thought.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

That's a good point. We can have a slide that already shows for the EPs.

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

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

The deeming PQRS and we can show the alignment and the EH side of the quality measures. So, that's a good point. Now ...

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

And then it spills to like what Neil was saying, it's like this is – we're on this path already, right?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct, right.

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

Right

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

So, about PCMH? Because, I think PCMH is probably, you know, the best indication of not only a high performing system but one that's using lots of functionality in relationship to, you know, to HIT.

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

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, that's a good opportunity for me to raise the other option, in other words, so PQRS deems for meaningful use at this point, it seems to me Meaningful Use may better track HIT functions and so that might be good to use as deeming for PCMH for example.

So, PCMH is saying you need to have, you know, you need to pay attention to your patient's experience, you need to have good HIT systems, you need to be monitoring your populations, but in a sense they should delegate or relegate the judgment of you have good HIT in place to Meaningful Use it might seem.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Yeah, I think, it really works in the other direction, because the stuff in the PCMH 2011 criteria it's virtually impossible to do the things that those criteria call out, but more than that because we've always talked about how it's important to implement the – doesn't really do anything, but it's how it's integrated into the processes of care that really drive improvement, you know, that's what PCMH gets to that I think meaningful use doesn't, you know, meaningful use basically says here's the tool, you know, and here's using it as a measure, but PCMH I think really drives the integration of those tools into actual practice.

So, you know, if you're using – in a sense to me that would almost define the deeming with some of the other features of the use of the system because it's, you know, in a sense PCMH is close to an outcome it's basically saying you're using these tools to achieve a certain level of performance in your delivery system. Anyway, that's just, you know, it's a thought. The problem with PCMH is its site specific more than individual specific and I don't know if that could actually be used in a system like this.

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

Neil, this is Christine, I mean, I think it's worth looking at, because I agree, I actually think that PCMH has a broader set of requirements than those that are facilitated by Meaningful Use they include many, if not all, of Meaningful Use objectives, but it goes beyond it.

But, it also depends, I mean, there are four different accreditation entities for PCMH and then we have a lot of private sector health plans that have set their own independent standards that may or may not align with those within each of them, you have must pass and optional, I mean, there's just a lot of different configurations that have led to some significant variation in implementation in the field.

So, it's challenging for me to think about, you know, how to do that except to leave it to the accrediting agencies to say, if you've completed Stage 1, 2 or 3 of Meaningful Use that counts for "x" number of, you know, their individual requirements.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I guess that's the way I was looking at it, it seems easier for them to say you get so many points for Stage 1, 2 or 3 than for us to track all of the different consumers of users of EHRs and then mapping those back into meaningful use. I can see how you can look either way, but I sort of thought it was easier the way Christine described it.

So, any accreting body, you know, whether it's PCMH or ACO can say, hey look one of the components of being an effective ACO or a PCMH site is to have effective use of HIT and so we're going to deem you in fulfillment of that section according to the stage you've achieved.

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

Well, you're right Paul, but it's further complicated by the fact that at least for Stage 1 which is, you know, operation for a couple of years yet, it also depends on what menu items you chose, so there's, you know, and how the menu items of meaningful use align with the elements that must happen or not in PCMH. So, it's got a real level of complexity to it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

But there are also things like connecting to community resources and, you know, other items that are not part of meaningful use.

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

So, it's not simple.

Michelle Consolazio Nelson – Office of the National Coordinator

And so, Paul, this is Michelle.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I just ...

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

It gets to trying to figure out what is really critical in relationship to transforming the delivery system, right? Because that's our ultimate goal and I think that, you know, when you get to the actual use of data to sort of provide functional improvement in your delivery system that to me is like the highest level of achievement, you know, because we know this.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right, so, is meaningful use – so here's the directionality I think, is meaningful use a part of being of a PCMH or is PCMH a part of meaningful use? I think it's the former which is why I think meaningful use deems satisfaction of this component of this other cause.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

It's actually they're overlapping, there are pieces of PCMH that go beyond Meaningful Use and there are pieces of meaningful use that go beyond PCMH.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

Yes.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

So, I think, that's where we're struggling, but if you were to ask me like so if you're thinking about the healthcare system and its transformation, which is, here's the why I put one circle in the other, which of these is more, which of these would be a more important certification in relationship to what the country is trying to do around transforming the healthcare system I think you'd have to say PCMH because it requires the implementation of these things into normal workflow and a real transformation of practices, not at level one but, you know, at least I guess I'm only referring to NCQA which is the one I'm most familiar with.

But at level three, you know, you need all of the tools and you need to show that they're implemented and integrated. Anyway, I don't want to dominate this and take up all your time with this thought, but it would just be so nice to be able to figure out a way to credit people for all the work that they're doing in that regard and maybe there is a way to take, you know, to say if you achieve a certain level of PCMH that there is a part of these requirements that you could be exempt from.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, let me try one more try using your graphical way of representing, you talked about the MU inside of the bigger, it like a Venn diagram, inside the bigger PCMH, the question is are there many of these bigger circles and I think in that representation MU would be a part of these many bigger circles and so do you say that the small circle gives you a component of the bigger circle or does the smaller circle MU have to keep track of all these bigger circles to get deemed from? Do you see what I'm saying?

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

With that you lost me completely, but that's okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, all right. All right maybe I'll try to write it out somehow and we can try to have a discussion, just so we can have a recommendation anyway.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so, I think, so Christine it sounds like you understand what to look for, you said you didn't look at any quality measures maybe if we look at it and you may or may not find, you know, more than few where

you can take some of these process QMs and deem that as a one to one or a one to many consolidated functional requirements.

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

Will do.

Michelle Consolazio Nelson – Office of the National Coordinator

Christine, this is Michelle, Jesse and I were going to take a first stab and give you something to start from.

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

Oh, awesome, even better, thanks.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

All right. Okay, then Terry Cullen, so this was the whole deeming thing and I think we just had that discussion, there is one – except for the following comment, so, the question was are we going to use data outside the EHR and I think one of the ways I responded to it is change EHR to HIT.

As we've talked about both patient reported outcomes and patient experience like CAHPS are now things that you can acquire instead of these onetime expensive ways of doing it on paper you could do it at a more ongoing basis using HIT namely PHRs and patient portals, in other words, patient facing HIT tools. So, that is sort of how we were thinking about capturing the patient's viewpoint and then consequently using that as a measure of let's say care coordination as an example.

Christine went onto – so the question was; well, would that also get us into program integrity, in other words using CAHPS for more than one program? Christine's response was well there is an HIT version of CAHPS that could be much more specific and both valuable to our program as well as not interfere with program integrity. So, I'm not familiar with what subset is in HIT CAHPS but you're just saying there is one, right?

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

Yeah, I'll actually pull it up right now because I looked at it earlier and it would deem a lot of like VDT, secure messaging, etcetera.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

If you made performance tied to a limited number of the questions, because there are more questions around, you know, did the provider have a website, is the website understandable those would be very valuable, you know, that would be great feedback to get but, you know, obviously you can't hold a provider accountable for that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right and the nice thing is – and I don't know the question – the attractive thing about looking at it from the patient's perspective is that if I know that I can access my practice, my PCP electronically that's a confidence and a comfort that I have as a patient whether or not I actually need those services and that's a better measure of what we're trying to do rather than trying to count these things and then sometimes, you know, forcing people to do things that weren't required.

