

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
November 7, 2013**

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Paul Tang?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

George Hripcsak?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

David Bates?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Christine Bechtel?

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

I'm here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Neil Calman? Art Davidson? Paul Egerman? Marty Fattig? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

David Lansky? Deven McGraw? Marc Overhage? Charlene Underwood? Mike Zaroukian?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Amy Zimmerman? Tim Cromwell? Joe Francis? Greg Pace? Marty Rice? Rob Tagaliod? And are there any ONC staff members on the line?

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

Elise Anthony.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks Elise and I will turn it back to you Paul.

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

Thanks, Michelle, and hopefully we'll have a few more members join in a couple of minutes. So, thank you for attending this Workgroup meeting and we have a few scheduled between now and the time of our final presentation in the first week of December so we have quite a lot of work to go through. Next slide, please.

To give an overview of our schedule today we're going to cover the recommendations from the Care Planning Hearing, we'll go over some feedback on the deeming recommendations and some of the input we have from the Quality Measurement Workgroup and start working our way through the category 1 as part of our final review before presenting in December.

Next call, in a couple of weeks, we'll be talking about the recommendations from the Consumer Workgroup on patient generated health data and review, you know, in concert with that review category 2 recommendations from our group.

The next meeting, which is right before Thanksgiving, we'll be reviewing the remaining priorities for categories 3 and 4, and then we'll be presenting our recommendations to the Policy Committee on December the 4th and in January we'll be finalizing our recommendations on the deeming quality measures and the functional measures that would be deemed.

The reason it's set up that way is because the Quality Measure Workgroup won't be presenting their final recommendations until December so we have until January to present our combined combination of their quality measure recommendations, what we think about that and what functional objectives would be deemed as part of that. We'll also be covering the imaging recommendations from the December meeting. Any questions about that?

Okay, I might throw in another ringer here, we've had some questions about our use of certification only objectives and we might want to discuss that as well if we have time for it today. Okay, next slide please. I'm going to quickly – let's see so Leslie wasn't there yesterday anybody else who wasn't there yesterday?

Okay, so Leslie I'll try to go quickly through this and also sort of hit the high points in terms of what we want to discuss with regard to the hearings that were presented, the summary of the hearings that were presented yesterday.

The first is on care planning, which is relabeled from advance directive. Next slide, please. And really they talked about three piece or four pieces of advance directives and care planning, one is of course the main goal of that is to get the conversation started and have people and the families understand what their roles are and what the subject person's wishes are and how they can best execute that.

As a byproduct of that you create documentation and artifacts and some of the documentation can be actually the directive itself and the care plan, another way it lives is in the OLST kinds of things which are basically orders and we'll differentiate between advance directives in the following slide.

And the artifacts can be anything from handwritten to video, to structured data so the computer can do something more with it. And what was interesting is they also presented some examples of how states have already started to create repositories for these things, because obviously in the ideal case you know exactly at the moment you need it what's the most current wishes of the individual. Next slide, please.

So, an interesting summary of the difference between advance directive and POLST as an example for all the OLSTs is for the advance directive they typically say adult, well kids can also have serious illnesses that could cause decisions to be made or considered in terms of end of life and so that's one of the differences between the two.

Another important difference is in advance directive you're talking about future treatment and by nature the orders that are written as part of an OLST kind of agreement is really medical orders that are current treatment and could be carried out by emergency medical personnel. The advance directive is more of sort of a wishes sort of objective instead of orders that could actually be carried out.

Similarly, advance directive appoints a healthcare representative to speak when you can't and the POLST sets up part of the orders. They do both guide inpatient medical treatment. So, that was sort of interesting in terms of pointing out the differences between these two. Next slide, please.

This summarizes how some states have already – have laws on the books or are in the process of developing this and so very few states actually don't have – aren't speaking at all about it. So, just showing a little bit of the maturity of how states are taking up this activity and this is a state directed concept. Next slide, please.

As an example, New York has an eMOLST and sort of as it indicates it's an electronic version of this and the nice thing is that of course is something that both the individual and providers can access in an up-to-date way. Once you indicate all your wishes then it can be reduced to a PDF document that you could print out.

So, what's nice is this registry that's been created is there, its accessible 24 hours a day and actually I believe, and I'm not positive about this, it can be connected to EHRs, that doesn't mean that you're actually incorporating the orders but at least you can view them and that's sort of what we've talked about as, you know, a desirable attribute you not only can maintain it in an up-to-date way but you can access it all the time and can bring it into your electronic health record system.

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

Paul, this is Neil, I have a question. Is it possible to have multiple of these documents on there or is it a single – somehow identified with you so that you there can only be one? I wasn't clear on that yesterday.

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

Oh, boy, I don't know the answer to that question either Neil. It's a good question.

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

There should only be one. There should only be one, but I don't know how we make sure that there is just one.

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

Yeah.

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

Correct, because that's – you know, that's a concern that we've all expressed in the past which is how do we know that we're dealing with the most recent document.

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

Right and then like on the East Coast when you guys go to Florida and stuff how do we know – you know, just because these are state-based – so these are some of the questions but it's nice to know that states are starting to wrestle with this and it's certainly important for us.

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

Yeah.

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

So, maybe we can – the reason for going over this is to start thinking how can – on a policy level how can we start promoting this or even acknowledging and recognizing this. I just – this has been really – it was good to hear.

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

Paul, this is Charlene, do you recall what they – how they stimulate usage of this and if it is used, you know, do you recall that from the conversation?

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

Well, let's ask our New York representative.

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

Okay.

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

So, Neil do you have any comments about this?

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

I do not. I really do very little hospital care. I'm not really involved, but I would be glad to find out and get back to you.

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

Okay.

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

Well they – so this is Dave, I mean, the way that they're used in, you know, in Massachusetts and in Oregon is that is if anybody meets certain criteria then we – you know, we have an approach where we try and make sure that there is a – a MOLST is at least considered and then – you know, and then it goes with the patient and it's been exceptionally effective. I mean, in Oregon 70% of people die at home whereas in Massachusetts today 70% of people die in the hospital.

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

Wow.

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

So, it's a big deal.

