

**HIT Policy Committee's
Meaningful Use Workgroup
Transcript
July 30, 2013**

Presentation

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Meaningful Use Workgroup. This is a public call and there will be time for public comment. Please remember to speak your name so that we can capture your name for the transcript. And with that, I'll take roll call. Paul Tang?

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

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

George Hripcsak?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Amy Zimmerman, I believe she's on mute. Art Davidson?

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

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Charlene Underwood?

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

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Christine Bechtel?

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

Good morning.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

David Bates?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

David Lansky? Deven McGraw? Latanya Sweeney? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Marty Fattig? Neil Calman, he's on mute as well. Marc Overhage?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Mike Zaroukian?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Greg Pace? Joe Francis? Rob Tagalicod? Tim Cromwell? Marty Rice?

Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration

Here.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Are there any ONC staff members on the line?

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology

Elise Anthony.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Elise, and with that, I will pass it back over to Paul.

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

Good. Well thank you very much Michelle, acting both in your capacity as FACA Coordinator and as – and thankfully, still as our meaningful use lead staff person. So thank you very much. And thanks to all the workgroup members for participating in this call. It's a very important call before our draft presentation to the Policy Committee, so thank you. We have an aggressive schedule today, just like we will next week as the Policy Committee. What we're trying to do is go over the – our recommendations as we're going to present them to the Policy Committee. What we'd like to do is go quickly through the slides, just to refresh our memory and really as a report back from the subgroups to the full workgroup and emphasizing only the changes that we left – things that we left that was not discussed in previous call. So we're concentrating on that and not revisiting old discussions and decisions that we've already made, but this is sort of an all-in-one before we present to the Policy Committee.

Then we'll revisit the deeming discussion, we haven't updated ourselves, make sure we're still in the same – have the same draft recommendations to present. I have a little bit of feedback from CMS and then conclude with the usability hearing which just took place last week. There's an important topic that we'll need to discuss in this workgroup, not on this call, but probably between our August and September presentation to the full workgroup. All right, so I think we're going to star – any question on that or Michelle, do you want to add anything? Or George?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I think that's good, thank you Paul.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Nope, good.

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

Okay. Let's start with the PowerPoint deck that was sent to you for this call, and we're going to start with the subgroup recommendations, and that starts on slide 23. And what we'll do is we'll have the subgroup leads walk us through sort of a reminder of where we left off and a bit of a discussion on some of the unfinished business we have from before, starting with slide 23 and we can turn it over to David Bates.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Sure so...

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I'm sorry David; I'm going to cut you off on this one. So slide 23 is the advanced directive objective. The Certification and Adoption Workgroup has started to plan for a virtual hearing and they're hoping to have that hearing by the end of August to hopefully inform the September feedback to the Policy Committee. So, I just wanted to give you that background first.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Great, so, we didn't make any changes on this one pending those comments. Okay. Can we go to the next slide?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

This is Mike Zaroukian. Do you mind if I add just an idea, it's not even a proposal for a future stage, but as an immunologist by background, I'd just like to get the idea into the pool of meaning, if you will, about patients under 65 and requests for organ donation status. Nothing to do with it otherwise today, I just wanted to get it out there for consideration in the future.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Good point.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Thanks.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay, so can we go to the next slide, which is clinical decision support? On this one we added a use requirement for problem lists, we added a CDS trigger reference from the public commentary. We moved the immunizations recommendation here, because of Subgroup 4's recommendation and certification items for problems, meds and allergies were added here rather than as separate items, per public comment. So that's a short summary of the changes here. Are there any comments about that? Okay, so let's go to slide 25. Twenty-five is about reminders and here we were asked to provide a little more specificity around what we meant by clinically relevant, so we added some words there. And we added something about patient preferences based on the consolidation work.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie...

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle, go ahead Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

One of the things we've done in other areas is to use the word patient-specific and that gets to any sort of clinical, social, family history information, beyond demographics. So we might have an opportunity to align that.

Paul Eggerman – Businessman/Software Entrepreneur

I'm not sure I understand the comment, because obviously, you're – the clinical, social and family history is for certification.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I'm just trying to align the language. We have – the Standards Committee has a standard that reflects patient-specific, which includes clinical, social and family history that's in other measures in one and two and will be used in the clinical decision support, I think, as a standard as well. So, just for consistency sake, it was just an offer.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

That's – go ahead Paul.

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

I think this is actually – so this actually defines what we mean by patient-specific, i.e. taking into account these parameters.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

This is a reaction to the public comment.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay. Thanks.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

This is Marc. Do we need a clarification of a reminder for what? I assume it's a reminder for a return encounter with the provider.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yes. I mean we said for preventive or follow up care.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

I guess the question is, that could mean a lot of things, it could mean an appointment, that could mean that their mammogram – to go get your mammogram scheduled and – we want to be that non-specific.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike. I've put in an inquiry in the past to ONC and they would not consider a reminder for an appointment to count for meaningful use in that category, despite the fact that many of us would see that as perhaps the most important of the reminders. So it's just important to indeed have a clearer sense of what would count and what doesn't.

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

So, this is Christine. This has been in – this was in Stage 1, so this has been the language we've had all along and we actually did have a specific discussion where we agreed not to have appointment reminders count, because we were really trying to get more to underuse of care, if you will, things like that. So really about what's a – follow up care, preventive care that you need, not necessarily just your appointments.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And I guess that's all I was saying is, I think it would be helpful to be more specific about that, either to parenthetical this is not just for an appointment or reminder for the testing or...

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

That's right. And I think actually in Stage 1, and I'm not – I recall that we actually explicitly had a statement that it didn't include appointments. So we might want to put that back in.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah, I think that would be good. I had trouble actually remembering and I thought we did count appointments, so. Okay, so Michelle, can we add a parenthetical there.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yes.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay. Okay, should we go on to 117, which is the eMAR. Here the big thing that we did was to increase the threshold. We think this will be achievable again, once you start doing it. Typically, you get to a pretty high proportion. We also defined mismatches. Okay, let's go to 27. This is imaging. Here we asked that more than ten images be ordered and picked that because it was a pretty simple use case, the aim was to try and ease the reporting burden. We moved imaging and radiation dosing information here. This is formally included as questions elsewhere and we plan to review the threshold after the Stage 2 experience.

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

Excuse me David. On this, the capability to indicate imaging and radiation dose – its radiation dose, what is imaging dosing?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

That was me. That's just my language. So I wanted to spend some time on this because this is the first time the group's seeing the language. So any language fixes would be appreciated.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Sure. So imaging dosing exposure would be say from a CT scan.

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

Oh, oh, okay – the radiation exposure from imaging or radiation therapy?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yes.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Correct.

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

Okay.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

So should we change it to that language that Paul just suggested, would that be clearer?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yes.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay, other comments about this?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike. I think just again, to be explicit; we're talking about imaging radiation dosing and radiation therapy dosing exposure?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Correct.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Okay. That's great, that works for me.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay.

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

And is the clarification that EP is now menu versus core?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Umm.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

It was – in Stage 2, it was only EH, so it's moving to core for EH and adding to menu for EP.

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

Thanks.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul Egerman. I also have a question as to the definition of imaging. I mean does imaging include pictures, for example.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Maybe we should say radiographic imaging, because it would not include pictures.

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

But it does have it in the measure, it includes photographs, yeah.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yes, because that was a discussion on a previous call.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

This is Mike that was my point in saying imaging radiation dosing as opposed to imaging, per se. It's the dose associated with an image, not the image, per se.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

This is George. Certification is for radiation, so we got that one down. The core measure is about images, which according to what we said last time, could be photographs and images and electrocardiograms, which has nothing to do with the certification criteria.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Well the...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So we are including radiology, pathology as well as all different modalities?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

I don't remember the discussion about photographs, to be honest.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Well the – but the certification criteria is about dosing exposure and there is no dosing...

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Right, right.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Associated with having a picture taken.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Right, agreed.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike, but I think I understand the other side of this question, correct me if I'm wrong. But the notion is if a photograph is part of a result for a test, then regardless of the nature of the photograph, we have been interpreting looking forward on this as being part of the requirement. If a photograph is a patient portrait, but that's not a result, then of course it's irrelevant. But if it's part of a result such as a photographic image in a colonoscopy, then that would count.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Right, for the core measure, this has nothing to do with the certification criteria and about radiation exposure.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Right, so – exactly, yup.

Paul Egerman – Businessman/Software Entrepreneur

So a photograph of a part of the body as part of a surgical process, that would count also?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
It looks like it.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yes.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So is that a result though?

Paul Egerman – Businessman/Software Entrepreneur

It's not necessarily a result, its part of the procedure, at the times a picture is taken and a procedure occurs and possibly a picture's taken afterwards, but frequently a picture is taken before the procedure.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Right, so that's my point about the issue where it's a result as opposed to a procedure. So I suppose if we're doing a biopsy to test to see whether something is abnormal looking, you could do that, but I would generally not have expected a surgical procedure in and of itself to constitute a result for which imaging needs to be counted or included.

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

Would it help to delete the word results?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Or it helps to leave it in, from my perspective, by saying this really only pertains to a test where the result has an image that helps you interpret the test result. And that, I assume, was the background rationale for including the images, because it helps give context to, or interpretive value to a patient with regard to the result and the clinicians, the EPs verification that that result makes sense, based both on the language of the result and the image they're seeing.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

I was thinking about it a little differently, I was just – which may or may not be correct, but just thinking about it, this is a requirement that electronic health records be able to include images for a variety of purposes.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Right and I was – this is Mike again. And I was interpreting it as the notion that says a result can be reinforced, verified, corrected, adjusted, etcetera, if people can see the image upon which the result is based, the report and the result is based, or use it in part of the patient education and counseling process. So I wouldn't have considered it to be an important piece, per se, for all aspects of images in the EMR. I see it as the same reason we used to go down to the Radiology Department and look at the films ourselves instead of just looking at reports.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Gotcha.