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

Yeah, I think, there will be a couple of challenges that we I think probably need ONC's help investigating and that is number one I think that the HIT CAHPS, I'm going to look right now, is...first of all it's only specified at the clinician and group level so it's not hospitals.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

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

And I'm not sure that it's individual clinician as opposed to group level, so I don't know how that works for a solo practice for example, but it kind of makes sense for HIT CAHPS to be at the group level because there are systems and processes as opposed to – so you can make the assumption that if one is doing it the other one is too, so, I'm okay with that. But, then we have to deal with the hospital side of things. The

second piece of it is hospitals are already doing HCAHPS as part of their reporting and so they've incurred those costs, there is an infrastructure, there's a process that's happening.

But it does actually cost money to field HIT CAHPS and, you know, look at your data and all of those things so you could – you know we have to think about that. But on the other hand CMS has a long history of providing the infrastructure in federal programs like CPC the old group practice demonstration project things like that where they have made the infrastructure available so that it doesn't cost the practice.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, is this something that you feel comfortable and willing to undertake that question or is that something ONC needs to help us with?

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

We need ONC's help. I'm happy to work with them, but we're definitely going to need ONC's help particularly on the infrastructure piece and then I think we need to have a gut check. We'll look at the HCAHPS question, but whether or not they have appropriate questions that we could use in the – that could deem already for meaningful use if there was a performance threshold requirement, so we'll look at that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so do we think this is a deeming or do we think this is a consolidation?

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

It's kind of both, because ...

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

It's kind of both if you look at these questions.

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so, if you want to start it, Michelle do you think you could just help her?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, so maybe Christine and I can work together and I can get the appropriate people from ONC.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct, yeah, thank you and then just throw any deeming – if you think whatever applies to deeming you can certainly pass it off to me.

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

So, this is Charlene again, clarifying, if we would require this, again, what is ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

It's not required. It's not required this is a way to deem or consolidate.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, Paul, I think you need to be clear, I mean, if we have deeming is the thing that's optional and consolidation is the thing where we're just changing our functional objectives, I mean, there nothing, there are no choices being made it's just here's how our program is structured. So, it sounds to me like this is more deeming than consolidation.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I agree.

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

Yeah, I agree with that.

George Hripcsak, MD, MS, FACMI – Columbia University

Which could be Christine doing it, that's fine, but it's a deeming thing not a consolidation thing.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I totally agree.

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

Yes.

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

Yeah, then it gets to functionality, you know...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yes, no that's right, that's right. Okay, but I think Christine was volunteering because of the consumer side.

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

Yeah, consumer side to look at those questions.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I'd be happy to help too Christine, this is Leslie.

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

Thanks, Leslie.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, good, thank you. I think we took care of Gayle's question and I think we took care of Rob's question about the alignment.

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

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

And Terry Cullen's question, none of the measures are included in core, oh, did she mean – she didn't mean core measures she was meaning core.

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

CQMs.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Meaningful CQMs right.

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay and that may be true but this was on the deeming side.

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

Right for Stage 3.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, that's optional, so I think that that's just a statement and it's true and it's still okay.

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

But, I think, it does mean Paul that we have to make sure that if we go do another comment or public comment period for the Policy Committee or in our recommendations to ONC that we flag that those measures need to be brought into the Stage 3 NPRM for comment. Does that make sense?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Her comment was not in core, it didn't mean that we weren't – it wasn't part of ...

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

Oh, no, what I heard her say was those – many of the measures not all but were not in the final measures list from MU2 2014 so they would need to – any that weren't in that would need to be in the final or be in the Stage 3 NPRM process that's what I understood.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

There are two comments, one is they aren't in core and that's okay, because this is an optional program. The other is that if they weren't in 2014 then you don't get a place to improve that was an issue.

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

That's right, yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

That's true too.

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

Well, but not if you do the six months pathway.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

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

And there is a way to work for it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well or – right, you either do it six months – well, I think your choice would be good performance and then of course the question arises whether you have a benchmark, because I don't know where the percentile is coming from.

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

Right, that's what I'm saying. So, if at the beginning of the 12-month period you reported and, you know, your baseline and that was an indication of your intent to go down to that deeming pathway and then, you know, you have, you know, at the end of the – you signal both at the end of the six-month period you report and that way you've got a baseline and a benchmark next measure.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah, you just would be in double jeopardy you wouldn't know whether you had improved until the end of the year.

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

Well, not if we have the population health dashboard though.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yes, which I think you consolidated, right?

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

Yeah, but it's still in the certification criteria.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah, yeah. So, this does raise the question of where is the bench – is the benchmark being set by CMS for all the people who are reporting and maybe that's also where Terry's question comes and if nobody has a report than you may or may not have, you know, a large sample.

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

I thought it was just improvement over where that practice or hospital was so they're comparing them themselves not to others.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, that was one track.

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

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

You could easily be an improver or you could be a high performer and how do we set the high performance threshold if we don't, if CMS doesn't already have enough people reporting on that measure.

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

Well, I guess it doesn't have to be in the context of only meaningful use, right?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Correct.

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

You know it more than I do, but if they say, none of those measures are particularly new so if they have enough data to say, most people, you know, high performer top 10 percent means this number then you ... because they should make that available before people decide which pathway they're going down.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Exactly right.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

And what would the time period be for that? I mean, these are like cross sectional things, right? You know, are 80 percent of your people in control for their blood pressure, like would you have to meet all of these things in one slice of time, you know?

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

So, we had proposed a six-month reporting period.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Right, but what's – so during that six months I guess what I'm trying to say is to reach a certain threshold on an outcome measure like that, right?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Would you have to have – would you have to be able to show that during every day of those six months 80 percent of your patients are in control of their blood pressure? Do you know what I mean?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

It doesn't really function that way.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right, I hear what you're saying.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

It really functions as a – it's a cross sectional view when you're asking something about that, it's different than looking at whether or not you gave 80 percent of your patients, you know, an after visit summary, because that takes place over a period of time but this is a different type of measure.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right, so, I think the way it would be written, Neil, is for the people you saw during that reporting period, so, in this case for the people you saw in this six-month window what percent of the last, in this case blood pressure, were controlled. So, I think the numerator is the last reading and the denominator is determined by the window.

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

Okay.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

So, we have anything else that's functioning like that right now in terms of how we're reporting things out? I'm just trying to see ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, actually we already have blood pressure control, so, I think, in Stage 1 you have QMs that function this way, so, in the reporting period, which was 90 days, three months, for the people seen during those three months I'm guessing that the numerator was the last "x" last cholesterol, last blood pressure. There is no threshold of course but that's what was reported. Does, anybody else know right off the top of their head? I'm pretty sure it's the last.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Yeah, I mean, if there's no threshold it's easy to basically just to do that. I'm not even sure, maybe if there was no threshold it might have just been the percentage of people who had their blood pressures measured.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, that is a, you know, a quality measure, but there are control measures as well.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Okay, sorry.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

No, no, no that – I mean we have to figure out these questions. Okay, so the challenge here is to be able to write this criteria.

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

So, Paul, you know, the percentage measured is that one of those ones that Farzad is asking us to like try and carve out those types of measures which are indicative of the process then?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, I think, the percent measured let's say a blood pressure certainly could sub if we weren't already consolidating a vital sign or blood pressure.

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

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

But we would not use that in deeming.

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

All right, okay, it was just ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

All right.

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

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, can we go to the next slide then please? Okay, then we have a number of things related to specialists and here we got into the discussion of whether registries participation in registries deem or consolidate, it's probably more a consolidation for a functionality like patient list for example and then we got to the point of well not every specialist has and very few specialist have registries that are broad-based. So, I don't know – and then we got into QMs. So, let's tackle the registry question first, is this something – and I think you already did do that in consolidation is that right, Christine?

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

I'm sorry, Paul, I was on mute, can you repeat that?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yes, is participation in registries something that deems you in consolidation?