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

It is and we'd like to – while we wouldn't – we aren't in the business of dictating hospital workflow and policies we'd love to make this available, make this possible through the –

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

Exactly, exactly.

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

Systems that we, you know, influence.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, this is Leslie, I was at the session and they really talked about the collaboration that New York had across the state and really promoting the registry in every provider setting. And so they've done a good job – they have done a good job with communication and outreach as well and I think they talked – Michelle might remember, but I think they talked about engaging clergy and other sort of non-medical people to help to promote this throughout the state.

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

Christine, they also work through the Department of Health. So, I mean, the thing that occurs to me is that certainly, I would imagine, it would be easier if there was a field in the EHR that had – there was free text, but that you could put the link, you know, to –

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

Yeah.

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

Either the registry in your state or you could put the location or the name of your healthcare representative, in other words, you know, how do I find the most recent copy to get the content.

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

Yeah, so we've talked about these things and let me – so let me just finish up these slides and then let's talk about it. It just – it was very interesting and it stimulated exactly the thoughts that we've just already started discussing. Next slide, please.

So, there actually, and I don't know the status of this, there was a senate bill already introduced with a letter of support from the house, some members of the house, about patient centered care planning, this topic. So there is some thought about it in congress.

So, to summarize again, it's really not a document or a check box it's really starting the conversation and making people aware of the results of that conversation in as up-to-date fashion as possible as we've been discussing. Next slide, please.

So, they didn't have like a 1-2-3 here's the recommendations for MU Workgroup but it reflects the discussion we just had. We'd love to be able to support this. It's really – anything can happen to any one of us at any time, why should we limit it – well, I mean, that's a bit of a rhetorical – we put 65 because that might be more relevant and pressing, and more broadly applicable, but there is no a priori reason why you should limit it to just people in one age group or another.

A key thing is that you would like to have 24/7 access to all parties that gives some of the chance of keeping it updated and of course then getting it available to wherever you happen to be at the time of need.

And one of their bottom lines, so it's obviously still early, has a lot of potential, but so one of their recommendations might be to start a pilot for all of the reasons, you know, you might think of it, well how do you get – how do you stimulate the use of this, how do you stimulate the uptake, how do you get the interfacing. So, that's sort of one of their bottom lines. Next slide, please.

Where we left off, if you look at the functionality goals we want to have all the relevant information necessary to make informed decisions about an individual's health and healthcare and the functionality we left off was to record what does exist when they're 65 or older. Now as you know we've been trying to go at this since Stage 1.

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

Yes.

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

And it's gone as far as a menu requirement as what you see here. So, we might even think about – so we have a lot of things we could think about, change it from menu to core, expanding it to EP, which we've recommended in the past but it hasn't made it through the final rule and then other kinds of things and actually this does bring up again the certification only requirement because we were talking about just having the field there.

So, let me open it up to discussion. What avenues do you think we can be most supportive? It sounds like we're all in agreement about the importance of this. How can we most support it in the context of the EHR Incentive Program?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie, I think there is a great opportunity for us to have certification and standards lead the way because part of this is so difficult to get to because we don't have a way to identify easily from an EHR how do I query and find anything out. The work we're doing on Blue Button for instance we could advance that to include the ability to seek out and get any advance directive, POLST or MOLST within an EHR.

We could look at standards to seek out expert systems to retrieve – a MOST or POLST. There are things that we could do that would help guide the industry to promote use by having standard ways to do it because it's not only difficult right now but this is a low market opportunity where there is not a lot of money out there to support the use of technology in advance directives and so it's one of those areas that if you're an entrepreneur do you spend your time on interoperability, do you spend your time on standards or do you spend your time on trying to get to the core application. So, you do the core application but you don't have any way to integrate or interoperate and it becomes a chicken and egg.

So, I think this is an area where we could have great opportunity to promote and identify which is – the standards that allow for how do we find it and then the standards how do we consume it once we've found it across a wide area.

And there was a high degree of support for doing more than just recording it and trying to find it, it was how do we get it ingested into the EHR in a meaningful way both a PDF of an advance directive and perhaps an order set structure for the MOLST and the POLST.

So, we could help to drive adoption by putting in the technology to support the advance directive use, without that we're going to continue to have Apps that are disparate and out there with no market to push them ubiquitously.

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

Good points. Others? Other comments?

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

I think we have – I think having, this is George, having it in a form that could be included as an order in an EHR is a good thing, but be careful about automating too much it's just too dangerous an area where you could cause a lot of side-effects, you know, untoward effects.

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

This is Charlene; I kind of want to go back to the concept that was recommending of doing a pilot. I think that we should encourage if we're going to – and I'm also in favor of a standards-based approach, but because some of this is new in practice you don't want to standardize something until, you know, you sort out what works and what doesn't work. So, again, I think New York is an excellent example of what works and it sounds like in Massachusetts it is too, but I would want to gain that knowledge before I would harden the standard at this point in time.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I just feel, I feel that this is a low risk opportunity to do standards-based and EHR approach. This is such a high need; we heard that over and over, and over again. And it's not an area the market is going to address. So, I would just – I would really push on this if there is a dramatic need out there. And it's not rocket science we just need to decide how to get it down and give people an opportunity to use it.

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

So, Leslie, it's Christine, I have two questions, one is the Consumer Technology Workgroup has been working on standards for patient generated health data and I think some of them would apply in this case. I think there may be a difference between – so that's sort of my first question – the difference between the actual legal form and, you know, patients giving – find it or some of the other standards. But, I know we have a joint meeting with the Consumer Empower Workgroup to talk about these things in a couple of weeks. So, I don't know if that gives people some comfort around the thoughtfulness of the standards work that has gone into or Leslie is that –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The patient generated health data team we've looked at the idea of using the Consolidated CDA structure and questionnaires that can be formatted in a way that would meet the needs of that conversation that Paul talked about of the advance directives. So, asking questions and being able to get a response back in the record and have it consumed as well as doing both a semi-structured approach which could be a format with a patient narrative in it. So, we are working on that with the goal that it could be used in Meaningful Use 3.