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

So I think – this is Paul. So I think the clarification that Mike is seeing in the language is that if it contributes to the “result” of something, it can be a procedure, it can be a test, then it is useful, and I guess another example is a photograph of the individual wouldn't count for this objective. That's about the only thing I can think of that people might take a picture of that we wouldn't consider a “result.”

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie. So we would consider anything coming from cardiology or pathology, many kinds of tests that resulted in an image or imaging is part of this?

Male

Yeah, why not?

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

Right, like the colonoscopy and the scan...

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Right, so as a provider who's trying to follow this recommendation, I would say, if I've ordered something and I'm going to get a result back, and that result has an image, I need to make sure I'm including the image in the scope of our implementation.

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

Yeah, and what's nice about changing it from a numerator/denominator percent to ten images, it really makes this question of people's interpretation – it's much more flexible in interpretation. Before when we had a percentage, then all of a sudden you have to worry about all these denominators. Here we're saying everything that could reasonably be associated with an order, which includes a procedure, then, would count as one of these images.

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

And so, it would – this is Neil. It would be fine if an image came back on paper and it was scanned into the EHR that would count, right; we're not asking that these images be transmitted, according to what I'm reading.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, this is Leslie. One of the things we heard on the standards side is accessible means it could be a hyperlink from your EHR, from your browser. It could be many different types of things that makes that accessible to you, but not prescribing that it gets transmitted in a certain way, in a certain format to a certain system. So there's a lot of flexibility here and opportunity to do this.

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

Because right now, one of the – the most common reasons why something would not get – a result would not get transmitted electronically and is scanned is because there's an image attached to it. So, we're not really moving that ball forward, but that's fine for now.

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

Yeah, this is on the way to some better place.

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

Yeah.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

But to your point, – this is Mike. To your point though, that would mean, in my organization, we're going to make sure we have high quality color scanning capability for those image results – those results that contain images that are coming back for which we want high enough resolution that the resulting scanned image is useful for the purposes we've discussed so far.

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

Right.

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

That's correct. Let me ask one thing, what happens if you are in a rural setting and no one does – none of your resulting ancillary departments do have electronic capture?

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

Yeah, that's...

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

Is that like, an exclusion or something?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Well, is that really realistic though, Paul, in the sense of – this is Marc, I'm sorry – in terms of, for example radiographic imaging is almost exclusively digital now, even in the smallest of facilities.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And the number 10 helps us, too there, because maybe they only have it in one particular type of image that – because they basically are doing ultrasounds and have a length of stay of five hours or something.

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

Well that...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Can't help it...

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Or at a minimum their electrocardiographic system.

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

Right, I mean, Marc would know better about whether the penetrance of digital imaging is everywhere, and he's saying yes, so that's fine.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay, so this is has been a good discussion.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Before you move on David, one – it's Marc again, sorry. One thing that I worry a little bit about as we say images and that is a very broad term. So for example, if I have 128 slide CT, that's 128 images and I don't think that's the intent here, so I don't know if we want to somehow envelope that with studies or...

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah, it might be better to say imaging studies, because that's what we mean.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

That might be closer, yeah.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Well, I don't know, that one sounds ambiguous, too.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Well the other thing – this is Mike – the other...

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Would be, if you're doing surgery, what's that – I don't know.

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

We could say imaging encounters or imaging episodes or something like that.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike. Actually I resonate very much with it because it's really not ten images per se, because you could do that all with one patient; I think its ten imaging studies with at least one image in the study.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

All right, what we really mean is, ten patients who have images.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yes.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Well I think we mean ten encounters, if you had several encounters for the same patient and you took pictures of their wound several times that would be several.

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

I would say ten imaging encounters.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah, or ten encounters that include imaging.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Right and I don't think it has to be ten different patients, I think ten different studies would do the job, either way. But we don't have to worry about the number of patients.

Paul Egerman – Businessman/Software Entrepreneur

So if you did three different view – radiology views of an ankle that counts as one?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Right.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Right, that's one study with three views, right.

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

Yup.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay.

Paul Egerman – Businessman/Software Entrepreneur

But if at the same time, you do the ankle and the knee that counts as two?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Two different studies, two different orders.

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

Correct.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yup.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yup.

Paul Egerman – Businessman/Software Entrepreneur

Same patient.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yup.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Right.

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

Well that's kind of interesting. So I think the word study is actually a little bit clearer than encounters, because those would be two...

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yup.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yup.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And not to – up too much on this, I apologize David, but the capability to – the certification criteria here, capability to indicate imaging and radiation dosing exposure. I think – I mean the intent here, I think, is to say that certified EHR technology should be able to display along with the image, or somehow associated with the image, I mean so that you know they're linked together, the radiation exposure associated with that imaging study. I think – the problem I have with this as its stated is that, as was alluded to, some imaging has zero radiation exposure, obviously. And secondly, the – I don't think it's useful in isolation, necessarily, to say well, the patient got exposed to millirems or whatever it is millisieverts I guess it is now, of radiation. I guess just the certification criteria seems to be so non-specific I don't know how to interpret it.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Yeah, this is Mike. We're actually implementing an upgrade to our EMR that has this capability. So one of the things that I think is worth commenting on, what Marc says absolutely, also the notion of do we expect EHRs to be able to take in the results through a device integration, not just have, if you will for example, designated fields where a technician could manually enter them. We're certainly in a world right now where both capabilities are there, so there's an MPPS standard if you will that I don't understand, but exists and allows our state of the art equipment to provide the dosing and the calculations done by the EHR and it'll all be set. So I think our certification criteria should take a look at the notion of whether what we mean by this is, if you will, fields to record it versus the ability to take in through interfaces or other device connectivity the kinds of data that would be needed.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah, so I agree about both those points. The other issue, which we haven't touched here, is, whether we want the record to be able to track the patient-specific dosing exposure.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

A cumulative...

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

That was the original intent. This is Michelle. So, I think I just need help with the language, so I will forward that along.

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

And the question on the tracking again, I think we had a little bit of question on the tracking because again, because people get their images taken in so many different places, does it make sense to even track at this point. Because you can't really do a cumulative, because of – it's hard to do cumulative. So I would not say that. I would – the systems that can do it, I think, I think we should be able to display it.

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

This is Paul. Maybe a little bit of the history would be helpful in that Mike speaks actually separating to a different requirement than certification only. So the concern was obviously that radiation exposure, cumulative lifetime radiation exposure, is something we'd like eventually to track. Why it can't be attached to this particular measure for each imaging study is that there's still work to be done on the standards and how to interpret it. So, my understanding is that, let's say that a body mass index is relevant to the implications of the dose an individual has had. And so this whole notion of, how do you measure – does the source imaging device transmit it to the EHR and how do you interpret it, what's necessary to interpret the risk to the patient. All that's still to be worked out, so we tried to capture that in certification criteria, but I think we may not be clear on all – I wonder if it's a separate certification requirement.

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

Doesn't it also matter to what body part? I mean, I think this is a pretty complex area. I guess what I'm – I think that leaving it in certification and sort of – this sounds like an evolving process that people who know a lot about this are probably working on.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Well, we could move this – the tracking part of things to a future stage, because...

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Yeah, I'd be...

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

It is relevant what part of your body got radiated. But clearly, the reason to be able to do this is so that you can figure out how much radiation exposure someone's had.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Right and we can probably pull from Intermountain's experience; they've been doing it for a year and a half or so now. That would be a source.

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

And again, we can make it a floor, and again, this is from the vendor perspective, at least you've got the floor there and some systems will track it and others won't.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And this is Leslie. If we do it that way and for a future stage, we can include in view, download and transmit, so a patient can start aggregating their own information about their dosing.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Good. Okay. So I think we have consensus about that, we'll come up with some different language and do that offline. That was a good discussion. Let's go to 119, which is family history. So that was changed from core to menu and we identified high priority conditions based on public feedback.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

David, one more comment, this was one that was consolidated originally, but based upon feedback from the public, it was pulled back out on its own.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay, any comments about this? Okay.

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

Do we know what the term high priority means?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Well, I mean we gave examples of it there.

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

I know, I'm just thinking, we always get criticized when we do things that are ambiguous, so that people can't really tell if they really met it or not.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Right, I mean I think this is reasonably specific.

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

Well, it's i.e. not e.g. here.

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

Well...

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

For example...

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

Right, so are we just – are we going to give the list of what we consider high priority?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

This is the list, cardiac, breast cancer, colon cancer. That's what you need to do to meet this objective, you can record others, but it doesn't help you meet the objective.

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

Okay.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike, I want to jump in with a couple of other pieces then. So I think it is important to be explicit, if we want specific ones, we need to do that. The other thing I think we need to be explicit on is does not recording anything mean you ask and the answer is "no" or is the – and therefore are we asking people to record a "yes" or "no" answer to each of those in order to demonstrate that they're meaningful users for this measure?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

I think that you could say family history negative would be a legitimate – depends how the vendor sets it up, but, I don't think we need to ask each person to say no cardiac, no breast, no colon. any more than we need to say no cardiac on mother, no cardiac on father, no cardiac on siblings, no cardiac on children. So I think a negative family history is enough of a negative to count towards the objective.

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

This is Amy. So these – am I clear that what we're saying is these are the only three that count here? So, high blood pressure or some other kind of cancer wouldn't count?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Yeah, these are the re – we wanted to pick some – the request was for us to be specific from the – I think the public comment. And so these were the high priority ones. That doesn't mean you don't do others, doesn't mean the vendor doesn't include other things, but this is what we're going to count. If we have a list of 20 things that you might want to count, then it becomes half the visit.

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

Well – it's default.