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

No, we consolidated objectives and we had like three or four that came down into two.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, that was under the public group, public reporting or public health.

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

Public health.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Hey, Paul, we didn't do it that way but certainly list the excuse for not doing list could be registries.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yes, yes.

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

Do you mean patient lists?

George Hripcsak, MD, MS, FACMI – Columbia University

I don't know how much else we would consolidate other than ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Maybe reporting? How about the – we can certainly do the public health registry and you could do category one list.

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

No, we, eliminated lists because we said you had to do that already for a couple of other things including the population health dashboard.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

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

So, I think that the question I have about registry participation is do you get the feedback loop and is it performance stage or is it – do you see what I'm saying?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah. So, in a sense I think part of the answer to this is registries essentially is already patient lists, which is the most obvious thing that would be consolidated on a registry is already consolidated under other things and you reduce the number of registries in public health. But, then we might look at it is there a deeming pathway for registries?

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

Yeah, I think that's the question and I think it does have – you know, and I don't know enough about the particular registries we've proposed in meaningful use to know how well they tie to and can make data available to the federal government for reporting, because if it's deeming I think what we heard from Rob Tagalicod is sort of program integrity perspective, if they're getting deemed for all this stuff but there is no performance indication.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

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

I think that's problematic.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, I don't think by definition we wouldn't consider any participation as part of it.

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Because we want it to be performance.

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

Right. The other thing, Paul, is that there is a – there was an RFI out on clinical registries, I think the comment period closed yesterday, so CMS has gotten a lot of feedback now from a broad variety of stakeholders around registries, clinical registries, how they should be tied to PQRS for participation and things like that, it was a provision in the health reform law, so, it might be worth asking the CMS folks who are working on that to weigh in on this.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle; the Quality Measures Workgroup is also looking into it and I believe Kate Goodrich is

part of that group anyway, so maybe we can defer some of this to them or help them – ask them to help inform our group.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

Paul, a second? This is George. So, number one, we made patient lists certification only so we don't need to deem it necessarily.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Number two, we talked about in deeming that we would be able to take care of it, remember, because that's the other way, that's the way of reporting, but in fact we don't need to because you already made it certification only under consolidation.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

George Hripcsak, MD, MS, FACMI – Columbia University

But the question they're asking is can they do deeming through professional registries and that I don't think makes as much sense for the reasons you just said.

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

Yeah, I agree.

George Hripcsak, MD, MS, FACMI – Columbia University

Because they're doing a functional thing and they'd have to do well in the registry.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

George Hripcsak, MD, MS, FACMI – Columbia University

To deem with it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
And CMS would have to know that.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, that probably is not going in the right direction. The other question that's embedded in here is that specialists don't have as many CQMs and one of the response is, well, it's a little bit of a horse and cart or chicken and egg, because NQF for example relies on specialty societies to propose them.

So, one of the things that can – this program can potentially provide an incentive for specialty societies to develop more outcomes oriented measures, that would be good. But, they're not excluded from anything since deeming is an optional pathway.

George Hripcsak, MD, MS, FACMI – Columbia University

I mean, ideally there would be a process whereby a registry organization works with ONC or CMS I guess to say, here are the outcome measures we're measuring and here are the results for everyone who is participating in the registry and then rather than having to pick two off of your list Paul or our list, you know, this registry is allowed to, you know, there's two outcomes the specialist exceeded in and that's what would kind of make sense for deeming. But how we would set that up I don't know.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, Michelle, it may be easier – this is another question to put on our list for working with Kate maybe there are some ways that we can put our heads together and try to come up with another approach to this.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, I think the bottom line here is the whole country needs more and better measures for specialists and this is putting yet another incentive for specialty societies to work on developing measures that are outcomes oriented that go through the NQF process, that's not a requirement, but that's one of the ways to get, you know, deeming in many programs and that would help us with this alternative pathway. And, Christine at the same time pointed out and we also have our own pathway to help measures get through and get noticed and that was the innovation pathway for CQMs.

So, the proposal we had in the RFC was if they could get waived by one of the core measures if they submitted a measure they've been using and the experience they have on something that's a measure that they developed themselves, as long as they provided some of the information about that measure from a mini NQF endorsement application.

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

Paul are we – it's Christine, are we going to do any other Request for Comment as part of this process that you know of?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

It's not on our schedule and as you can see it's – so, no we've not done that before, because the next step would then be for us to make recommendations to CMS and ONC, and then they, as you know, would put out an NPRM which gives everybody another chance and then they would take those comments and make the final rule.

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

Right, but since ... said that the rulemaking process won't probably go until January, but I wonder if we have time – I mean, I'm just thinking about David Lansky's comment in the Policy Committee to ask specialists to propose subsets of measures for deeming that need a couple of requirements, you know, being outcomes oriented and things like that.

I don't know if we want to – if we were going back out for public comment to ask about the deeming and consolidation approaches, generally not re-opening the functional requirements but just the approaches that we could include that there, but I wasn't sure if we would.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

We weren't thinking about it. MacKenzie, do you want to comment on whether that's a reasonable or appropriate thing to do, come out with a Request for Comment on specific things?

MacKenzie Robertson – Office of the National Coordinator

So, sorry, this is MacKenzie, we can talk about it internally. I know we've usually done the larger versions of the Request for Comment, but the Meaningful Use Workgroup has done them separately before. We also do have the blog where we can put a request for public comment that's not as – it's an easier list to just do a blog thing.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

MacKenzie Robertson – Office of the National Coordinator

And see what kind of feedback from that, it's just not as formal of a process. So, we can talk about that off line.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, okay. Okay, any other comments about the Policy Committee comments? Okay, why don't we move on then and let's see, I think that – so I think we addressed – so, we have the “to do's” that Christine was going to look at the CAHPS the whole, HCAHPS as a deeming opportunity. We're going to work off line with Kate on possible things to align with CMS's quality measure reporting program and we're going to get some more information about the registries, and we also have to sort of understand benchmarks for percentiles in the deeming program. Okay, next, let's see, so we would answer those questions and come back with a proposal on our April 30th call.

Okay, why don't we move onto the comments on the clinical documentation and that's under recommendations, it's slide 31. So, we had these recommendations approved with the following comments. So, number one, moving into core and what's in green is basically Paul Egerman, no this is recognize the difference between clinical documentation – typically considered the progress notes of EPs, that's how we sort of define which text are we talking about.

Now the question is does that apply to EHS, what's the clinical documentation for EHS is it the progress notes of all clinicians, of physicians or what are we talking about when we say clinical documentation in a hospital record – if clinical documentation – is clinical documentation a menu in EH at all?

Michelle Consolazio Nelson – Office of the National Coordinator

I think it's just EP.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

I'm checking.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think it's just EPs. So, and we're not recommending that clinical documentation be included in Stage 3 MU, correct?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I thought that notes were going to be discussed, this is Leslie.

George Hripcsak, MD, MS, FACMI – Columbia University

I'm trying to look it up too.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah. I'm not sure we ...

Michelle Consolazio Nelson – Office of the National Coordinator

What's your question, Paul, for Stage 3, what was our recommendation?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah for hospitals?

Michelle Consolazio Nelson – Office of the National Coordinator

For hospitals we didn't make any, we didn't clarify.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah, so, I think, our original – I think our original Stage 2 recommendation was notes for both EPs and EHS, and what came back in the final rule was menu for EPs, and I don't think we did anything more with EHS, it is more complicated, but, do we have a position for EHS and notes, clinical documentation?