I mean, we are doing ballot reconciliation right now. So, that – advance directives were one of the use cases we put forward on the team. So, I feel strongly that we need to push forward to make sure that advance directives in some way are included more than just that recording that it's there because the next step is if it's there you want to find it. How do you get it? How do you put it in the EHR? How do you use it? How do you know what the provenance is and the timeliness of it is? We've got to start somewhere it's not going to go away.

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

Yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And –

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

Leslie, I'm sorry that gets me to my second question which is standards and you are on the Standards Committee they need to be the ones judging whether or not the standards are ready or they exist –

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

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

– I think you guys have done lots of work on that. So, I think my question is what would the policy requirement or whatever be in this case that we could use that would – that is likely to be, you know, complimentary to the standards that exist. What's the policy here?

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

Well, would the recommendation – so moving from menu to core and also having the field for the link where – having the field for the link in the EHR to make it available in settings where, you know, these registries exist.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So the solution maybe a registry but they could also be a market alternative. So like MyDirectives.com we'll see several different approaches to it.

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, standards need to be focused on how do find it, once you get it how do you consume it and not dictate where the location has to be that might be driven by market opportunity or the particular process of a provider. But we could focus on how do I find it and how do I ingest it when I get it.

And also it's important to note that as we did this in the Workgroup we did this under the construct of overall care planning so this isn't just narrow to advance directives but can be used under the umbrella of care planning, this would just be that first attempt.

And I think someone made the point earlier we don't want to just get the legal documents scanned and put in the record, although that's a good first step, we also want to be able to help to generate conversations and to help move the market in a standard-based approach so we can get more of these things inside the electronic health record. So, if we could –

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

So, Leslie –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes?

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

Those comments are really helpful, so I think what I heard you say in terms of the policy approach is two pieces, one how do I find it, which is I think what Paul just mentioned around the field that could contain a link and it could contain a link anywhere or it could contain something else, you know, based on its in my car or whatever.

So, there is a how do I find it, we can make it easier for providers to document that and then how to consume it I don't know – is it a certification criteria that would say something like, you know, with the ability to store a copy of it?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think that we could have the certification requirement for the use of the standard for consuming it in the Consolidated CDA structure. I think we could use things like the expert system finder like the InfoButton and we could find it.

The policy could be if it is recorded that we have – and we're capable, we have the ability to retrieve that electronically and store it in the EHR because we need to start someplace and I know that it's hard to say, well we don't know where it is and what it's going to do, but we have done it in the past where we've said, where the provider has capability to bring that into the EHR.

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

You know, I think just the starting point is whether it exists and a link if available is a really big starting point.

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

I do too.

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

Because, you know, yes you could scan in a document now but the EHR would not have the functionality of some button, some sort of saying find me the AD and all of a sudden if that were possible you could see that you could either have an alert saying "hey, I don't have one would you like to ask about it" or "hey, I'm in the ED there is one available would you like to see it" that alone would just go so far and yet would keep us out of...I don't think we're in the business of dictating policies or practices.

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

Right.

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

But we want to make these things happen and right now without a special field there is no way for a clinical decision support to help you either capture it or use. And I think that would be a big step and that step alone would ask the Standards Committee, hey what standards are around, what could be promoted and how could it be included in the C-CDA for example.

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

So, Paul, this is Neil, I just want to make sure we're not – let's just take the New York for example.

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

Yeah.

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

I want to make sure we're not moving backwards. So, if there's a central repository –

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

Right.

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

So, let's think of like immunization registry or something like that, right, then really what we want to be able to do with my EHR I don't want to store it I want to be able to access it quickly through my electronic health record potentially update it and send it back to a central repository. I don't want my electronic health record system to be the place where people assume that's the latest and greatest.

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

Correct.

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

I mean, we just looked at data in New York City and there are – it is a vast minority of patients who use only a single source of healthcare in a year and we now, through the exchanges, have that ability to look at that information.

So, is there a way to conceive of that using health information exchange on a national level so that we're not populating something in electronic health record that we have no way ever of knowing whether it's the most recent document and – because I worry about having the wrong thing in the chart –

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

Sure.

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

As much as I worry about having nothing in the chart.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think that's a really reasonable request to look at how we could do that.

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

But that said it's the link would follow whatever, however this evolves. So, let's say it's a link to New York right now and then we do evolve into something where it's consolidated or at least a centralized version of it across the country you would just switch that link over or New York would redirect the link to your MOLST there to a central location. Do you see what I'm saying?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well it's in multiple locations if there's a standard that says I can look and seek multiple locations with a common way you could see the most latest and greatest. So, you don't have to dictate a regional or a local, or national approach we have to dictate how do I find any available and know the provenance, know the currency of it and so forth. So, I think it's worthwhile to investigate this further. But where there is a capability like in New York then to further say in policy that it should be reflected in the EHR.

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

Right, so can I just make one other comment which is maybe this is a place where incorporating a PDF is the actual right solution, because there are a lot of subtleties to this stuff.

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

Yes.

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

It often needs some text statement or something to actually really understand what somebody's wishes are.

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

That's why I would think that it's a "text" document for human consumption. This really –

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

Right.

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

And it's not moving – we're not jumping and trying to say you can have the computer operate on structured text. I think it's really –

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is –

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

So, why are we concerned that there might not be standards yet for it if we're really just talking about an open sort of text field kind of a thing or the ability to just capture a PDF or something like that?

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

So, this is David –

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

I think David Bates had a comment.

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

Yeah, so, you know, I disagree with that, I mean we've been doing this for a while and the way that we do it is, you know, have some stuff as structured and some other parts as text and that works pretty well. If you don't have some parts of documents like this, you know, as structured it's really hard to do any analysis of things and you can't use it for decision support and so, you know, I think it would be shortsighted to have it be a textual document or certainly a PDF. I mean, PDFs are really not that helpful.

One other point, you know, I don't want to wait to implement this until we have a pretty broad exchange. I feel like as long as you, you know, have the document you can figure out what its provenance is and a date, time stamp, you know, you'll be able to have at least some assessment of whether it's the most recent and this is an important enough thing that you'll want to know which one you have.