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

George, this is Christine. Wouldn't it be easier to just say, record family history data? To me...

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Well that doesn't mean...

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

If the confusion is high priority...

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Oh, oh.

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

Then leave it to the judgment of the provider what's important to – I mean, all I know is patient forms, when I fill them out just say, tell me if you have any like history of major disease, they don't necessarily get into specific ones.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Well that's where we started and then we were advised to go this way. We could get rid of the word high priorities because now we've defined exactly what we mean. We could say record family history of cardiac disease, breast cancer and colon cancer period that could be the objective.

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

I really think that's a step backwards. I mean – and second of all, if you're going to an endocrinologist, they want to have a history of – they're going to ask for a history of thyroid cancer and the ENT doc's going to ask for a history of throat cancer...

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Well we could go back to record family history and get rid of high priority; the problem is then you can't aggregate it any way, everyone's going to interpret it differently and just going to say, negative. But we could do that. Get rid of high priority, because that was the objection in public comment, they didn't know what that meant, how do you know if you're high enough priority, for me its high priority. So just say, record family history data. Then you start getting into well what's the standard for all of family history, we don't have a standard for all of family history and then it's a free text box of whatever you wanted to type in. And this is a discussion we had, but that's how we ended up here.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I think there is opportunity in standards for family history. And if you leave, it to relevant family history instead of high priority, then it's up to the physician discretion and then in the certification criteria we can put in structured family history with recommendations.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Well actually, if it's relevant, it's up to the potential auditor, not up to the physician, and that's why they don't like words like that in there.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

How do you – that you're sufficiently relevant that someone will judge you so? So...

Male

But, I don't think – I'm sorry, go on.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Better opportunity, I agree, we're taking a step back and there's opportunity for family history data not – in many other areas and additionally we hope to see in the future family history coming from the patient themselves, as patient-generated health data. So I'd hate to see it just so narrow. We can put the standards under the certification criteria that's been worked on now through Sharon Terry's organizations and others that have been putting that forward.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

This is Mike, I'm going to second that, but I'm also going to say, to me this is much like problem list, what's important enough to put in a problem list. We've left great discretion to our eligible professionals to say either document the problems that you think are significant or if there are no significant problems, indicate the same. And I think family history would work the same way and we'd have a lot more buy in from all of the eligible professionals across all specialties if they're allowed to basically choose the family history that they want to record or indicate there's no significant family history. And to the other point, patients can populate this and that'll help going forward.

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

This is Paul. Let's just remind ourselves of the context. We had originally wanted family history because it is important, but one of our guiding principles is to choose objectives where there's a mature standard. One, there's a standard in existence and two, that it's adopted. In this case, family history doesn't have a standard, I don't know when Leslie's going to be available, and it's certainly not widely adopted. So what...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It might not be widely adopted, but it has been in use for a while and there's just more – I wish I could – is David McCallie on the line, because we did get some information back from different standards organizations. I'd love to come back with more information, because I feel very passionate that it does meet the standards requirement. We could have them actually take that and reflect it against the NWHIN criteria for maturity of standards and report back on that.

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

That would be helpful. So our compromise was to pick some high priority that is where there's strong evidence about it affecting this individual's health. And, by the way, cardiac disease is a little broad and so Amy's question about hypertension I think would fit...

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

Yeah, I would throw diabetes in there, too. I mean, I'm surprised no one put diabetes up, because that's huge.

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

Now that we're not doing standardized PSA testing, family history becomes an important factor for that. So I really think that this needs to be an issue of discretion on the part of the provider. And I think trying to – by what's most high priority would be a mistake for us.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

So let me propose a compromise. I mean I agree with most of the comments that have been made. Let's make it record family history data. We could have a sentence saying, after that, examples of high priority family history issues include cardiac disease, breast cancer and colon cancer, but that would leave it totally optional, it would be clear that it was relevant.

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

So, I think...

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Go ahead Paul.

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

Maybe we need to have some report back. That's actually like Stage 2 and the problem we're having is the lack of standards in use, and I don't know the maturity of the standard, but I think the majority, if not all, existing EHRs don't record this as coded information, by a standard.

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

Right, I would agree with that. This is Charlene.

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

And that's our problem.

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

Because family history again, it's pretty much all over the map in terms of how people capture it and there's also in the practice, there's a lot of feedback from the practices in terms of how they want it captured to be in their style. So, either narrow the focus or standardize that little tiny bit of it or – but there's an issue in terms of adoption of the standards around this space.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Again, we'll come back with the groups that have been working on that and have it against the NwHIN standards, so that we can have a final understanding of what's mature and what's not. And that'll help us inform how narrow this can be.

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

So the NwHIN standard would tell us how much it's in use?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, we adopted that in the Standards Committee, it gets to usage and prevalence and ease of use. There are a bunch of criteria, and so that's how we measure whether the standard is mature enough.

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

Is that something you can get to us in the next – this week?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yup, we can get it to you now. Michelle, do you have access to Dixie's report from NwHIN, I think she sent it out again yesterday. I can get it to you if not.

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

Okay, great. Thanks, so David, if it is a low adoption, how do you want to handle it versus high?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

So that's a nuance – that's tricky. I mean, I'm sympathetic to the comments about being broad. On the other hand, it's just not useful if it's not coded. So...

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

But coding three diseases is not an on-ramp to figuring out how the whole – how a comprehensive family history could be set in standards and broadly used, in my opinion.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

This is George. What I would suggest is if we want to go broad, we had considered consolidating this into VDT. In other words, family history is a little broad, but it's more rational from a clinical point of view and it doesn't need to be a separate objective, it's just part of the kind of consolidation we've done for other things for VDT. We had this separate because we were going to code it, we were going pick three diseases and it felt more like vital signs or something. But since it's going to be vaguer and broad, I don't see why we wouldn't want to consolidate it with either VDT or with clinical summaries or wherever it fits best.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike. I'm going to – I want to just describe, good, bad or ugly, what we do, because I think it's consistent with it and it's a starting point. So we, for the last decade, have used ICD V-codes for family history things related to important stuff that we want to drive clinical decision support with like premature history of coronary disease or colon polyps or colon cancer in the family. And so we've been able to leverage that for CDS ever since that time and I guess the question is, for our Stage 1 we were able to do this. And for Stage 2 and beyond, whether and which standard we should use, I think it was critically important for us to be able to structure family history using something we could agree on and use for the time being. So I'm a little concerned that we're talking a less aggressive approach to this than we could take to the benefit of our patients by recording these, using some structured standard that is in place or could be agreed to, even if it's not yet the long-term approach that might be used.

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

It's Christine. We did not – we actually consolidated it George in VDT and then unconsolidated it. It just wasn't going to work exactly and so in part because it kind of buries it, and it takes it a little bit off the radar screen, it also means that the threshold changes dramatically because VDT has one overarching threshold for use and offer, but it doesn't say what percent of data has to be recorded where necessarily. So it creates a lot of challenges to consolidate.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah, I...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. In addition, if you're using it for VDT, just like any HL7 message, we can take data that comes in, reformat it and send it out in the way that could be done in VDT. That doesn't mean we've had to capture it in a structured and meaningful way. So we really want to make sure that the intake is done in a structured and meaningful way, because there are all kinds of applications, not just care, but research and others. For the patient to be able to collect their information as well in a good and meaningful way, so, I think – go ahead.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle, I'm sorry; we're going to have to move on because we're never going to get through everything that we need to. Mary Jo sent out the documents from Dixie, so if people can take a look at those and we'll follow up on this one offline.

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

And if I could just say one last thing, I know we're getting the hook Michelle and that's good, but the menu measure in Stage 2 does reference structured data entry, so it feels like we lost that. That would be – to me it's a fairly easy fix.

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

So I think, and Michelle just caught me right before saying similar things, that David's heard this discussion and maybe David can come up with something we're going to present to the rest of the group next week. It's useful to have this discussion, but we probably – well, anyway, I think David can summarize his feeling about this and then we'll present that to the group.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Sure. So, I'll do my best. It's a very good discussion and there are good arguments and a variety of directions. Okay the next one is electronic notes. Here we changed the period to four calendar days, that was altered based on the clinical documentation hearing. It's a pretty simple one. I'm going to keep going. On hospital labs we were explicit about using LOINC and we lowered the threshold from 80% to 50%, based on – but we're going to review that based on the Stage 2 experience. Now on order tracking and order tracking we changed from test tracking to order tracking to be able to cover a number of procedures.

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

Just one catch real quick. If you could – we've been calling them consults now back in care coordination, so just change referrals to consults, just for consistency.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay.

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

Same thing.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

This is Mike, I'll just say, there are some systems where consults are inpatient and referrals are outpatient, so we need to bear that in mind as we think about it. So I order a referral to a consultant in the outpatient world but I order an inpatient consultation in the hospital.

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

Okay, all right. Well we were trying to stay consistent to the use, but – so put it in parents or something, all right?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay. Next one is UDI. Here the – this is a new objective. The menu objective is that EPs and EHs should record the FDA unique device identifier when patients have devices implanted for the first time and that they should record these for 80% of patients seen within the EHR reporting period.

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

Just a little verbiage clarification, you don't mean that if they get another implant, not to record it. I think you mean that when the procedure occurs during that encounter, right?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yes.

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

Then that should be clarified I think.

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

Yeah, because you don't want your second pacemaker to not have it, at any rate, so that was just a clarification.

Neil Calman, MD – The Institute for Family Health – President and Co-founder

So for each newly implanted device...

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

For each newly implanted device, yeah.

Neil Calman, MD – The Institute for Family Health – President and Co-founder

Great.

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

Yup.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay. Next one is – do we need to go through the certification only things? I guess we should. Okay, so CPOE became certification only based on consolidation work. I don't think we need to spend a lot of time on that. Same thing is true for ePrescribing.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

David...