George Hripcsak, MD, MS, FACMI – Columbia University

Well, we think it's important the question is what effect it would have and what benefit it would draw, you know, on the hospital side we might get – it's harder to define – well, our definition was pretty much like a note by anybody during a hospital stay, which isn't that hard to achieve.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
And I think originally we just said there had to be one, one note during the admission.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Is there an opportunity, this is Leslie, to say that what's required is a certification for the structure of the note so that regardless of who is the person creating it we at least have a way to transport and move it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
That's a good point we could make it a certification requirement.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Because it would benefit not just the movement, but I think retrieving it for – retrieving notes in a structured way for research and others, this is generally where we see the narrative and it's not very easy to get to or understand. So, I think it's worth some discussion.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, the important part of a hospital – see a hospital admission is really an episode and the summary of that episode, the discharge summary is probably the more important document to refer out in transition of care. So, I wonder if we really are concentrating on the discharge summary versus all the clinical notes in a hospital episode.

Marty Fattig, MHA – Nemaha County Hospital

Hey, Paul?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah?

Marty Fattig, MHA – Nemaha County Hospital

Yeah, this is Marty, just a comment about what's occurring today, at least in our organization, and that is that these clinical notes are all being dictated and then scanned into the system, so they are available, the problem is, is when you try to compile data based on, you know, a population you can't get the data out of a scanned document.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

Marty Fattig, MHA – Nemaha County Hospital

And so, you know, I see a lot of value in some sort of clinical documentation that is actually part of the record and not a scanned image.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Can we refer this question about hospitals to the subgroup category one? I think that makes sense and then so the subgroup can make a recommendation back to our full workgroup on whether to include hospital notes and potentially look at the question of is it really the hospital notes that we want or the discharge summary so that it can be used in transition of care. So, why don't we refer that to that subgroup?

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, moving onto number three, I think the group liked our track changes idea and the only concern was raised by Paul Egerman about this is progress notes in the chart not the notes that are generated by ancillary systems like a radiology report. So, the fact that the radiologist made changes in composing the report is not covered under track changes when it gets reported into the EHR, the medical record then it's essentially like a text box. If you chose you, you the provider, chose to copy the radiology report into your progress note that would be known as a copy and it might be totally appropriate, but it would just be known to the reader if you pushed that button. Any comments about that? Okay, next slide, please?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Paul, this is Art, I just have a question about that last point.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yes?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

So, if you copied a radiology report would that report provide the provenance that it came from the radiology report or is that something ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

In copying you're able to pick that up, that metadata?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, the comment here had to do with referring to fraud. I think we do need to refer to fraud because that's one of the concerns that's been raised more broadly. It was nice that Terry said that, Terry Cullen, said that in the VA they already have Blue Button that includes the progress notes VA-wide and that's been going fine.

Further down is just a comment about the legal record and needing to know – what you'd like to do is have a – what was seen as of that date, this refers to, well, gosh, what did the clinician see – there's a combination of what was available and what was seen and you would like to know both what was available as of that date, so for example if a radiology report or a culture result was not available at the time that the person made the decision you'd like to know that.

And the other thing we introduced is and you'd actually like to know what was seen, what was reviewed as a part of that since nobody reviews everything in the record. The new recommendation and that's something we're referring back to the clinical documentation group, which is our group, plus certification adoption is Farzad's question about, well are there some functions in an EHR that actually don't have a face, an ethical face value.

So, for example if you were typing in your note and there was this little pop up box that said, hey look if you say one more thing you'll get, you know, a higher code that seems sort of beyond...there are some functions that just seem clearly motivated only by the coding itself rather than the content and are there such functions and could we actually proscribe those.

George Hripcsak, MD, MS, FACMI – Columbia University

So, why, this is George, I feel nervous about this one. I mean, what one person thinks is up coding another person thinks are tools to help you document. You know, once we're in the business then we're going in with a fine tooth comb going in and saying, hey here's a tool from company X – this one seems to be just up coding, but then this other tool from Company Y, yeah, it could help you with up coding but it actually also helps you just get your note done faster, so does this one count and not that one like? I think there are rules about – aren't there rules about attempting to up code in a systematic way or is that not true? CMS's again on the organizations?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah, I think there is guidance. Does anybody on the call know CMS guidance on this?

George Hripcsak, MD, MS, FACMI – Columbia University

Well, if there is I would rather that handle this situation rather than us coming up with a check list.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Of every tool you could put into documentation and then deciding ourselves, okay, this is thumbs up, this one is thumbs down. Like, you know ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, maybe ...

George Hripcsak, MD, MS, FACMI – Columbia University

Expansion, cut and paste, you know, there's a bunch, decision support, there's a bunch of things and then how are we going to really decide?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And if there's unintended negative context or like a physician office who is using these things to just eliminate FTEs in their organization and try to – as possible you don't want that penalized.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, Michelle, perhaps you could ask CMS colleagues about the CMS guidance about coding.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

And in particular sort of the up coding and bring that into our call for the, you know, clinical documentation.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Remember that the whole – one of the main recommendations of the Policy meeting that was presented at the Clinical Documentation Hearing was that we should be decoupling payment coding from clinical documentation so clinical – I mean, that's a solution that would solve Farzad's concern much better than trying to go in and fix it a little bit at a time.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I think this is mostly a public relations issue that we're trying to deal with here, right? Because of all the public criticism and stuff that's been published.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Exactly and I think that's what Farzad is saying as well, but it's, you know, hoping...sometimes you can't define things but you can recognize it. So, are there any – either line and as George is proposing, is maybe there is a CMS line we just need to apply in here and the way Farzad referred to it actually was a code of conduct for vendors. So, it's one thing to inform people about what the coding criteria are, it's another to coach them into writing things and yes it's hard to define.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

But there is probably some way – so, what he is asking is, is there a way that we could have a code of conduct and is there a way to at least remind people of the CMS guidance for example?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah, well why don't – this is Deven, I did just find some guidance on line, but probably best to get it from the original source which is CMS.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

It's just from last March so it's fairly recent. Why wouldn't we just add a reference that, you know, consistent with Medicare guidelines?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Right.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Regarding coding and avoiding fraud.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer
Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, but I don't know that we should say any – but there's a million things we could talk about that are CMS rules that people should follow and I don't want to sprinkle meaningful use with them.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well, right.

George Hripcsak, MD, MS, FACMI – Columbia University

I would rather let's just say the answer is that CMS covers this in this way and therefore we don't need a functional objective that's related to it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, I think the only thing – I agree with you George, about you don't want to sprinkle it with all kinds of guidance, but here there is a problem, there is at least a perceived problem and there is some real problem there we just need to try to nip it in the bud and one way to do it is to remind people of the relevant CMS guidance to this function and that's why it's sort of a code of conduct thing rather than an explicit test.

George Hripcsak, MD, MS, FACMI – Columbia University

But, my concern is that the problem we identified in the Policy meeting was that it's a combination, what's going wrong is a combination of using documentation to decide payment, yes, what Farzad's worried about the reaction to try to fix documentation to improve payment, but then also the reaction against it to try to stop people from doing that which has made it infeasible for doctors to write notes and thus the comment I don't notes anymore I just write them from the attending physician.

So, I think that – I don't want to create – it's like a nuclear – it's like a cold war where you up it on this side and then you up it on that side, I'm trying to cut it off. Because there will be unintended consequences the more we push on trying to stop this from happening.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

All right, I totally understand. So, let's look at the official guidance and see if there is something we can work with either to refer or somehow translate. Because it is a problem and, you know, it is a specific problem and it seems like we can try to reduce, you know, mitigate it in some way if that's possible.