You'll want to have something in your system which you think is the latest you may then want to go out and look for other things, but I think it's going to be a number of years before we can do that at a really broad level. So, in the interim that's the approach I would suggest.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, I agree, I think it's an iterative process but by identifying the standards up front it gives people a place to work towards and it's also important to note that as we look at clinical decision support with patients involved we're starting to gather their preferences and their values, and their biases, and their direction which is a part of care planning as well as part of advance directives.

So, this is going – we're going to advance several things by advancing advance directives. And I really feel strongly that we should be promoting the end game and coming in with perhaps iterative measure towards it, but this is too important guys to drop.

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

Okay, so let's start coming to closure on our recommendations. Let me try to summarize where we've been and the options that we could explore. So, one is we – in Stage 2 it's more than 50% of unique patients 65 or older have an indication of whether such exists or not in structured data that is a menu option. So, first branch point is do we want to say anything about that becoming core? Then we'll just keep getting more and more specific.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

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

And I think I could lay out some of these things. Second is whether we should change the age group.

Third is an approach of whether this is certification, rather than dictating behavior that this is just something that we think what's missing is the fields that are understood by the EHR and some of the standards where they're useful in terms of making decisions like finding and clinical decision support as like David mentioned and whether that's a certification. It's really making it possible to do different things rather than dictating the workflow processes or behavior at this point.

There may be others out there, but let me start with those let's say three. So, one do we want to do anything about menu/core of the existing Stage 2 measure?

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

For EP and EH Paul?

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

Oh, that's another good point, okay; right now it's just EH. So, right now there is a menu EH measure of 50% of 65 and older.

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

I thought it went to core in Stage 2.

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

Pardon me?

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

I thought it went to core in Stage 2.

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

At least what I'm reading here it's a menu. I'm pretty sure that's true. Michelle can you confirm that?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yeah it's just menu in Stage 2 and only for hospitals.

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

Yeah, for hospitals, right. So, there are a number of branch points. So, first let me ask the question for EH, current menu 50% 65 or older existence of an advance directive, do we want to do anything with that in Stage 3 as a recommendation?

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

I think it should be core personally.

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

Okay, others?

Marty Fattig, MHA – CEO – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Yeah, this is Marty, I would agree.

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

Okay.

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

This is Art, I agree.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Leslie, agree.

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

Okay, so we have that stage. Okay, let's go to EP. In the past we had recommended that EP also be there as menu and so let me just throw out one strawman because this is something where we sort of go menu then core. What do we think about EP menu same – well right now let me test out the same requirement which is 65 and older or 50% of 65 and older whether it exists or not?

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

That was also my train of thought. I agree.

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

So, you're saying core, right, David?

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

I'm saying actually menu for EP to just get people started to do it.

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

Yes.

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

Okay.

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

Okay.

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

Paul –

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

And this is Mike; I need to share the concern about the possible issues of reconciliation and having a source of truth and potentially competing sources of this. So, we're actually in the planning stages right now to integrate some of the ePOLST components, very structured, to David's point, in many areas and could inform decision support and we think rightfully so, granted I don't think that's where we can be as a nation yet, but I'm quite concerned about the burden EPs would have trying to figure out how to reconcile what they may have with what someone else has.

So, if there is going to be a core requirement for hospitals I'm just mindful and wondering how are we going to be operationalizing this in the EP environment. Are we going to try to focus on obtaining and reconciling, are we going to go on the basis of trying to leverage hospitals or state registries, or whatever. So, there is a little bit of devil in the details part that concerns me about this, although it's partly cured by provenance and date, time stamps.

I'm a little bit worried, in fact I'm more than a little bit worried about how I'm going to be able to manage particularly my own patients who may have 3 different versions of it out there when by and large either me or their oncologist have the latest version.

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

Now remember Mike this –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But that doesn't –

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

This is a presence only requirement.

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

Yeah, right.

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

Yeah, you get credit any way.

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

You get credit if they have one or you get credit if you have a copy of one?

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

No, no you get credit if you indicate that it exists or not.

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

So, it does not have to exist in your system?

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

Correct.

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

Okay.

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

And you don't have to swear that it's the latest one either because that would be really hard to work out I agree.

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

Right.

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

I mean, I'm worried about this too.

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

And you don't have to say where it is?

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

Correct.

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

Wow.

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

Well –

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

Well do you at least have to say where it is and the date?

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

No remember these are baby steps and remember this has been already hard and we've not – we've not made it past hospital menu in the 6 years we've been dealing with this, not 6 I guess it's 4 years.

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

– menu item and Paul I guess I'm stuck a little bit because I feel like we should discuss what the criteria would be and then decide what's menu and what's core.

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

Well the strawman draft is to mimic the hospital which would be 50% of unique patients 65 or older have an indication of the presence or absence – the existence or non-existence of an advance directive.

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

Right, but, you know, we have said for a long time that is insufficient and I don't agree with starting EPs on that track. I would rather talk about either a two-part thing that says record presence, absence and, you know, and then have a – if it's a certification field that is the indication of where to find it or if it is back to kind of I think where David and Leslie are where they're saying, you know, there is a way to locate it, retrieve it and store it.

I mean, that stuff is much more important and there maybe some of that that we could do – and I don't know if it's menu or if it's – you know, you're going to get a lot of providers in New York and Oregon doing that or if it's a certification criteria. So, I'm stuck on that, because I think that original construct of do you have one or not "yes/no" is not meaningful.

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

Well, this is Neil, I agree with you with one caveat, I think that when people are forced to ask it then the deficiency of not having it becomes apparent and it makes it easy for an organization to create it as a standard of care to get one. So, you're asking it and then you're getting it.

So, that is – there is some stimulus there but I totally agree that we should add the fields for whether it's been requested and where it's located, because I think that that's the critical thing that people need to know and it also gets beyond somebody just checking a box and going "oh, that's okay."

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

Well, yes, I would hope that people implement it in a way that has a workflow that, you know, triggers "well, gee you don't have an advance directive let me have a conversation" you know but in the practices that I've been in it's on the registration form and the providers don't necessarily have time to talk about it. So, I totally get what you're saying and I agree in theory but I think we should talk about our options here and then once we lay out all the options we'll see what could be menu, core or certification.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I think that also having two different standards might be difficult, more difficult and more of a burden on an integrated system than for instance if we took what we decide is going to be core for EH all of the things and then made that menu for EP perhaps then at least we're monitoring and registering the same thing but there still is the option for the EP.