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yup.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

This is Marc, I'm sorry. On the UDI one, I'm sorry to go back, but the menu measure, where it says should record the UDI for 80% of patients seen within the reporting period. I think you've got to qualify that as to which devices you're talking about. Because I mean devices...

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

For implanted devices.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Well but the second one doesn't say that.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah. No, no, it should say that.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Okay. Thanks. Sorry.

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

Good catch.

Neil Calman, MD – The Institute for Family Health – President and Co-founder

Also while we're going back, can I ask a question about the notes? You blitzed by it, but are we really saying that only 30% of people's notes have to be completed within four days. Doesn't that really undermine the whole ability for patients to have access to their records? That means 70% of the records of the notes could be completed later than four days.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

The intent is to set a bar in a place where people can get over it.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

This is going from menu to core, and that's why we're trying not to go too high on the threshold yet.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike. I also would have assumed that I have to count all the progress notes I've captured in the EMR, whether it's 30% or higher, and I have to meet the threshold for that, not that I can have 50% of them longer than four days and 30% skate in just under four days. So I thought the 30% was intended as a minimum number of progress notes you need to do in the EHR as opposed to elsewhere. And then of the ones you are doing, you're meeting the four-day threshold. So that would need clarification if that's not the case.

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

I interpreted that the other way.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Yeah, that's why I'm glad you mentioned it, because I think we do need to clarify it.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Trying to re-read it and decide exactly.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Sure.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay. Well, we can clarify that.

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

What do you mean?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Oh, I think I mean it the way that Neil interpreted it, not the way that Michael did.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So what percent of notes need to be documented in the EHR. So if I'm a vendor, I'm going to count all the notes that I can see were entered directly in the EHR, I'm not going to count the notes that were scanned in or for which there's an encounter but no note. And then I'm going to check to see how many days it took before that was signed.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Right and both – you look for the encounters, you look for the notes.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

And then I'm going to say, are all of those notes that are signed, that were done in the EHR out by four days or not.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Um hmm.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

And then yeah, your point is, you could take either argument and I'm good with either one potentially, but I'll be telling all of my doctors, number one, do all your notes in the EMR, if I can. And number two, all of your notes have to be done by four days. Not a – all the notes you do in the EMR have to be done in four days.

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

So if you're going to take longer than four days to do your notes, don't do it in the EMR?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Something like that, yeah.

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

No, that's kind of –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

This is George. This is 30% of encounters have a note, and the note only counts if it happened in four days. This is not seeing that you wrote three notes and one of them was within four days, this is 30% of all your encounters have a note, but it only counts if you did it within the four days. That's what – because look at Stage 2, this is a carry forward from Stage 2.

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

Right, that isn't the way I'm interpreting it, I'm just questioning whether or not – that's basically a standard that we want to put out there. I mean...

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

It's not a standard; it's an on-ramp. We were menu before, now we're going to core, so we're making everybody do notes. So we picked 30%, it'll probably be 90% that get done, but we just didn't want to go straight to 80% or something I think.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Right, there are Medicare rules about this, too. So, those are really what are going to drive people, not whatever we say.

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

All right.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay. So let's go back to – let's see, we were up to ePrescribing, which was pretty straightforward. Demographics were again made certification based on consolidation. We added an additional element for communication preference.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Michelle, this is George, should we put where it was consolidated to on the slide?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I apologize George, can we put where – what did you say at the end?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Like when these are certification only, because they got consolidated, should we put on the slide where it went to or not?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Well, some of them didn't go anywhere.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Didn't go anywhere, okay.

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

Consolidated to nowhere.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I mean, there's an assumption, that for example, you need demographics, vitals, things like that for the quality measures, but they didn't necessarily go to anywhere. I mean we could put them in the care summary, for example, but it's just something that you need kind of across the board.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Okay.

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

Well, so just a note like that is useful, maybe that's George's point. This is Paul.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Well can I ask a question then, so for the consolidation works that we have up front, I think we describe that, should we do it in both?

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

Ah yeah, for clarity I think that helps.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Okay. Thank you.

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

Paul, this is Christine. I know that some issues have been raised around consolidation, and I think they're highly legitimate that warrant some revisiting. Where do you want – when, where, how do you want to do that? I think you saw the email we got from a vendor that talks about the experience where something was consolidated in Stage 2 and actually caused a whole lot of extra work for providers and for vendors and it made it harder for vendors to like know where – or I'm sorry, providers, to know how they were doing. So there's some revisiting that I think needs to occur.

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

Well let's see if we can't talk about that in the 30 minutes we allocated for deeming, if we still have 30 minutes allocated for deeming.

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

Okay.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay. Let's keep going. So demographics we just talked about. Problem list, no big changes, they were removed as separate items and added to 113 as a use case. Next one is med list; this was added to CDS, which is 113. Med allergy was added to CDS, which is 113. Vitals were retired because we felt it was topped out. Smoking was retired, again because it was topped out. Lab results were retired because topped out. Patient lists were retired.

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

Lab results wasn't retired because it was topped out, I think lab results got consolidated into something else.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

That could be correct.

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

Yeah, and I think it's like care summary...

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

Yes.

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

And some other things.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yeah, okay.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yeah, it's one of those. I'll add them into the notes.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Okay. Patient list was retired.

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

I think it was – again consolidated, but that's fine.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

It's all – okay. CPOE was added to order objective – this next one, CPOE for referrals. And I think that that's the end of Subgroup 1.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yeah.

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

Okay, so we'll move into – thanks David. We'll move into Subgroup 2, and which ones are we concentrating on, there's new – there's some new information in here, right.

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

Yeah, it's mostly – we're actually going to start with patient-generated health data is the first one, where we have some new info.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Sorry Christine, I think you actually need to start with VDT, the BlueButton piece of it.

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

Oh, ABBI, right, thank you.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Sorry, slide 46.

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

Yup, so this was one where it was a menu item and we had a lot of discussion about use cases and how it's working in the real world and we needed to go out and talk to folks who have been working on the Automated BlueButton Initiative. And the long story short is that this is definitely a functionality that is sorely needed, in fact, it's probably needed well before Stage 3, but that that's work of a certification criteria, so that the system is capable of enabling a patient to say, any time "X" happens, I need you to send my information to "Y." But there isn't a requirement to get a certain number of patients to do that, for example. Are there any comments on that?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

This is Marc. I guess a concern about the certification criteria is while I like the idea, the complexities of privacy and making sure that to who it's being sent to is a provider – I'm just a little worried that there's a lot of complexity about the security and privacy issues there that make this – I worry about it, I guess. How it could be implemented, especially given the experience we're having with trying to implement Direct and the provider-to-provider space. And here we're opening this up to a much larger set of – well, anybody, the patient designates. And I certainly understand the patient's privilege to do that whoever and however they want, but I just worry about the certification criteria being worked through far enough.

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

So we did consider that at length and we had a presentation as well from folks at OCR and also from Deven McGraw and essentially talking about the patient's legal right to have their information in the form or format that they choose, even if it isn't secure. There is no doubt that there is work to be done on patient education, but in terms of making it easier for providers to comply with patient requests, we felt that this was needed. But it does build upon the existing certification – not certification, but the existing standards that are being piloted. So, that's the best I know how to respond here.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Okay.

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

This is Amy and this is just a small technicality, but, in here you've still got the words high priority family history if known, so I would just say whatever we end up doing with high priority family history, we make those semantics consistent when we resolve that.

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

Yup, thank you.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thanks Amy.

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

Good catch. Okay, so patient-generated health data, this was really a fun one. The Consumer Empowerment Workgroup held a listening session about how patient-generated health data is being collected and used in the world. And we were trying to get a sense of whether or not this was the right approach for patient-generated health data and anything else we'd need to do, etcetera. The short version of that – the outcome of that hearing is, that while there's definitely work to do, survey was a very immediate next step that the field appears to be ready for.

And so they – the group and actually we had the Technology Workgroup, the Empowerment Workgroup and several members of the Meaningful Use Workgroup in that hearing as well. And so there was a lot of support for this, as written. I think there were some other issues that were raised, so there three mechanisms for patient-generated health data that are most commonly used today. One is surveys, one is secure messaging, which was having also, of course, and in meaningful use and then the third are devices. And there are essentially kinds of four things you need to be able to do with data that comes through any of those channels. So the patient – you need to be able to collect the information, right, through the survey. The provider needs to be able to review it, the provider needs to be able to acknowledge receipt from the patient or back to the patient and then they need to be able to store the data, ideally in a structured way so that it's usable for them.

So based on those findings, I think we're in very good shape with respect to this criterion, but we would very much benefit from knowing from the Standards Committee whether or not we need some additional, for example certification criteria that would enable the provider to more easily acknowledge receipt of the data and/or store it. So, we're suggesting that here. And then the – so that's – well that's one piece, let me stop there before I – and then I'll talk about devices in a second.

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

This is Amy and I have a question. When you use the term survey, I'm assuming you mean what you've got listed here as questionnaires, so it could be screening tools or any other type of questionnaire and not limited to just a survey?

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

Yes, sorry. Uh huh.

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

All right, only because I mean screening tools – I mean I just think its semantics. When people think of survey, they don't think of it necessarily as a questionnaire or screening tool, so I just think again, we want to be careful on semantics so we communicate what we want.

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

Okay, any other comments? So on devices, this is something that you all will recall we've had in the placeholders since the very first draft, back when we were working on Stage 1. And we continue to have sort of a standards issue here. And as I understand it, we did some work to reach out to Wes Rishel as well, who's on the Standards Committee, and he said essentially there are standards, they're very complete, although they were built seven years ago, but they haven't really been adopted in the US. However, there may be another approach, at the hearing that we held, there was just a real energy and support for trying to connect some of the consumer devices to electronic health records in more efficient ways, in ways that would show the level of granularity of data that provider's need, which is probably not every step I took on my – things like that.