Marty Fattig, MHA – Nemaha County Hospital

Yeah, Paul, this is Marty, and with the implementation of ICD-10 in the future that's going to be even a bigger problem because vendors are going to try and help us with converting to the ICD-10 coding and may even do more of this.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

All the while, George, we should be proposing the notion of getting away from payment by documentation, but as you can recognize it's going to take quite a while to make that happen.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But, this is Leslie, so is this really a question of is the ethics and the law concerns are the CMS's responsibility and the only area where we could provide any assistance would be in certification

requirements that this is how an EHR behaves with these certain things, but, I agree I think it's a slippery slope.

George Hripcsak, MD, MS, FACMI – Columbia University

There is nothing unethical about being told by the system that you've done these things and you'll get paid more if you actually write them down. The unethical part is when you encourage people to make up what they did.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Well, the system can't tell you that you've done these things that's the problem. A system can't say, well you examined the ear but you forgot to record it, so therefore if it's saying, please record the ear exam, now if you've done it – I mean, I don't see it as slippery as you do George. I think there is a pretty, I mean, I don't know how to structure our recommendations, but I don't think it's quite as slippery as you're making it out. I mean.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, let's – I think we'll be able to recognize it if we can see it. So, let's look at the official wording and see if we can't find a way.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I agree.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah, all right. I think that does it for the recommendations. Do you want to go to the next slide and make sure I'm right there?

Okay, then what we're – so, we have just a few things to tidy up in the consolidation and deeming proposals if we can just have one call for each of the Workgroups and I may not even need one deeming depending on what Christine does with the CAHPS.

But, finish up the proposals, actually deeming we can look at – probably look at the full set of quality measures. So, have one more call for each of the subgroups and then present our finalized approach at the April 30th full group Workgroup.

Then break up into – and then continue with the divergent public comment and in the meantime the subgroup can work on the ones that we're not talking in the full group. And my proposal is doing that over the following month and then get as a full group on May 28th. Does that make sense?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes, it does.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

All right, okay, next slide, please? Okay and next slide. And, Michelle, I'm not sure what to do here?

Michelle Consolazio Nelson – Office of the National Coordinator

So, sorry, there were a few open items from the consolidation group and one of them Christine wanted to kind of check back on the VDT and care summary where a few items were put into those and we wanted to make sure first that we weren't kind of overloading those objectives, and then if there – because there were items put into them where there any that needed to be required elements of the care summary for example? Because right now for the care summary the only things that are required are medications, allergies and the problem list. So, I think, Christine wanted to just kind of check and see, you know, now that there's been more thing put into the care summary do some of those things need to be required.

And, I think we had wanted to talk about it in the full workgroup. So, Christine maybe you're not prepared and I'm sorry I should have given you a heads up, but if it's something that we should talk about now it would be great if not we can talk about it another time.

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

Well, I think, I was waiting on you guys to advise or maybe it's CMS I don't know, but I think, you know, the issue here is we were all very surprised to learn that of all of these information types only two or three

are actually required to be at least part of the care summary, I don't know what the similar requirement is for view, download, but I don't think that was our intent certainly in Stage 2 that you could do a care summary that only gave two or three items when we have this longer list that we spent, George will recall, a long time, you know, talking about it and debating.

And, so, I think the first thing is to get some feedback as to why did the NPRM and the final rule list these fields but then the implementation only has two or three actually required and didn't really make sense.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Can you go to the next slide; I think that's the slide they're talking about, please? Okay, so, I think what's on the left side is what was in the final rule but also what we said.

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

Correct.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, in other words problems, medications, allergies are they required for everyone and I believe the language we used for the rest were and these other fields as appropriate or something like that, you know, as relevant or I think that's how we had our recommendations.

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

I don't – that's not my recollection, but I think, that's the homework we need to do, because it doesn't make sense – I mean, and I'd like to have an answer for VDT too, but, I mean looking just at care summary, you know, we wanted to have things like smoking status and vital signs. What were the ones that were actually required again Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

Problems, medications, allergies.

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

So, no vital signs and the smoking status, no patient name which is hard to imagine you wouldn't do, but anyway, no referring or transitioning provider's name, I mean, that's, you know, like, uh, so I think we need to understand what we suggested, what was in the rule and, you know, why it's just those 3 things, because my concern is if we're adding the CPOE for referral family history, if family history is not in fact required to be recorded in care summary and present, and it's also not required as part of VDT then in fact what we've done is just remove the family history requirement and not – you don't have to actually record family history.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Michelle, this is Leslie, too in the standards requirement for the consolidated CDA there are many more fields that are reflected in that standard than what's reflected in this necessary item list which was reduced. How do we reconcile all of that?

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

This is Amy and I've been real quiet because we had a lot of construction going on in the background, but it's quieted down so I feel I can speak now, I'm confused why it says on the top of this slide must include if the provider knows it but then on the bottom it says all summary care documents for those three that you mentioned used to meet the objective must include. So, is the top list you must include it if it's known?

Michelle Consolazio Nelson – Office of the National Coordinator

Correct, this is directly from the Stage 2 final rule.

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

Okay, so it is required if you know it but it's not required to collect it, is that the distinction?

Michelle Consolazio Nelson – Office of the National Coordinator

Essentially...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Or it gets ...

Michelle Consolazio Nelson – Office of the National Coordinator

My understanding is that if problems, medications, allergies aren't there then you're not going to get counted for it, if you will, for Meaningful Use. The other, you could easily kind of say that the provider didn't know it.

George Hripcsak, MD, MS, FACMI – Columbia University

So, this is George, I think the logic was that every specialist has problems, there are going to be problems and there is the potential of medications that you definitely want to know, if there are medications you always need allergies, but there may be some specialists who aren't in the normal course collecting a detailed family history on every patient or some of the other things and so I think that's how...

Michelle Consolazio Nelson – Office of the National Coordinator

Exactly.

George Hripcsak, MD, MS, FACMI – Columbia University

Immunizations would not be pertinent to everyone. So, we would need I guess like if you want to...and then what we did before since they were separate objectives you could put exclusion criteria under each one, now if we're going to consolidate under this one I don't know if we have different exemption criteria other than one general one that says its required unless you don't collect it in the course of your specialty, that would be a way around it, in other words the bottom would say "must always include" and the top half would say "must include the following information if it's relevant to the specialty or something like that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, I think it's a little bit simpler, if the provider knows it means is it in the record. So, if there is a...if there is an immunization in the orthopedic surgeon's record than it goes, but it's not required to count as a care summary if they don't have any immunizations in the record.

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

So, this is Amy, it really – from the point-of-view of must include its must include if you have it in the record and that is auditable, did you have it in the record at the time so they have to include it, it's really – it's not putting the onus on collecting it though.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

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

So, for something like smoking status or vital signs if you didn't – if you don't have it or it doesn't require the provider to collect it I think that's what – I'm trying to just make that clear as direction for myself.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct.

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

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, I think, in some sense the top half is sort of like a certification requirement so when you push the button the care summary will grab everything that's on the top half and go, the bottom is actually a use requirement not just certification. So, in order to qualify for Meaningful Use you have to have either none or some list of problems.

Michelle Consolazio Nelson – Office of the National Coordinator

And part of the reason they did that is because they consolidated those items.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Correct, yes.

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

Right, so, I guess the challenge is we had already agreed as a Policy Committee there were certain types of information we wanted to make sure did get recorded. So, the assumption under consolidation was put the information in use.

So, if we move structured labs for example into the care summary and they're not actually required to be recorded in the first place I'm worried about setting up a scenario where it is important for your specialty to collect family health history or to, you know, put structured labs in, but for whatever reason it's not part of your workflow you don't do it and therefore we removed it as an independent objective under the idea of consolidation but it doesn't actually get recorded somewhere else.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, let me try to interpret what I see here. So, structured labs, if you have labs then they must be structured I don't think that's a contradiction of what is said here. If you have vitals then they must be included, do you see what I'm saying? So, I think this is consistent with what you wanted.