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

So, I think – listening to the discussion let me try a different approach, because I think it will flow better. Let's start with certification and as we discuss we can increase – we can add to certification to add behaviors but I think, you know, we're mixing all the discussions at once and it's my fault for starting it out this way.

So, let me start with the certification criteria and there are two aspects that could be required one is the presence or absence and in a sense that's already there because it's been menu and that means the vendors had to put it in. The second field we've been talking about is the field that accommodates links to where that might be or further information. So, are people in favor of adding that second requirement to certification?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Find it and ingest it, two things, correct?

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

No right now it's just the field that has the – that accommodates a link to more information about the advance directive, I don't want to specify that that's where it is, it could be other instructions or something, but there is a link that relates to the advance directive.

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

But Paul –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Because sometimes it won't be a link Paul it's just – so – define it as a URL. So, it's just –

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

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Another language around that that we could get to –

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

A pointer, a pointer. How about a pointer.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

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

Right so it could be a name and a phone number in that field.

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

Yeah.

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

Okay, yes, I like – I agree with that so far.

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

Because you can take whether that's a null field or not as part of your decision support to either ask about it or start the exploration of where more information exists. Okay, so are we agreed that that would be at the minimum of a certification only requirement, this additional field?

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

As a minimum.

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

Okay. Now, let's start talking about behavior. So the first thing we agreed on was to make the current menu measure a core and now that's only taking advantage of the field that says presence or absence exists or not exists. Let me go further on that and I think this might be easier too.

So, continuing on with the hospital is there anything more we want to do from a behavior point-of-view now that we already have the certification requirement for this additional field?

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

I would say yes we want to make sure it's there half the time.

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

Okay, well so that's already there with the core, right?

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

Okay.

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

Yeah.

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

Okay.

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

So, we –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, could we say that if the capacity exists in the provider that they would then ingest a copy and/or document in either the structured or unstructured format so that we would have the matched standards in place and then we'd say, great if it's present and the capacity exists with the provider bring it in.

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

I would be worried that one the standards don't exists or are widely adopted in the first place.

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

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

I'm thinking the walk before run kind of thing, because as you know this has been a very hard journey we don't want to knock people off by leaving –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But its 6 years away or its 4 years away Paul and the market will not address this unless there is direction because there is no money in it and so I just think this is the sweet spot for us.

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

I disagree I think the market – I think there's tremendous money in this. There is probably more money in this than anything else we've done in relationship to people having advance directives and keeping them from having extended end of life care and stuff. I think –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Oh, I'm not talking about that I'm talking about I'm talking about a software developer; I'm not talking about money for cost of care.

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

No but if the insurance companies begin to demand the collection of this information the software companies will be required to do it by their, you know, by the people who use that software.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

I think – I mean, I do think there is a big movement in this direction but I do think that we should stimulate it with some movement of our own here.

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

And I would say the market is going to do this too not for the money point, I think just people – it's a demand point, people want to have this accessible and that's why people do this. I don't see the money part Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Then I don't think it's bad to say if the capacity exists inside the – so we've said this is certification, we've said now its core to say is it present or not and they we say where the capacity exists you have the ability to ingest that into the EHR.

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

You have the ability to what?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

To take it into the EHR. So, in other words where I have the capacity, I've said that one exists and where I have the capability I'm going to bring that into the EHR as a structured or an unstructured document.

We would put standards in place that would allow a series of choices, it could be the PDF, it could be a consolidated CDA that's very structured that is designed as a questionnaire or as a MOLST or a POLST that's been defined in standards.

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

Or maybe it's just simply good enough to look at it though. I mean, you know, because it's going to be virtual out there. So, you know, I think –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well, you can't –

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

I think we're getting prescriptive in what we're trying to do here.

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

Right. I think one of the things –

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

So, then why don't we create a certification criteria that allows people to do either one, they can look at it or they can bring it in, but I don't know if that's for us to decide.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

I think what is compelling to me is that it's been 6 years and the market hasn't moved. So, I think having something that is a certification criteria that allows providers to become a market force and saying, you know, my EHR can do this. I would like to be able to do this, you know, what needs to happen here is much better than just a yes or no check box. So, I like the, you know, pointer as a minimum and then some certification criteria that, as David and Leslie are talking about, would allow you to bring it in or view it if you wanted to.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right the standards would support either I'm just advocating that further on the behavior side –

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

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That if the capacity exists and you say it's there –

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

Leslie, the issue we've had with these prescriptives is it becomes very, very complicated and it adds to the burden to prove "oh, was it available or not." So, I think what some of us are saying is once we make this available there is plenty of reasons that people would want to take advantage of it and we don't have to prescribe something in a regulation.

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

Where are we taking this from?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I just –

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

Sorry, Art?

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

When we say take it in, what's the source another EHR, an HIE, a state registry? I just wasn't a patient's

–

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It could be any of those above or it could be a commercial product. It could be any of those. The likelihood that it would be not – not in querying each other's EHRs as the source. We might be looking at the patient's PHR, we might be looking at something like a HealthVault, we might be looking at something like MyDirectives or a registry. So, we wouldn't prescribe the source we would prescribe the mechanism of how to query that source and how to ingest it once it's been found and that's where the standards work would take place.

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

Right, but I mean, behaviorally I think what we're trying to do is make it possible for them.

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

Possible, exactly.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

To bring it because I can imagine being in a hospital and having a pointer that is not a link to an external site it's something else. I'm able to get my hands on the advance directive or the MOLST or whatever and I have to keep repeating that workflow, no I'd much rather just store a copy with a time stamp and provenance in the EHR so that I've got it.

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

Right, I think we – I'm going try to bring us to closure it's been almost an hour. So, we got the certification criteria, we got the EH core.