And so what Wes said, which I thought was interesting is, there may be an opportunity to work with some of the device manufacturers to use more modern interoperability approaches. I think we would benefit from doing some immediate work to see if that's possible to do, at least as sort of certification criteria, something, I don't know, if it's an open API or what, that's for the standards folks. But I just would suggest that we look maybe at a different technical approach and continue to work with the Standards Committee. I know Leslie's on the phone, here – the workgroup she chairs on consumer technology is doing work, and I think that Leslie, you're aiming to have some draft recommendations by the end of August, is that correct?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes we are. And to that end, on the work that's been done by the Continua Health Alliance for standards for interoperability devices, they have just recently completed the metrics for maturity using the NwHIN standards that I referenced earlier, and I can also provide that to the group. So, I think there is real positive energy and a lot of movement that's happened in this space. So, it's very encouraging.

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

So my suggestion would be that we have some kind of – I don't know if we need a placeholder here for continuing to work through whether some kind of an approach to device data is possible for Stage 3, but I'd like to suggest that we continue that work stream. Are there any comments on that or objections to anything?

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

No, but Christine, this is Amy again. I have a separate question going back to the wording structured and semi-structured questionnaires, I'm sorry about getting you off medical devices for a minute. But would that include like intake forms as – so like the Clipboard type thing, is that covered under this or no? So I'm still struggling with sort of, if I'm a provider and I need to do this on more than ten percent of my unique patients – if its screening questionnaires and there are some standards whether it's kids for developmental screening tools or other things. But what if there is none for a particular patient or does this mean every patient needs it and what happens to the Clipboard form, because they consider it the same here.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. So the questionnaire structure allows for a lot of flexibility and does include in the early template formation, pre-visit kinds of information and family history kinds of information, as well as device and others. So I think we're – the ability to have a questionnaire is great, because it's very flexible, we can use it for a variety of reasons.

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

Right, it could be a health risk assessment, it could be functional status, and it could be pre-visit information, etcetera. So the idea is that the sphere of patient-generated health data is fairly broad and the sphere of eligible providers in meaningful use is also very broad. And so we wanted to leave it flexible and enable providers to really get excited about stuff that matters to them and that would create some efficiency in their workflow and improve care process. So it's very open for that reason.

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

So Christine, can I just clarify the objective or the measure, which isn't listed here, but you say provide for more than ten percent. So you are making the ability to fill out one of the structured questionnaires to ten percent or that ten percent have filled it out?

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

The ability to do that.

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

Okay.

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

It's – and so, it's – we always face this question, right, so it's probably not a station type of measure. I think we could go and think about the challenge with thinking about the percent who've done it is. I think we get to the same concerns raised with the five percent threshold under view, download, transmit and it's not some – patient-generated health data is something I think we want to get providers excited about and eager to use and some experience with how it benefits them. And my concern with a sum percent, even if it's lower than ten percent of patients actually filling them out is that it'll just feel like a requirement instead of something that is really beneficial to both providers and patients.

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

That's...

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

So how – this is Amy again. How would you actually measure providing the ability to ten percent of your patients?

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

It's the same way we've done it before where it's an attestation, they have to – they attest to the fact that they had it. It's the same measure as in view, download, transmit, where they've offered it to 50% of patients, it's the same approach.

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

Christine I'm totally – I completely agree with you about trying not to make this feel like a – requirement where there's gaming. It is a little different from VDT, which is something that the patient just accesses versus this you almost have to push out the availability of a questionnaire.

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

Yup.

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

So, there's more involved on the provider side.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike, I'd like to actually jump in because we do this. And there are two methods I'd like to use case check for counting. So, I'm a little aggressive with my patients with regard to encouraging them to fill out questionnaires, so I actually will send them a secure message with a link right to questionnaire. That would be easy to count, track, measure, etcetera.

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

And they get a two-for.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

There you go. And the other thing is that I would like, on the other hand, for those who find it convenient to leverage a patient portal that says, for your upcoming visits, these questionnaires are available to you to either describe a history of a problem or update your family history or whatever. And just by deploying that routinely, I could attest and say because that's a routine part of our portal and 72% of our patients are signed up for the portal, we should be good. So as long as those two models are both good, we're probably a large way there.

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

Yes and you would get a two-for in both situations because you would get this if the patient logs on to the portal, fills out the questionnaire, guess what, you just counted toward your five percent use for VDT.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Yeah, we're all over this.

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

What about secure messaging, does that – can you make a three-for out of this?

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

Well that's what I said the other two-for is secure messaging. So if he sends a secure message or the patient sends back, yeah, absolutely.

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

That would be good.

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

Right.

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

Then there's a lot of synergy, good.

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

Right, so, are we ready to move on?

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

Thank you for the clarification, I didn't mean to take us off track.

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

Okay, so the next one is clinical visit summary. And Michelle, I just – we'll probably make one change on this slide because the original intent was, as you guys know, we've talked about this a lot. So there's some angst in the community because there's a fixed list of information that has to be required and – or has to be included in the visit summary. And in Stage 2, the certification criteria do give the providers the ability to customize the display, but they do not give the provider the capability to exclude any of the information in that core data set. And so there's some of that that may – that the providers have felt isn't necessarily relevant to each visit.

So we were originally going to monitor Stage 2 implementation experience, but that piece of information CMS did confirm, thanks to Peter Basch and Mike Zaroukian, that no, in fact, you can't exclude any of the data. And that really wasn't our intent, so we've just basically edited this to say intent is to make sure you can draw from and that you can include and exclude. And so we can delete the monitor Stage 2 implementation experience. Mike, does that work for you?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Yeah, that's a great summary, thank you.

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

Okay. All right, so we can skip patient education, I believe Michelle, right, because we've already talked about that; same with secure messaging and same with communication preference.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And so this is Marc. On the clinical summary, you flew through it so fast. The second certification criteria, can you clarify what the intent is there, is it that the EHR will allow a provider to specify the patient – or patient to specify their preferred communication preference?

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

Yes. So we should clarify that language.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Didn't say that, it sort of wishy-washy...

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

Right, right, right, right. It's really...

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Okay. Okay.

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

You got it. Okay. So Michelle, we can clarify that. So the last one is clinical trial query, we did a lot of work, and I know Leslie's on the phone. Going back to folks in the research community and trying to understand the state of play and it is variable, but there are some databases that would be able to respond to an inquiry from an EHR using the Info-button standard. And we have been told that if this were to be part of meaningful use, it's highly likely that the major ones like for example clinicaltrials.gov would get there very quickly. Is that a good characterization Leslie?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yup, it's a great characterization. They're waiting to have a way to communicate easily and this works.

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

So our suggestion here is to maintain this, again, only as a certification criteria and – but to keep it as such in meaningful use to be able to enable some acceleration in that part of the market. And if there are no comments on that, I'm done.

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

Thank you. Okay, let's move quickly to Subgroup 3, which ones are you highlighting Charlene?

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

Okay, this is Charlene. I wanted to highlight – I wanted to touch base on 303 and the notification, 308.

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

Charlene can I just – I know you want to highlight reconciliation – or you don't want to – reconciliation, but I thought that on the last call we said there were really no changes from Stage 2 to Stage 3 in reconciliation...

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

Yes.

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

And you guys went back and forth a lot. And if that is the case, then I think we should probably use the exact language so that people are not confused.

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

Okay.

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

Unless you need some of the clarifying around receives another patient from another setting, da, da, and da. We don't need to talk about it here, but just wanted to throw it out.

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

Okay, well, I'll re-review that, okay.

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

Thank you.

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

Okay.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

And this Mike, here is where I want to jump in and try to champion the comment or believes an encounter is relevant, because that's the objective, the measure doesn't reflect it. If I can put it in the measure, I can kill approximately 200 clicks a week for average docs who are trying to faithfully reconcile at each visit.

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

Okay, that's why we – the change in the measure.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Yup, that's all.

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

And we have that there, so...

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So as long as we can keep that, that's great.

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

Okay. Um, the major signal we did was just signal some standards work around this space, that was the major advancement, and then we'll see where that sorts itself. In 303, what the request was last time, there was really no change, but what I – I tried to restructure it so that we represented the three concepts we were talking about, we consolidated this one and what I – we kind of defined the major use cases in terms of transitions. So transfers of care, and we listed out the kinds of those. Clinical request – consult requests, and if we need to put consult/referral in there, I just tried to keep it really consistent with the use cases that they're using from the standards perspective, but I listed the kinds of consult requests and then consult note. And then what I did is I listed specifically for transfers of care and consult requests, the type of information that we want to require this time, in addition to what's already required in Stage 2. And then we identified, simply for the transfers of care, we also wanted to include patient goals and patient instructions and/or orders for the next 48 hours. So I just reordered this one. We left the measure at this point 50% and ten percent, I know that point was discussed last time. I think we should probably signal this one where we want, again, base any changes it's based on the experience with Stage 2 and the adoption levels, the relative success in adopting this function in Stage 2. Are there any comments on that?

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

So Les – not Leslie, Charlene, what's the core requirement versus optional, in terms of data here?

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

The core requirement is the concise narrative, the contact information for professional care team members and then the indication of whether there's a designated family member.

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

Okay.

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

Now what I did – I excluded, because we consolidated the referral – the response back from a consult into this, I didn't see any need to require those as mandatory information on a consult note, so I excluded the consult note, unless someone would disagree with that. So I kind of organized that thought a little bit.

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

So does that mean there's no requirement – so why are you listing it, maybe as a question?

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

Because we actually wanted to have – we wanted to ensure that – why did I list it? Because it's one of the things we want to count in our measure. So, we want to close the loop on the referral. By types of transitions, there are those three types and then – that we want those actually counted. So they're indicated in the measure.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Wait, I'm confused. This is George. What are we talking about? Nothing is optional that I see, there are three initial things for two types and two additional ones required for another type, but what's optional?