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

So, I understand that, but let's take family health history.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

Where it's not typically, I mean, it may not be part of the workflow it's not in the same that I would say, you know, labs are pretty essential, right, to care and things like that?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

So, how do we approach something like that where we want to...we agree there was a priority to actually collect it?

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

What you're saying is we've sort of backed down this way right?

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

Yeah, correct, yes, exactly.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

We've taken out a requirement to collect information and substituted a requirement for the EHRs to be able to pass it on irrespective of whether or not anybody has collected it or not.

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, the only two things I think that you might have escaped or backed down are CPOE for referrals because it's new and family history. The others I think, you know, part of it is basically they are either now still required with problems, medications, allergies or they've topped out like vitals and smoking status.

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

Well, actually, Paul, can I ask one more – what about demographics where this is like detailed, more detailed race, ethnicity and language information, because we removed that as a recording objective too.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Because it was topped out.

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

Okay. Well.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So.

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

Yes, although if the standards evolve to a more granular level we would have to revisit that, but I ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

That's correct, that's correct.

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

I get you now, okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, I think the question we have is for family history which was, what percent was it before or is it...is family history in Stage 2?

Michelle Consolazio Nelson – Office of the National Coordinator

It's menu I believe.

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

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so that's an example where it's a menu and so you actually don't, you know, you haven't changed things.

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

Well, except that, you know, we saw plenty of menu items where no one picked them.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

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

But, is it menu and three though, because I think it went to core or that would be assumption.

Michelle Consolazio Nelson – Office of the National Coordinator

It went to core and we asked for 40 percent.

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

Thank you.

Michelle Consolazio Nelson – Office of the National Coordinator

The only other place – there is a piece about family history in CDS, so there is another, you know, thought around that too. So, it's kind of in different places, it's in the care summary and the VDT, and in CDS, that's something else to think about.

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

But it's not a required CDS?

Michelle Consolazio Nelson – Office of the National Coordinator

No.

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

All right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

So, this might be a time to insert Farzad's statement about trying to be bold.

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

Yeah, but, you know, Paul, I like – I agree with that on things where there is lots of, you know, reason to think that's going to happen, but to me family history feels more like disparities and patient engagement, you know, so that's what I'm worried about, but anyway, I mean, I think there's ...

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, but there's no evidence that collecting family history improves patient engagement or health really not on this scale. I think that it's not like – it's not the same as patient engagement or health information exchange. I think it's a lesser priority and I think we're being asked to pick the things that are most important and focus on them.

Neil S. Calman, MD, ABFP, FAFAP – The Institute for Family Health – President & Cofounder

Well, interestingly from patients, right, one of the things they complain about most is having to give the same information over and over again. So, really once you've recorded a detailed family history somewhere you really shouldn't have to do that every time you see a new doctor.

George Hripcsak, MD, MS, FACMI – Columbia University

I mean, in the long run that's right this will – your PCP will or medical home or whatever will be solving this and the specialist will just get a copy of it in the long run.

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

Right, but I think the issue though is, and this is an issue for the workgroup to decide because it's not necessarily specific to consolidation, what we're talking about is whether we convert family history to a certification objective only knowing that it was only menu in Stage 2 and so therefore it's not going to be core, there's going to be no requirement to collect it at all, and if people are comfortable with that then they're comfortable with that. I'm less comfortable with that obviously, but, it's for the group to decide.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

It's also one of the things that are talked about a lot in transitions of care to have that history brought forward.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

True, it should be, as should the rest of the chart I don't see family history particularly affecting...there is social history that could affect transitions of care much more than the family history of disease which is what we're talking about.

I mean, that's important for care and doctors should be collecting it or eligible professionals should be collecting it as needed in their specialty, although if we're going to come up with a common family history that makes sense to put forward then the ophthalmologist really does need to collect a detailed family history about the breast cancer and colon cancer, I mean, either they're going to do it or not and they can't just ask about glaucoma.

In fact that was our notion early on about family history that it should be a set of important things that are relevant on the important diseases. So, now you have ophthalmologists who aren't going to be required to ask about glaucoma but will be required to ask about colon cancer and breast cancer the two more important ones and that's where I'm seeing that it's just not quite fitting across all specialties, and that's why I think the flexibility is okay.

There are just many things that they should be doing in the physical exam, they should be doing things that we're not sitting there and coming up with objectives forcing them to do certain parts of the physical exam that everyone should do.

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think I agree with George's point.

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

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

This is not quite as strong as the others and so it might give us an opportunity to be bold.

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

Okay, can, so, if we're done on this it sounds like there is more agreement that this can just sit in the care summary as it is and not be independent and not be a required field?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right.

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

I have another concern that I'd like to raise unrelated to family health history when you're ready.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think we're ready.

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

Okay, I am worried that there is – you know, that the big sort of placeholder that we had in Stage 2 and really in Stage 3 for the care summary that was really important I thought was care plan field including goals and instructions.

So, I wonder if that should become the patient goals, you know, for their care when they're, when you're sharing a summary it seems to me that that is pretty essential to make sure it's included so that it's problems, medications, allergies and that field because we did a lot of work proposed in Stage 4 around the care plan that would be much more robust but that was really the only representation of it I thought we kind of had in here. So, I'd like to know if it would be okay to move that into a requirement.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

One of our issues with that one was the lack of standards.

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

Right, so it would be a free text field.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah and so is that an HIT thing or is that a professional ...

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

Well, in my view it's essential to care to move that from provider to provider with the care summary. I mean, the care summary is designed to facilitate a more seamless transfer of essential information and I don't see how that's not essential.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

So, in a free text are there other free text fields?

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

No, not that are required.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

So, I guess my thought is that, you know, as part of the process people are going to be writing in what they feel is essential to convey to somebody as part of the transfer of care.

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

That's the goal. In the goals and instructions?

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Yeah and they need – well, they need to have some place to say what's going to happen.

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

Yes.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I mean, there's got to be some field where it's not just a bunch of stuff that's, you know, categorized and that's transferred but where somebody can say, hey, I'm sending you this person and here are the three things that I think are most important to be looking out for in the next three weeks. I mean, there's got to be some place for that kind of information to be tasked. So, is there such a place?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Leslie, is this part of the C-CDA?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, we have – there is opportunity to put that in the consolidated CDA.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

And it's called care plan?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, we have in the long-term post-acute care team we've developed the beginnings of a longitudinal care plan as a template under the consolidated CDA and it includes things like goals and team members, and many of the more expansive care coordination fields that we've asked for. So that's ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

It sounds like it's sort of ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Go ahead, I'm sorry.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

... is that it?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah, I think, we're a lot further along now than we were about a year ago, but it has opportunity, it definitely has opportunity and this is one of those things where we don't have a mature standard because we haven't had a mature behavior of offering all of this information so it's a chicken and egg.

We have been very proactive under Larry Garber and others, Holly Miller and Russ Leftwich's team that said okay let's design this with the opportunity to mine, because we know that Phase 3 of Meaningful Use or Stage 3 will be around care coordination so let's be proactive. So, I wouldn't let this get in the way, because there is opportunity and this is a huge area for efficiency.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think it's good that there is – that the folks are working on this proactively. This sounds like something related to Neil's comments earlier in the call, this is a job for PCMH, in other words, it's part of delivering care in that model or ACO and I think we can provide the support when that behavior, as you said Leslie, we have to have the behavior first. This HIT committee doesn't dictate behavior, when the field and profession, and the models evolve then we want to be there and thankfully we're working on the standards to support that, but I don't know that we drive it ahead of where both the standards and the behavior are.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, I was saying that behavior is...because there is no way to do it easily and so post-acute care guys would say, hey, I don't get anything, I get the patient with no information, I got transitions with nothing meaningful, there is no care plan associated and coordination doesn't happen.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

That's behavior, because those guys are all getting things on paper right now and so we can put it there but the behavior is not there, we need to shape that.