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

Certification criteria is what the pointer or –

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

It's the pointer.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think it's both. If you're not going to require that it be ingested and you're saying the market will drive that and the standards should incorporate both how do I find it and then what are the standards for ingestion and that could be a standard for just to view, it could be a standard to download or transmit in using our other language, but it gives a way to view it or to see it or to use it. I would strongly recommend that we put both of those in the standards for certification if we're not going to move anything on the actual behavior measure.

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

So, Leslie, those are Standards Committee kinds of activities, we're trying to deal with just the policy side on this. I know you sit on both, but –

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

Right, but Paul, I think she is saying that – which I do agree with, which is the certification only element and I think – around being able to bring it in that's the function not the standard, begin able to bring it in and store it in the record if you want to. I think that is really essential here and in terms of the burden I think this is a case where the benefit really outweighs the burden. For all the reasons we know around cost, around workflow, around patient preferences at the end of life all of that stuff. I think it way outweighs burden.

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

So, this is Mike, I need to add one more thing because the usual use case for me is the patient has, either through a lawyer or through a form I've given them previously, filled out something, they have the advance directive, my commonest is "can you get me a copy" because it's not electronically anywhere.

I understand we're looking at a future where that is more and more common but do we need anything around the issue of if what we're really trying to do is incorporate an existing advance directive so we can use it and that really does create Meaningful Use of that information do we need any standard that deals with that or do we need any behavior that deals with that because I thought that was my responsibility, once I know it exists it's my job to get it.

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

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

Well, I think that's what is in – well that's what I believe we would achieve by having a certification criteria that allows for not just the pointer but for the storage so that if you did, and it would accommodate I think, you know, based on what Leslie is saying, multiple sources. So, if it was a scanned PDF, because that's the best you've got then it should be able to be stored in the record so you can access it easily.

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

Right I just want to make sure we're covering that.

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

I think with – yeah.

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

Yes, yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

We would accommodate a wide range of choices on the certification and standards and then in the policy we're just simply talking about is it present "yes" or "no" as a core that's what I'm hearing. Is that correct?

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

There are two things one is present or absent and the other is some kind of pointer to more information about this, it could –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

It could be the document, it could be a structured document, it could be instructions about where to find, but there is a way to go find out more about this person's AD if it exists. So Paul would it make sense to have the presence or absence be core for EHS because the performance on the objective is really high anyway, but also to have it be a menu option for them to, you know, for the pointer rather than having it be just certification only have it be a menu option.

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

Yes, so that's the question on the table. What's your opinion?

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

Well, that's my opinion, I think it should be.

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

Is that it should be, okay. Other people's opinion?

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

I would support it; this is Charlene, being a menu option too in this particular one.

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

Okay. Others?

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

I would also.

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

Okay, okay so we've made progress on the EH.

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

Wait, wait, wait then there's the third component of the standards to bring it, you know, to store it, if you want to that would be certification only though. So, I want to make sure we don't lose that.

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

Okay. Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Is it possible so then, if we're going to say the pointer is menu could we also put, if the capacity exists, to ingest it as a menu item.

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

I'm just nervous about pushing too much at one time that would be my opinion, concern.

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

So, the vendors will have to, in the case – I mean if they could view it, you know, as well as reconcile – , you know, bring it in – I mean, so to me like what we want to do is – if I think this through a little bit you've got the CDA which I think you're going to want to update which contain the presence or absence of this information and potentially a pointer if it exists, I would think that would emerge. So, then you've got to reconcile that and bring that in. So, you have it. So, why do we need another functionality to accomplish that?

I can view it and then good vendors will bring it in and do more with it – I mean, if you've got it, you've got the placeholders there for it, you're going to create the demand in the market why do we want it to be more than that?

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

Charlene, I'm not totally sure I'm tracking you or what you're saying. I think what we've heard is that the – I think so – when there's a – the reason I would not do – I would not be inclined to do a menu option as opposed to certification around the bringing in is because I think the market is all over the place and so sometimes you don't – you know, you want to just go to the registry and view it because you know that that's the latest copy and there's a link and it's easy to do and find and you don't need to bring it into the record.

But in the case that Michael is raising where all you have is a paper copy I don't see how, you know, I don't see how you're going to be able to really follow the patient's end of life wishes if you've got to go digging for paper that, you know, somebody could lose along the way and so having a way to store it if you need to but it's not a menu option makes sense.

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

This is Neil there's got to be a way to store it.

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

Yeah.

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

I mean, there's just got to be, right, we don't have charts on people anymore.

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

Right, exactly, so I would say that the standards – I think what we're hearing from Leslie is she believes there is and so if we put this in and get feedback from the Standards Committee and if they say "not doable" then I guess it's not doable, but I think we should put it in.

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

Yeah and this is Mike I just –

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

But to clarify then I think I'll claim confusion here then. So –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, guys if it's a Consolidated CDA that's already required in Meaningful Use 2. If it's using it for patient generated health data we're already working on that.

So, we're actually asking the vendors to simply accommodate another template using something they already do. So, it's – I think that it's something that we need to move on and not think we have to create something totally new to support this. We want to modify the existing standards.

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

Do the, this is Mike, do the standards then have to create the functionality that lets me reconcile what I've just absorbed from the registry and compare it with and reconcile it to the one I've already recorded carefully and in structured manner and if not –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The document itself, the Consolidated CDA accommodates provenance, time, date stamp and all of that. As we move forward on the more advanced kinds of reconciliation like in care planning from multiple sources we have that work to do. But right now you'd have much more than you would have in a paper record for instance.

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

I understand that but that's I think to Paul's point about the issue of for those people who are already doing what they feel is a pretty good job of capturing and being responsible for it they may actually find it more difficult to maintain things if they need to absorb things in but they don't have the EHR functionality that lets them to do the entire reconciliation.

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

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

Well, I think the reconciliation might be step two. I think it's, you know, I mean, I think that would be a big leap forward but I'm not sure we're totally there yet, but I think being – at least having the capability for human intervention and making it a little bit easier would be good.

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

Yeah, the problem is now I have two things in my chart or maybe more than two things and they don't agree and yet I don't have the tools I need to reconcile them. I've got to kind of print them look at them side-by-side and decide –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well, you'd be able to see the time, date stamp, you'd be able to see when they came in just like another Consolidated CDA you're getting from as an observation or a result from someplace else. It's the same if you – yeah –

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

I completely get that but just like a patient comes in with their most recent medication list I've still got to find out if it's still true.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, right.