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

They're not optional, it's just for a consult note, I don't think you would include – you'd be required to include those types of information on a consult – on a note back, or am I wrong? You're just responding – you're just doing your note.

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

Does it help to call it a consult result note?

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

I can do that.

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

It's the return, it's the result of an order, is I guess what it is.

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

Yes.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

A consultant report.

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

Yeah.

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

I can – clarify it.

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

So there's...

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

But I think what Charlene is saying is when you do the note back, does the provider really need to include number two and number three again.

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

Yeah.

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

Which actually, I guess, could that be true if I, as a patient, just took myself to the specialist without having started with the PCP, so the PCP actually does need all of that, or – I'm not sure what makes sense there.

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

Yeah, I – that was what I – when I started rewriting it, I said, okay, does this make sense. So, we can go back to the standards group and ask that too, but that was where I kind of carved it out.

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

Yeah, I don't think two and three do make sense for a return consult note. And it's not really a return consult note if it starts with consultant, it's really something different. But I think it should include number five because it's really critical that patients, and that providers transmit what's supposed to happen immediately afterwards.

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

Do you want five in the – I can break it out, that's not a problem. I was – we need to think about it different was the only thing I was flagging, that's all.

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

Yeah, I mean I get – and I have the same issue with number four, so – which I've raised before.

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

Yeah.

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

And I almost wonder if all of them should be included in them.

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

I think one, four and five make sense for a return note, but I don't think two and three make sense for a return note from a consultant. I mean, what – I hear what you're trying to do, is just trying to sort of lump these into very few categories, but they're really sort of different categories of...

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

They're different, yeah.

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

Like transfers and stuff and I think the more explicit we could be about that, the better. And maybe write it out in a clearer framework, maybe a little chart or something, with this type of note or this type of transfer, these information components should be included

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

Yeah.

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

Neil, this is Amy. Would there ever be a time where in a return consult note, there may be new professional care team members. So you see an orthopedist and they've now referred you for PT or something, and the – I'm just thinking. I mean, I think you don't need to return it if it was given to you in the first place, but if there are new care team members that are getting involved in the case from the specialist...

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

So maybe we could just...

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

Then that may be relevant.

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

Yeah, and there might – so you might just specify additional care team members as opposed to trying to regurgitate everything that was sent in one direction back again.

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

Yeah, no, I agree, not having to repeat what was sent, I just think that if there's new information, then that might still be appropriate.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Yes, this is George. I'm a little worried about re-engineering the consult note, which is like a very common thing in healthcare and now it's kind of casually saying here's what – because you could imagine the consultant would gather some more family history. Do we now have to put that as number six? And some things they have to put in what they think is relevant, so I think what we ended up with is that the heavy transition, which is where a patient's in the hospital and goes to another hospital as an example of a very heavy transition, you want to include a lot of information. But the thing that happens commonly, we're trying to have an on-ramp, since there are going to be un – there may be side effects when we get too prescriptive about what has to be in every consult note that every doctor sends to every healthcare provider for every patient in the country. So that's why I worry about putting too much in the consult note. But I see the problem, we kind of skipped consult note in one through five, so you have to decide what it is, but I would try to keep it as close to current consult notes for now, and see how this goes.

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

I mean in the next slide you have this sort of taxonomy of different types of transitions.

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

Yup.

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

But it kind of gets garbled up, I think, in the former page. I don't think it's as clear in the prior page that you're talking about which types of things.

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

Yeah. I can try again.

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

But I think George is right that different consult notes – there are – like in anything, there are key components that absolutely should be included in every note and I think it's okay to call those out, but I think there's a lot of variability in how they're written and in what's appropriate to be written by different types of consultants.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

And this is Mike. As a person who asks for a lot of consultations, in my world the two major pieces, aside from a consultation – a referral purely for a procedure, is I want to know that they think and I want to know what they did. And so that main notion that implies, if you will, an initial consultation which is the first time they've had a chance to weigh in on what they think and what they recommend or what they're going to do. If it's opinion only versus assume management for the problem versus assume management for the entire patient, will drive some of those differences that George talks about, etcetera. So I think we want to be as little prescriptive as possible, but I think we also want to distinguish the initial consultation from the ongoing progress note/care of various members of the care team.

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

We're going to have to more on. Let's – maybe Charlene – I don't know whether a table format –

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

I can put a table...

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

Or...

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

Yeah.

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

But also I think George's commentary, we're trying to move something to electronic, let's not try to dictate what needs to be done for everybody.

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

Trying to close the loop here is what I was trying to do, so...

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

Yeah, and almost – that was our guiding principle, is just to get something back and know that you got it back, so let's not try to over-prescribe the actual what goes in it.

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

Well maybe we should really get back to being that simplistic.

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

It was really simplistic.

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

Yes.

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

I mean, that's a huge list right there.

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

Yeah. Let's try to just get back to our original principle and try not to over-wire this.

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

Right.

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

Yeah. And I can put this in like a table, maybe consolidate it, too, and put optional or something, which is – or something like that, but, keep it very simple.

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

Well, once it's optional, then as you know, the vendors all have to do it, so try to keep it to our original principle, and keep it very simple, let's just move this stuff to electronic rather than you write everything.

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

Exactly, okay. All right.

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

Okay, let's move.

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

Okay, the next slide was the referral loop, care plan, notification. Okay, this one is actually a new menu objective for a hospital. We defined the significant events. The question that we had left open was how to measure it. I think we came to the consensus that we would use a number rather than a percentage and so we just chose the number 25. And again, we see this as one, once you do it – once you get the infrastructure in place, then you'll do it all the time most likely. So again, we tried to choose a low, but – and we can increase that number, so that was – we just chose 25, but that's – as opposed to a percentage. Sometimes this will be done through an HIE capability, too. So, are there any comments on the number or capability?

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

Okay.

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

All right and that was it.

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

Thank you. Thank you. Okay, let's move on to Group 4. Art?

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

Yeah, hi, so, I think there are just a few things to talk about, I don't think it will take that long. We want a half hour still for deeming?

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

Well, we have deeming and consolidation, so, if we can move through this quickly, that's great.

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

Okay. So the main thing, as you can see on slide 66 that I think a key thing here is that we've moved this to certification only, this case reports to public health, and Michelle that might be changed to something in red. And I'll quickly go through the other ones as well. The main points are around registries that we've combined from three different ones down to two, and there's just a slight difference between the EPs and the EHs in that one includes healthcare associated infections. But basically that one is just a merge of several others and we think that one will be okay. Do you want me to go through anything more than that? I don't want to really delay...

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

This is Marc. When you, on the case reports, you said certification only. I guess I'm a little unclear looking at that about which criteria for case reporting...

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

That's – Marc, that's only – that was just around a future stage, so I don't think we need to spend...

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Okay, I'm sorry, I'm sorry, I missed that. Yeah, yeah, yeah, thank you.

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

Okay. So – and then I don't know that I need to go through much more of this. We did discuss earlier that the immunization clinical decision support is added to 113, which David discussed a little bit earlier. And I'd rather that spend our time – unless someone has a concern, just getting on to the deeming discussion.

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

Okay, any other comments? Okay, Art, you might maybe talk to me a little bit about merging so that I know how to represent the rationale.

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

Sure.

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

Okay.

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

Would you like to do that offline or now?

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

Yeah, offline would be great.

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

Sure.

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

Okay, thank you everyone. I know there's a lot to cover and hopefully we can do a good job at representing some of the changes that have been made for the full group next week. Let's turn out attention now back to deeming, which I think we can start on slide – I'm trying to find it here...

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Eight?

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

Yeah, eight would be fine, so back to slide eight – may have to build that up please. So, we're back to – actually, this may not be the new slide there – I did new slides because Charlene had mentioned – tried to – to state this in the positive and we found a way to do that. But really it's we're assuming that if you're a high performer or high improver that you are using the EHR effectively. And going to slide nine, the two things we've set up for EPs, and one we adjusted, I think Paul Egerman made this point, we adjusted the top – high performance as being top quartile and still talked about improved performance as a 20% reduction of the gap between your last year's performance and the top quartile. That does have the implications for how you choose things for Stage 2. If you're – that means you, in Stage 2, you need to have measured something that you want to improve upon in Stage 3, if you want to take advantage of deeming, which is optional.

So the two areas that we chose were one, high priority diseases and the other was control of high priority chronic health conditions. Did – one of the things we did take off, if you'd go to the next slide please and build that out. If you – we did take out mammography, because of its high performance, so it's a topping out phenomenon. And I'll just go through the high – the EH, if Altarum could move on to the next slide please, slide number ten now. Then we chose patient safety and care coordination, so if you recall, the organization that's trying to deem would pick two out of each of these two categories. For EHs, it was something different, for this it's patient safety and care coordination and if we could go one more slide please, and then open it up for comment, which is to address the reduced disparity objective for two out of the four selected reports, you'd be reporting on them using a disparity variable that's meaningful for you. And so whether – it's both the – and the goal was to improve your reduction of the gap between your mean performance for your entire population and your disparity subset.

Let me pause there for any comments on the notion, so this is back to our original which is, for EPs and EHs, if you would like to take advantage of this optional deeming pathway, you will report on four things. Two from each of the categories in the respective group, EP or EH and show either a high performance, or high quartile performance or a reduction in the gap between where you were in the previous year to where you are in this year for Stage 3. And then for two of the four reports, show an improvement in reduce – by reducing your disparity compared to your mean population. It's a little complicated that last piece, but...

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

So, I'm wondering – this is Neil, I'm wondering if we couldn't just add that as an option under the selection. So basically just say, high top quartile performance or improved performance or a reduction in disparities.