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

But, I do agree with Leslie about making the right thing to do the easy thing to do, but I also think, you know, but the field will exist as an option and so I get that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

However, I don't completely agree with the idea that we're not driving behavior within boundaries, absolutely that's correct, but however, you know, people weren't collecting on a broad scale granular race, ethnicity, language and gender data before meaningful use, they weren't doing on line access for patients and certainly not VDT before meaningful use.

So, there are lots of ways, you know, whether it's using, you know, clinical decision support or whatever that we are in fact doing that, but within some fairly respectable boundaries, so that's – I think this is a small piece of those types of important drivers, so I'll say that. I don't know how everybody else feels.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, I guess I might look at it as when the tool became available people took advantage of it. So, getting lab test results back to patients is a behavior and in some cases is mandated by law, we had no easy way to do that before now that we have EHRs and patient portals then we facilitated that. So, I think it wasn't the chicken egg thing; we wanted to do something that wasn't really easy or possible on paper.

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

And when the tools became available we made that part of meaningful use.

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

And that's what I think Leslie is saying.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

That's exactly what I'm saying.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Well, but that's the behavior, the intent coming before the tool, here, I think the behavior isn't there yet.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think it's there it's just totally messy.

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

Yeah, that's what I thought, but I thought it was there and it's just not consistent and not easy. Okay, well, I think, we should move on and maybe we'll come back to this at some point.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay.

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

So, I think, Paul, the other question is going to view, download.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Go to slide 35 then, please.

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

Yes.

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

Okay.

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

So, you can make available additional information and still align with the objective that's good. Okay, so that's interesting Michelle that the language here is a little different than in care summary, because this is about there's either they're excluded which makes sense or there is no information to record which kind of implies they've asked, that's interesting.

So, the concern that I would have here is amendments. The ability to offer the amendment and we did have a discussion about the idea that there be some sort of, you know, kind of easy to recognize way for the patient or family member to suggest additional information that should be in the record based on what's there that maybe incorrect.

So, I don't, that's the one I think piece that I am not sure if we need to actually keep it separately from consolidation or I mean from VDT or incorporate it. I mean, it feels like it should be here, but how do we be sure that that's actually offered, because we're going to have a, you know, a big change in the landscape starting next year around the volume of health information that will become available and we know there are going to be challenges and problems, and inaccuracies.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Would this be a certification requirement then?

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

Well, it is and that's what this assumption is, but this is where we, you know, we kind of went back and forth and had this language in the RFC about making it available in an obvious manner, do you remember that Paul?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Right, right, yeah.

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

So, it's really that piece which, because, you know, if the landscape wasn't changing so dramatically I'm not sure I'd worry about it, but I think it really is and so what we had originally discussed in the group was could we make a recommendation that ONC develop kind of a common branded feature, like a button, and that, you know, everybody can recognize and then you make that part of the certification criteria and you just turn it on, that's all you have to do is turn that on and then we know that there's a button somewhere that's going to do that. If we have that part of this recommendation somehow still preserved then I think this is fine. I just want to make sure we haven't inadvertently done something here through consolidation.

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

Well, if it remains as a certification criteria and however words say that makes it obvious isn't that the affect you're looking for?

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

But you're asking for it to be more standardized aren't you?

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

Yes.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I mean when you talk about a button you're saying no matter which system I'm looking at, because we're not doing training for all of our patient's, so no matter what system they're looking at they ought to be able to recognize this feature and it ought to function the same way in every system, that's what I hear you saying, right?

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

Yes, but, so that's the ideal in my view just shy of that my concern is, and what we've spoken and agreed about before, is if you simply make it an optional feature of an EHR, portals has been an optional feature of this for like a long time and people decide not to offer them. How do we prevent that? That's really the piece that if you make it a certification criteria it means the system is capable of doing that but how do you ensure that that's actually happening? So, if there is another alternative?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

This is Leslie and I think that your suggestion of having the standard is minimal but the testimony that we heard on the patient generated health data talked about the patient's offering their corrected information or their version of the drugs they were taking or amend my chart that's not me, that wasn't my record, we heard that over and over again as very meaningful and material.

So, I agree, I think it's a "both." I think we do need to have an expectation of a green button that says this is what the patient is saying as a correction or amendment for the record and then also as a standard, but then also some expectation that this is used. It's also a great fraud buster I might add.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

And not only a fraud buster but I totally agree that if people start seeing inaccurate information passed around that is going to become such a negative public relations thing for all the work that we've been doing that I just think this is critical.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so I think we're in agreement that this is a function we want to have. I think we want to make it obvious and I think there may be some disagreement on whether we assign another color to it. I'm not sure I would use up one of my chips for this specific thing but would love to have it, as I said we already have this, available in an obvious way.

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

So, Paul, what's an alternative to it, because we share the goal here, so ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

What's an alternative way?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I thought our language was pretty good, an obvious way.

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

Well, no because the public comments all came back and they were like, “Well, what does that mean,” and that’s not a – you know, I don’t want this to turn into a care summary where no one did it because there was ambiguity and they didn’t want to get busted in an audit.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so in – I’m not sure why it was hard – so, our obvious way is there is a link that says something like update your record or something as just a hyperlink and if you click it, it takes you to a text field and you write what you want to say.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But if it’s a standardized approach Paul then – and it’s one for every EHR then the patient doesn’t have to redo it if they see that’s been...in other EHRs it’s the same thing so there are some efficiencies.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Wait, the patient doesn’t have to what?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

If it’s the same thing, I’ve created my green button or my orange button here’s my corrected record and I want to send it to all my providers not just one.

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

No.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

That’s a different thing.

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

Yeah, that’s ...

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

I think there is value in that.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I too.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

If there were a standard designation for here’s patient contributed information that would be much more – I think that’s a more universal value than a color button for click this to enter in your notes, you know, in your amendment.

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

I agree with that but I think we should take that up, however, that raises an enormous amount of complexity around and you know, we’ve heard this in hearings before, is that data, you know, consumed by the EHR who chooses what data to absorb, you know, is the data treated differently than data that is say coming from a lab, if it’s lab data that’s coming out from my sending to you is it different from a lab data that came directly to you? You know, it raises all these issues.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

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

So, I agree, but I think, you know, and we have some of that for proposed I think for future stages.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

We do and we have standards work being done on that.

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

Right but we need a very immediate way. I mean, I sort of have heartburn that we didn’t really think this through about Stage 2 when, you know, we’re going to have for the next 2 years and if Stage 3 gets

delayed even more a time period where there will be much more information available to patients and they need an obvious way to say “hey, this piece isn’t right and here’s what I think is.”

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

The ... should be more for patient safety from a patient’s point-of-view. I do think this is a critical item because the more information that’s out and available to the patient the more they’ll be concerned about its accuracy.

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

So, maybe ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, is the issue about whether it’s a green button or a blue button and we use that chip or is the issue that, you know, how do we get this done efficiently?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Can we refer this to your subgroup then as you reconcile the public comments to propose a language for how you clarify what obvious means or, you know, however you want to do that?

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

Well, we did that and the subgroup proposed back to you Paul and I think you just didn’t agree the same idea of the amended button or I mean the sort of standardized display, we had these exact discussions in the subgroup and that was our recommendation.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay. So, how do the other folks, particularly the users of EHRs feel about using the chip for another colored button?