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

And compare it to what I'm using; what might be driving my decision support.

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

So, I think, Christine is right that – I mean, it's a nice thing but it's – reconciliation is a process with tools that are – it's complicated, medication reconciliation has been very complicated for us. So, I don't think we're ready to go there yet, but that's what we will probably need to do. So, I'm just saying not to prescribe –

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

Paul, we have a three-part –

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

And the whole point behind my point is that if I were to imagine comments coming back on the Stage 3 proposed rule I could see that in the absence of allowing for functionality like that what we may be doing is setting up a situation where people now have two un-reconciled versions and time, date stamp may not be enough for them to feel good about the requirement.

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

Right, so, I mean, I think what I'm saying is supporting what you're saying which is I don't think we want to be requiring behaviors at this point.

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

Yeah.

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

Because we don't know how to deal – we don't have the tools to do a good job of it.

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

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

Agreed.

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

And it's just – so I think it's a future thing.

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

Agreed.

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

So let me try to summarize, remember where we are on the hospital. So, far with hospital we are at – for certification we're adding a field that is a pointer to more information about an individual's AD if it exists.

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

Wait, I thought we agreed that was menu.

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

No this is certification.

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

That was – or, right –

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

Certification.

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

No, I thought we went around the table and Neil and me and others said, had agreed that that would be a menu option.

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

Oh, no all I'm doing is, yes –

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

For a pointer.

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

Right now I'm just talking about certification, okay? So, there would be an added certification about having this additional field that points to more information about an AD. We would also ask for standards help in the – and I'm sorry, and in addition a certification about the ability to incorporate this information into the EHR if it's available. So, these right now are certification for the EHR.

In addition from the behavior point-of-view we said to move the EH menu to core and we said we would add an EH menu of populating this new link with the new field with the pointer that's where that comes in Christine.

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

Yes.

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

So, that's where we are with EHs. For EPs – let's turn the discussion to EPs, now remember by having the certification criteria as part of the hospital it already now exists for EPs and we had discussed making a menu measure for EPs that mimics the hospital, that is more than 50% of unique patients 65 and older have populated the field of present or absent AD.

And we have – now the question is do we add anything about populating the pointer field, remember that's a new field and we've made it menu for hospitals and we've already introduced menu of presence/absence of AD. Do we have a feeling about populating the pointer field?

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

Does it help people if they have – I'm just thinking about specialists who say that sometimes we don't have enough menu items for them, so for those who would choose the menu item of presence/absence I mean it would seem to me to, you know, have another option, you don't have to choose it but it's there and it's kind of complimentary to a workflow of asking the question that you have that.

Now, the one question I have is so is that how often the pointer field needs to be filled in might be an issue because it's a subset, right? So, it's of the yes's you have information in that field, some, you know, threshold percent of the time. Is that how we're envisioning that?

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

I didn't get that last – the question is if –

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

Like I'm just trying to think about how CMS would write the measure and measure it. So, if it was an menu item for EPs and then we – I mean so it was conceivably the same for hospitals, then you would only fill out the pointer field for people whose yes or no presence or absence is yes present right?

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

Correct that's correct.

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

And then you would fill that out some percent of the time.

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

Correct.

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

But, that, yeah, right, okay. So, the – okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Or it could be an automated function that says, you know, here's a pointer that is a query that can go out and look for something. So, we don't want to necessarily say it's a burden of filling something out, it could be –

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Automated.

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

Right, right, right, okay, so I think what I'm saying is so for specialists, you know, does it help to have this actually as a menu item because they have more things to choose from?

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

Well, of course it all depends on how many are required, but –

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

Right.

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

I think listening even to you posing your question I was thinking making the field available just gives the most freedom, if you're looking for flexibility and less prescriptive, less unanticipated or unintended side-effects then just making it available as some of us have indicated is enough to drive the market, because people will want to use it where they can.

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

Right.

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

But we don't have to prescribe it; try to measure it that's where all this burden has been coming from.

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

Okay.

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

So, I would – so my personal opinion would be let's keep the certification criteria to start this going but let's ease into the EPs with the menu requirement about presence/absence. How do people feel about that?

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

Mike, I agree.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's Leslie, I agree.

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

Yes.

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

Okay.

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

So, Paul, it's a menu item for 50% of – what exactly –

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

Okay, so the menu item on the EP side there will be a new menu item mimics the trajectory, the path that the hospital has been taking for the same measure more than 50% of unique patients 65 or older have the presence or absence field populated.

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

I agree with that. Thank you.

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

Okay.

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

I do want to talk about the age thing at the right moment Paul.

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

Okay, I think this is the right moment. What's your –

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

Well, I think we heard really clearly in the hearing that there are real downsides to limiting this to 65 and older and so, you know, since we're not pointing to specific thresholds anymore I wonder if we should, you know, take an approach that is on the spectrum more like what we did with patient reminders where we said it's a low threshold because the population is everybody and that gave people flexibility to choose patients who really needed the reminders where that was appropriate, but so to remove the age ban entirely or think about 18+ or something like that. But it would require a change in the threshold obviously.

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

Well, ONC and CMS will get the most flexibility if we don't – if we're just silent both about the age and the threshold although I guess we could say presumably a low threshold as to wide age or something like that.

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

Right that's what I mean.

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

But it would certainly give them the most flexibility.

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

Yeah, I would rather say low threshold wide age because that respects, you know, all the things that we heard in the hearing and it gives providers – I mean, remember that at least for the menu option or the presence/absence it's presence or absence so, you know, if – I mean, if you are just taking account the yes/no question you could do that on 100% of patients or 80% of patients it wouldn't, you know, having an age range doesn't make a lot of sense to me because if you ask a 19-year-old and they say no you get credit for the objective it doesn't matter, they don't have to have one.

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

I think the touchy point is whether people want to be asking their entire gamut of 19 year olds, you know, of –

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

They definitely don't I can tell you that.

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

Yeah, I would.