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

Okay.

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

In other words...

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

That would be good.

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

Just to sort of simplify this as not having two separate sections.

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

Okay.

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

But it should be and reduction...

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

And, yeah, and – yeah, I think it should be and for the reduction in disparities. The other thing is just to say, it's – that's a hard thing to accomplish and I would say that if somebody really focused on that for a year in one of those things that would be enormous. It's a really hard thing to do.

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

Which, the reduced disparity?

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

Reduction in disparities, I think it should be mandatory to do it for one, but I think doing it one area, picking one area where they're disparities exist and really focusing on a population for a year and being able to demonstrate a reduction in disparities is a substantial effort, having done this many times. So I would be satisfied, even – as probably the biggest proponent of this, I'd be satisfied if somebody could demonstrate that in one condition.

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

I'd agree and so I'd even add to that and say, if we bring it in to describing it so that two in each, I would make it an "or", because I would agree with you, it is really hard. So if that's what you choose to do, because that's meaningful for you, like in your case Neil, then I'd just give you full credit if you do that as an "or" rather than an "and."

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

I – it's Christine. I don't agree because of the amount of things that are going to be deemed, because those functionalities that will be deemed are going to be deemed for a whole lot of patients that don't fall into either having a chronic condition or being part of an underserved population. So I think you're giving a whole lot of credit here and I – any my concern would be that folks could really gain that and say, great, I'll just reduce – given that there – all these measures are not new, I'll just reduce my flu vaccine rate, and then I get deemed for all this stuff. And I think that's just not near enough.

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

Suggesting that they all be ands? So do you have to demonstrate top quartile and improved performance and a reduction in disparities?

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

No, these are – you would either – the way we had conceived it as you either need to be in the top quartile or improve your performance by having that 20% reduction of the gap, right, and you need to improve in disparity areas – for two of the four of the same re – the same thing, right. So you...

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

But it turns out...

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

Pick these two, pick two, pick two, that's four and then the way it's written, for two of those you need to improve. If you guys want to go to one because it's really difficult, I could understand that, but I think you shouldn't be able to just pick one thing, reduce health disparity and get deemed for all of meaningful use, I don't think that's robust enough.

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

Oh yeah, I would agree with that. Yeah. I think that part should be an "and".

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

Okay, so the latest proposal on the table is to keep the four reports and create an "and" reduce disparities for one of those four things – topics you've chosen to report on.

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

Yeah. And I think that's important that it be an and because that's where you're calling out the issues about language and other things that in the deeming process were kind of – the capturing race and ethnicity data and all of that, so, I think that's good, putting it to use.

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

Language – umm, eligible disparity variable?

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

It should be.

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

Okay, so add that back in, well not back, add that in.

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

And so should gender, sorry...

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

This is Amy. I have a question on the 20%...

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

RELG we had, it was gender, race, ethnicity, language, and gender was the original data set.

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

Okay. You've got that Michelle?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I didn't, I'm sorry, I didn't get that. Can you say that again Christine?

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

Add language and gender to the EG on slide 11.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Okay. Thank you.

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

This is Amy and I had a question on the 20% reduction of gap between last year's performance and the top quartile. So it's not just a percent improvement over your – I just want to clarify this. It's not just a percent improvement over your previous numbers; it's actually a reduction of the gap between the top quartile. Do we know how broad that top quartile is and I don't recall whether we discussed sort of just a percentage of increase from where you were previously versus this decrease of the gap to the top.

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

It – this is to help normalize, so people may be very far, you can't get a 40% improvement, it's to get you – show meaningful improvement and what's meaningful? Well, it depends on how far you are from the top quartile.

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

I'm questioning, is it really – is improvement really measured on how far you are from the top quartile or how far you've been able to improve, period.

Paul Eggerman – Businessman/Software Entrepreneur

And this is Paul Eggerman, I had a similar question, because I'd make the observation if you're currently at the 50th percentile, 20% means that you'd have to improve by five percentiles. But if you're currently at the 30th percentile, 20% just means you have to improve by one percentile, it doesn't seem right.

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

No, no, no. So if you're at 50 and the goal is – you would have to improve by ten – you'd have to reduce the gap between 50 and 100 percentile, and that's not the same thing as percent. So let's pretend you're at 50% and the 75th percentile is 80, so there's 30 between you and you'd have to reduce your – reduce that gap of 30 by 20%.

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

By six, basically by six percent.

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

And then if you are further away, if you're at 30%, not percentile, and you have to get to 80, then you'd have to reduce by – you'd have to reduce it – you have to increase your performance from 30% to 40% to reduce that gap of 50, by 20%.

Paul Eggerman – Businessman/Software Entrepreneur

So if you're currently at the 50th percentile, you have – what do you have to do?

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

Okay, so I'm going to speak only about percent right now. So if the 75th percentile is 80%, and you're at 30%, there's a 50% gap. You have to reduce that by 20% or ten percent, so you have to achieve, to deem out, you'd have to achieve 40% instead of your current 30%.

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

Paul, that's correct, but I think what's the concern here, if you're just short of the top quartile, so let's say your top quartile starts at 80%, and you're performance is at 75 percent...

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

Right.

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

So you meet this criteria by increasing it to 76% next year.

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

Yeah.

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

That's the problem and most people when they're – who knows, most people are going to pick things that they're not too far off from, I think, and try to do that. So I think...

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

Okay, so...

Paul Egerman – Businessman/Software Entrepreneur

Yeah, or to put it differently, the farther away you are from the top quartile, the harder it is to meet this criteria, and I'm not sure that's what we want.

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

Well actually...

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

I think...

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

Go ahead.

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

The 20% is easy to meet; if you're far away if you need to get a 20% reduction, if you're close, it's probably easy to get a 20% reduction because the percent is so small. So maybe we just increase that to – or, if you're below the 50th percentile, you need to achieve a 50% increase in performance.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Guys let me – I would look at this slightly differently Neil. I would look at it this way. If you have an organization that's so close to 80% and they're getting better, maybe that is good enough. If you have an organization that's poor and they're at 75%, you do want to – this is a way, in effect, of giving them partial credit. If you have an organization that's at zero, that's pretty bad and maybe they should be able to move up to 16 from zero to get closer to 80 and that's a reasonable expectation.

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

I think you're right George, I agree with you. I think you're right.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Like it kind of gives you partial credit.

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

So there's nothing wrong with being at 76% if you've done that, and the organizations that are going to do that are going to blow by it anyway, so, it's doing, I think, what we want it to do, which is, it's fine if you go from 75 to 76.

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

But what – is it – I guess I was just thinking it might just be simpler and easy to – simpler if we just say a percent improvement over what you were at...

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

Well and then...

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

Instead of measuring it to the top quartile.

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

Yeah, I agree. I think that does make it easier.

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

I think it's very confusing to have to figure out this measure and I think – the point is to do improvement sufficient here. So if we have an improvement goal versus – if you're in the top quartile, I get that, but if you're doing a lot of work to improve to – a reasonable percentage of improvement, then you had to implement things to improve. But you may have reasons why you haven't been able to get all the way up to the top so quickly. So I would just put that out there as food for thought.

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

The reason for that is because, as Neil said, it is actually a lot easier to go from a very low score to a not as low score and the other thing is you would penalize the folks who are already one percent away from the top quartile, you'd penalize them to have to go a great distance – 20% of 70 is way different from 20% of 30. So that's why this sort of felt correct for that effect.

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

Yeah, no, I agree. The higher you are at the top, the harder it is to get that last percentage, to get that last mile, I agree with that. I just – something feels very complicated about it.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

And if you're at zero...

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

Are we going to know what these quartiles are, are they going to be published?

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

Yes. So that would be published by CMS based on the prior year.

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

And they would be published for sort of an average population, right, so –

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

Correct.

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

Yeah, so, okay.

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

In fact they can decide – so CMS can decide independently, we just gave a guide – saying top quartile, they can decide before the start of the reporting year, what that top performance – high performance is defined as, so everybody knows exactly where they're shooting for.

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

One other thing, just to clarify here, is it going to be okay to pick different – so for some of these, you could qualify at the top quartile and for others you can improve performance or are you picking top quartile or improved performance for all four that you're picking. I think we should just clarify that.

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

Yeah, I think it would be flexible.

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

Yeah, that's what I would agree, but I just think it should be clear that you're not – you don't have to – since the sentence starts with this or that, that you can mix and match.

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

Okay.

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

So I have one last question which is how broad a range is the top quartile. So you're looking at a percentage to get to the top quartile, but...

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

It's the bottom of the top quartile, right, that you have to approach?

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

Right, so then we also have, and maybe this is okay, I'm just pointing out, we also have here no incentive if you're at the bottom of the top quartile to get better.

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

Yeah, you're already better than 75% of the entire country, that's pretty good.

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

Yeah.

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

Well then, actually would you be eligible for this pathway or would you need to pick one of the other menu items?

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

No you wouldn't...

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

Now remember, it's a reward. Yeah, our principle is to reward...

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

Just a question.

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

Good behavior so let's not...

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

It's a question Paul, it's a question, I'm not making an argument, I don't understand. So if I'm already in the top performer – I'm already in the top quartile on two under patient safety and two under care coordination, I just show that and I get deemed, is that how it would work?

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

You'd get deemed for a subset of the functional objectives, correct – it's – to do that.

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

Well the other idea that I had, which would be interesting for high performers, is I wondered if there is a way for people to say, for whatever reason either it's going to be hard for me to either get to the top quartile or reduce my gap. But we want to give them credit for having done – having reduced health disparities in two areas. So like you could do the approach that's on the slide or you could do the approach that's on the next slide and get – and if you're a high performer already or I suppose if you're a low performer and you don't think you're going to hit the mark. I mean, is there a way to incentivize the disparities reduction here as another option?

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

I...