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

Could you just say what you mean by using a chip though?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Oh, so, you know, there’s a Blue Button that’s a great advancement, if you have 12 buttons it’s no longer a great advancement. So, once you have – so we have a Blue Button and there is a special thing, if we dilute that by adding more colors you actually are taking away from something that really is truly special at this point so that’s what I mean by ...

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

But, it doesn’t have to be a button, I mean, it can be a logo, it can be a – we’re not trying to – we want to let ONC work with patients and families to figure out what makes the most sense, it doesn’t have to be a color, it doesn’t have to be a button, it could be a red “x” it could be a set of words, it could be a star who knows, but, you know, I mean, just sort of a standardized way to make it easier for people to know what obvious manner means.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

You know, vendors and Charlene had to leave, are reluctant and I certainly understand that – the more we prescribe, truly prescribe here’s what’s going to appear on your screen no matter what – you’re just crossing – you’re getting on a slippery slope and that’s still a chip to me it’s like the value and the importance of Blue Button is so distinct that everything else you do to force everybody to comply with one thing takes away from that to me.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, maybe it’s Blue Button correct. We take the same theme and we add it, you know, it’s Blue Button correct but it’s from the patient point-of-view and it’s a standard-based approach which gets the information back and adjusted by the EHR.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

Well, Blue Button doesn’t just like – you don’t just hit the button and everything happens I’m sure it’s going to ask a bunch of questions, right, about how you want it downloaded, where you want it, how are you going to – I mean, so maybe one of the things, one of the options under Blue Button could be the option under Blue Button could be to have an option to correct or send a comment regarding your record.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think that's perfect.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

And that way we don't have to create a separate space. Christine?

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

Yeah, I'm trying to envision it. I mean, I think is it – do you mean like it's sort of an education piece? Because there should be a box that comes up that says the information you're about to download is your personal health information so like if you're on a public computer you may not want to store it there, you know, is it more of an educational like an oh, by the way if you need to correct it or is it a screen or something like – I don't ...

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I don't know, it's going to have to say do you want to view your record or do you want to download your record or would you like to transmit your record, right?

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

I don't know, I mean ...

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I mean, obviously – I mean, that's the functions that we're basically...

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

Yeah.

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

That's what we're calling it and so maybe a fourth option could be: Do you want to correct or addend your record?

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

Right, which I think is great, I think, you know, I think what we were trying to do was to make a very simple recommendation that says to ONC please figure out a standardized way that...whether it's part of Blue Button or it's somewhere else, or whatever it's exactly what you're saying, or some other option that made even more sense who knows they should look at that based on how VDT is being developed in the field right now because people are coding for it and it's different from Blue Button actually because in Medicare you're just downloading a text – and you've got to get this other App and you don't have a transmit I think as much or it gets – anyway I don't know.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right, it's very specific with implementation guides and use cases under the Blue Button project and it's expanded and is considered now a brand of multiple functionality, so I think, ONC could give us direction on this, but it is a logical outgrowth of looking at my record is I'm going to have an opinion or a change to it and we should make sure that those things are accommodated.

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

Exactly, so Paul that's all I'm – I think the subgroup said was we need a standardized way to represent the ability to do that whether it's a button or what Neil's proposing or whatever someone needs to make that judgment call somewhere in the process of developing Stage 3, but I think we have to know what VDT looks like in Stage 2 since it's never really been done before, so, it's just a very basic recommendation that says standardized uniform way to display, you figure it out what makes the most sense.

George Hripcsak, MD, MS, FACMI – Columbia University

All right, I think it has to be, this is George, accessible and understandable and that's what we say. Uniform means that when I'm using my iPhone to read it, when I'm using a computer to read it, you know, it has to be uniform between those two and I understand you mean metaphoric, you know, there is an analogy between them it's not identical but then if you start writing these rules then it has to be – let's say they did end with a button then half my screen space is taken up on my iPhone with a button.

So, I think, it's just say the goal which is, you know, accessible and understandable. I mean, because I also want a button for who's my doctor, what are my medications, what are my doctor's phone number because I'm having an emergency, those are all things I want to get to quickly on my portal that's beside the button.

So, I think, just state the goal which is that it's accessible and like maybe accessible and understandable is not the right two words, but take two or three words that say, "here's what we need to achieve," and don't even say it has to look uniform across all systems because some maybe designed for iPhones and other are designed for full, you know, displays.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And, I think, this is Leslie, and I was more concerned about standards for adjustable in a common way than necessarily a UI, because a UI will be varied and personal as you mentioned but it would be nice to know that consistent with the Blue Button Project when someone doesn't amend it that's going back in a standardized way across all systems.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, yeah that's a different standard, right. Well that ...

Neil S. Calman, MD, ABFP, FAAFP – The Institute for Family Health – President & Cofounder

I'm okay with the way you said it George.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Me too.

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

Yeah, I think, you know, we all agree on the obvious manner piece, right? So, something like that, you know, plus what George said that's all I'm saying is we just need a separate recommendation if it's going to live in VDT then it has to have also another recommendation to ONC stating what we just did. So, maybe Michelle could draft something that we could look at?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay and then maybe George can help. We need to move because we're going to close, the two things, one to clarify what we do, what's our work plan from here and then have public comment. So, we did not – so, I think we have good direction for consolidation and deeming. Deeming we're going to get some feedback from Jesse related to quality measures for us to consider as part of the list to deem from and consolidation we had some action items from today's call, so that's what needs to happen between now and April 30th however Michelle gets us together.

Then at the 30th we'll finalize our consolidation and deeming recommendations and then we'll continue on these "divergent public comment areas" that is areas on the RFC where there were more than one viewpoints from the public, we'll try to work those out on the full Workgroup call. And then we'll be breaking up into our subgroups to reconcile the other RFC comments in our new framework that is the consolidated framework. Does that make sense?

And then we'll – the May 14th call because we'll need that time to get the work done and then the May 28th call is we'll try to come back and see where we are with the reconciled consolidated objectives. Any questions about that? Does that make sense?

George Hripcsak, MD, MS, FACMI – Columbia University

Sounds good.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay. Any final comments? We'll open up to public comment.

Michelle Consolazio Nelson – Office of the National Coordinator

Paul, this is Michelle, the only thing, I put in a list of proposed items that we should talk about at the full workgroup level.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Just based upon today's conversation I'm not sure – so I had put in VDT and the care summary but I'm wondering if it would be better for the subgroups to do some work on it before bringing it back to the full workgroup or if we should just have the full discussion here, just worried about how long it might take in the full workgroup.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

But, I thought we just did VDT and care summary?

Michelle Consolazio Nelson – Office of the National Coordinator

Well, that was just a piece of it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

One small piece.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay so where do you want ...

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

Well, what's the other piece though?

Michelle Consolazio Nelson – Office of the National Coordinator

Well, you haven't even reviewed the comments from the public.

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

Oh, right, yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, so, okay you're suggestion then would be that group 2 does some work with that and group 3 with care summary?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, they'll do a little more work and then bring it – we'll still have the discussion at the full workgroup but maybe they need to do some work first.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Okay, okay sounds good. Okay can we open for public comment, please?

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Sure operator can you please open the lines for public comment?

Caitlin Collins – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Good, thank you. Thanks to the group for getting through this discussion and I think we've, you know, we've added some more ideas and gotten some conclusions and some further work. So, the next call will be on the 30th where we're going to go over the final proposed recommendations for consolidation and deeming before we break up to subgroups but we'll also be tackling more of these discussion items from the RFC. Thank you everyone.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

Neil S. Calman, MD, ABFP, FAFP – The Institute for Family Health – President & Cofounder

Bye-bye.

MacKenzie Robertson – Office of the National Coordinator
Thanks everybody.