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

Providers always talk about flexibility so this is where they could have a couple of ways to get there.

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

I thought we were saying that even if you – even if today my measurements were in the top quartile in four of these, it would not exempt me from the...

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

Correct.

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

In order to get deemed, I would still need to do the disparity – show a reduction in disparities, so I'm still...

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

For one?

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

I'm still doing that project.

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

Right, right, for one of them, yes, and I agree with that. But I'm also saying, well what if someone was able to show a reduction in disparities for two of them or three of them, maybe they did or didn't hit the mark, should that get them deemed also by itself?

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

I see, I see.

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

I'm not sure, I just had that thought.

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

I think we want to be careful not to get it too complicated and also I think we need to satisfy with – of performance.

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

Yes.

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

So, one last question, I'm sorry. This is Amy. And I ask because I really don't know. Are there situations where there's not disparity across these populations so that improvement in these reductions of gaps would not happen and would that negatively adverse a provider? Or do we feel pretty confident that there's always sufficient disparity?

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

Well no, I think, again, if they are a high performer and they have no significant disparity, then I think that's a good thing and they should get full credit for doing that.

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

Right, so in that instance, the improvement in reduction between the mean performance and disparity subset and mean performance of rest of patient population, is there always an improvement to be seen? Or do we need to...

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

No, they could be at the mean or better.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

So the question is whether – Paul, the question is whether 11, slide 11 has to be rephrased to recognize it's possible there is no improvement and therefore you qualify.

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

Thank you. You said it much better.

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

Uh, slide 11 – ah, yes. We can clarify that. I'm getting rushed because we only have five minutes and I want to give some time to the consolidation question that Christine...

Paul Egerman – Businessman/Software Entrepreneur

And Paul, this is the other Paul. I just have a quick question. If you are successfully deemed, you say you don't have to do a subset of the objectives, what is the subset that you don't have to do?

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

It's on slide 12.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

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

Whew, that was an easy question to answer. Okay, so I think I'm going to – just with the remaining couple of minutes, Christine, you wanted to point out something, a question on consolidation.

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

Sure. So, at the Implementation and Usability Hearing, Carl Dvorak kind of – for us that it's possible that the consolidation work while noble in its intent, actually creates more challenges in the market. And so we got an email, and Paul, you have a copy, from a vendor who gave the example of Stage 2 where the measurement of problems, meds and allergies was actually moved into the summary of care objective, and that's exactly the kind – that's one kind of the consolidation that we did for the Stage 3 piece. So the impact of that was that for vendors, when you consolidate – or when we consolidated then they had – the previously developed calculations that they used to report, how are you – how close are you getting to achieving "X" percent of medications recorded, it had to be redone, because it was now in something else. So there had to be a new combined calculation that was developed, so that's more effort for the vendor.

And then for providers, that process, according to the vendor, became essentially a little more confusing because, and the example given was if you report that – if you looked at a report that said you were at 50% on updating the allergy list. But you were at 99% of providing the summary of care, like then you knew where to focus, right, but in the consolidation piece, now you have 49% providing a summary of care with an updated problem, med and allergy list. And so you don't know where you're missing, if it's in problems, meds or allergies or if it's in the provision of the summary. So I get that point. The work that I think...

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Sorry.

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

Did...

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I'll wait until you're done.

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

Okay. The work that I think needs to be done is, there are some areas where that's true, okay, so structured labs is probably one of them, patient lists is probably one of them, things like that. There are some areas where that is less true, either because it's brand new, so you're not creating confusion and you're not making a change, so communication preferences for example. Or where you con – where we consolidated in a way where the thresholds align precisely. Or, and the other the kind that we did was like an immunization intervention and CPOE, they were duplicative. So some of it could probably stay, but some of it I think probably ends up creating a lot more rework for the vendors and makes it a little less easy to know where you're at or what the problem is in performance for providers. So, we probably need to take a look at that and we probably need more folks who understand how this worked in practice, to help us through that. Does that make sense? Michelle, I don't know if you want to add anything.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yeah I do actually. So just taking a look, I think part of the confusion with the problems, meds and allergies as part of the care summary is they were required elements, so vendors still had to prove that they are being done. Whereas most of the things that were consolidated are not required elements that we put under other things and most of the things actually were just consolidated because they were topped out, if you will, and the understanding was that they would be used as part of something else, but they weren't included as required elements of something else. So I'm just taking a quick look and I actually don't think that there is much room for concern.

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

Well Michelle, I have the exact opposite take that a lot of the things that we were comfortable consolidating weren't necessarily because they were topped out, we wanted to continue to keep them in use. So, structured labs is a really good example, that's really important to keep people doing and the way we consolidated it, it should still be required. And I know we went back and forth on that a lot, but that should still be very much so a required element of the care summary. It was just that we didn't want to have people have a separate recording objective when they needed to have it over there, so we have to; I think, go through and say, if there's alignment in the threshold. So you're providing a care summary 50% of the time, let's say and you want 50% of labs recorded with structured data, than that probably works. But if you want 80% of labs with structured data and you don't have a separate recording objective, it obscures the performance on that 80%. Do you see what I'm saying?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So this is Mike, if I could jump in. I really, really resonate with this and it may be solvable through reports, but that whole notion that says, you've actually got five or six or eight what used to be meaningful use measures that are still relevant, but are buried within another...

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

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Current requirements and the minimum requirement I would say that's necessary to help with that, in addition to Carl's point about making sure the measure counts still work right, is to make it basically dividable just – in other words, you can see a granular report of performance against each one of those measures. It's like a chemistry 20 for all the docs on the call here, you can't just say you're not meeting normal standards for a comp 20, you need to know what each of the results is that's off so you can easily diagnose and treat the problem. So I'm with you on that.

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

Right, which is doable, technically, but I think the point here is we were trying to streamline. Lots of folks are saying, we don't have enough time to make the changes to the system. And we're asking them to make a lot of changes. I think, that are probably of questionable value when you could accomplish the same thing without any changes being made and still have people using the requirements we want them to use and not have the vendors make a lot of changes. Just so that you can separate those parts out, as you just described Mike, so, I think for some of the consolidation items, they still make sense to consolidate where it's duplicative of something else or where it's new work and there's not going to be a lot of changes made and the thresholds align, then that's fine. But I think there are some, and I think we would need some help figuring that out, where there isn't alignment and it is – it looks nicer on paper, but it's in fact harder in practice.

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

Harder to interpret, by the way at least for the provider, I'm very sympathetic to what you just said and to the extent that you can break that out. Things that are really duplicative, it just makes extra work for them to separate it out, that's great to get rid of the separateness; but in our attempt to reduce the number – to make it more complex both to do and to understand, would be counterproductive.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Christine, this is Michelle. I think we need to revisit what was required then, because if – what I'm looking at, there really isn't anything that was required, so that's the first conversation that we need to have.

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

Yeah, I agree.

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

So just some offline work, like David had a little bit, between now and the present – preparing the presentation for next week.

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

Yes, but I think we need more than Michelle and I. I mean, we can re-engage Steve Waldren, but it might be good to have Carl or the vendor who sent me the email, somebody who really is in the weeds on coding these systems, to work with us and anybody else who we think could be kind of helpful here.

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

That's reasonable. So – like George and I, maybe we can help you with that, or something like that.

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

Yeah, and I guess I'm also questioning whether we think we absolutely have to do it by – so our recommendations or our discussion in August is the next big presentation, but I assume, are we coming back in September with any changes...

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

We are.

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

That the Committee recommends?

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

Yeah, we are.

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

Okay, so it might be that we don't have to do it in the next week, because that's going to be a challenge.

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

Okay. So, present the problem, the quandary and then – and your proposal for how we would address it, maybe.

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

You mean right now or...

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

Sorry – no, I mean for next week.

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

Okay, all right. And we can – I mean, we can work with Michelle and if you and George want to participate, let's – we can get a little list going on email and try to get a couple of time blocks on the calendar in the next couple of weeks, that would be great.

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

And we can recruit – Christine, this is Charlene, a vendor – additional vendor too, if you want, to the table for that meeting, if you want.

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

Okay. Paul, there's one request I have coming back to deeming, just to sort of get the information, is that an okay time to do that now?

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

Yeah, if it's quick.

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

The measure list, can we get the full measures because I don't know what some of them mean, like MI beta blocker, is that beta blocker...

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

So beta blocker after a heart attack.

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

Okay, so if we can just get the like full list of the measures, that would be great, because there are a couple of different variations.

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

Sure.

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

Thanks

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

Okay, I realize this was rushed, and hopefully we have enough to present a cogent discussion at the Policy Committee next week. We will get feedback from them and then we have I believe two calls between August and the September meeting, where we have to present our final recommendations for approval. The other thing we'll be discussing next week has to do with timing. You've been hearing certainly there's a lot going on for all the providers and the vendors, and it came up in spades in our Implementation and Usability Hearing last week. So, it's a discussion we need to have in this workgroup in terms of what recommendations do we have related to timing. So, that's something I'll tee up for one of our next two calls. Is there anything else Michelle?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

No, I think that's it.

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

Okay.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Are you ready to open for public comment?

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

Yes, please.

Public Comment

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Operator, can you please open the lines?

Ashley Griffin – Management Assistant – 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 have no public comment at this time.

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

Great. Thank you. Michelle, I'm correct, we have two calls scheduled for this next month?

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Um, I know one off the top my head, I'll check to make sure we do.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

There's one on August 16 and we have one on August 27, 2013.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I want to say the 26th.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

27th.

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

Okay. I really appreciate everybody's being on this call, it's really important that we have all of us here to discuss this, it's very important, it's our recommendations and our next two calls will also be very important, both in finalizing our recommendations, but also to discuss timing and recommendations around that. So thank you everyone and talk to you next time, and see some of you next week.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you Paul.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Take care everyone. Good day.