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

Yeah, guaranteed, right?

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

It's an impediment. So, you know, this is all a matter of watching out for the unintended effects and I think people do want to be – feel like they have to ask everybody, it's not appropriate, it interferes with the relationship, etcetera.

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

It doesn't keep people from doing it.

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

Right.

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

But you don't want it in the denominator.

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

Right.

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

I guess that's not at all what I heard at the hearing.

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

I would put it in a different way Christine, I think the hearing said, don't overlook people, don't exclude them versus we want to include everybody. Do you see what I'm saying? That's the way I heard it anyway.

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

Yeah, no, I mean, that's not the way I heard it. I heard people saying that it's – because – well, for two things, so because there is a need for people who are younger to at least know what an advance directive is, big barrier to filling out advance directives is people just not knowing and understanding the circumstances under which they are really appropriate.

The second thing that I heard was, you know, many people wanting to view advance directives as a component of a care plan which does apply to a broader range. So, I don't know precisely the right answer here, but it just seems to me the 65+ thing is a problem.

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

Rather than think of it as a problem I think it is the population where it's of most concern.

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

But why not 50, why not 45?

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

Because the likelihood of death, unexpected death is much lower.

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

Correct, yeah.

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

Of the need to have that crucial conversation and decision is less and 19 year olds often say they're going to live forever so if you're going to talk with them about anything let's talk about living wills for purposes of organ donation that's the one they'll resonate with, but they terminal CF patient who is 23 absolutely. The question is do we solve a problem by making the denominator much younger populations and applying it across the board.

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

No, I am saying, yeah, I'm saying to either consider removing it entirely and making it a very low threshold or saying maybe it's 50+. I mean, I'm going to pull up the slides right now because I can't control the webinar piece but that was really clear coming out of this hearing from several people.

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

Yeah, but I would just say, this is Mike again, I would just say that the incredible majority of my patients when they become – when they develop illnesses for which their risk of death goes up significantly or even risk factors that make it go up significantly that to me is the time when both of us agree it's a good time to talk about their advance directives or when they reach an age when anything could happen at any time and there won't be a time to discuss what to do if they become comatose etcetera, etcetera.

But for other folks it's "I don't really want to talk about it" and that's the commonest answer I get when I ask this question routinely is that I'm not ready to talk about it, I don't have one, but –

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

So, you just record a no.

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

I know but if I have to ask it every time I'm using that in my 15-20 minute office visit to compete against other important things.

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

Right.

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

Well, are you guys – have you constructed a workflow that enables you to only ask people 65+ then? I mean, the way I see it happening is –

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

Sure.

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

People are asking everybody anyway and then it, you know, right, and the hearing said, and here are the bullets from the slides, not just critically ill, not just those 65 and older. So –

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

Then we don't have a problem to solve.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's generally in the intake form in every hospital, this is Leslie. It's generally on the intake form on any hospital.

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Hospitalization that you're taking forward –

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

Right at the hospital we do that.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's for all ages.

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

So, but –

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

But not for the – you know, for EPs, we have a reminder that comes up that asks the doctor or their assistant to ask them, if they're over 65, it's very straightforward.

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

Right, so but what I'm suggesting and I'll just stop talking now because obviously I'm not making headway is, you know, at least thinking about coming down to 50+ so that you don't wait until I'm after 65 to have the conversation with me, I have an opportunity to do more thoughtful advance planning.

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

So, I think we've had quite a bit of discussion on this let's just go ahead and take an indication, a vote so we can make this recommendation. So, the recommendation I heard from Christine was to lower it from 65 down to, is it 55 or 50?

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

Fifty.

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

Fifty, okay so, those in favor of changing, making that modification?

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

Christine is.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Leslie.

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

And those opposed to that suggestion?

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

Neil.

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

David.

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

Mike.

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

Art.

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

Okay, I think we – let's go ahead and maintain the 65, remember these are just floors and it doesn't prevent anybody from doing anything. Our biggest point is to make it possible in the EHR to do something constructive with this.

Okay, so I think we've dealt with the – and it was a good discussion and that's why it's taken us so long from a year's point-of-view is because there are so many possibilities and we're trying to do the right thing without overshooting and balancing benefits and burden.

Okay, why don't we go and – we only have about 15 minutes left, let me start this discussion because it has been something that's been coming up every meeting and that has to do with deeming. So, if we can go to the next slide please, I think there's – next slide, and next slide.

So, I'm going to go through these quickly. We asked the – we asked both the Quality Measure Workgroup and a special group with combined quality measure and ACO to try to give it a population focus and said, what are some of the newer quality measures that would help us assess improving outcomes of individuals and populations that are HIT sensitive. Next slide, please.

One of the things they came back and said, as a recommendation, is we probably need to be thinking of a measure set and not individual measures, because it's pretty hard to capture it in one measure. Another concept is, as you talk about populations you're also talking about more the ACO kind of arrangements from the healthcare provider's space. So, that's probably more than an individual and is more in a group setting. Next slide, please.

So, there are kind of attributes they talked about one is we want it to be HIT sensitive that's an important part especially for deeming. We want it to be more patient focused and longitudinal. We want to include health risk assessment. Want to go across programs – we want it to be aligned with other particularly new payment model measures be applicable to populations, always look at the benefit outweighing the burden since CQMs has been one of the burdens and kinds of requirements in Meaningful Use and promote shared responsibility. Next slide, please.

So, they constructed a matrix and tried to test that with some exemplars and the one you're about to see has to do with frail elders. Next slide, please. So, there's two matrixes they've constructed one is with a population focus, re: ACOs and the other was with an EP focus. And if you look at the columns are the attributes and the rows are measures that together form this measure set about frail elders.

So, green is a good alignment and red is not a good alignment. Now one of the things that came out of the discussion is probably if it's going to be used in the deeming instead of balancing it across attributes one of the attributes that are probably going to have to be mandatory, but I don't know whether that means mandatory green, is column one where it's HIT sensitive. Because one of the discussion points and we've had this discussion as well, if it's something you can achieve without the benefit of hearty use of an EHR then it's not actually fitting the EHR Incentive Program. Next slide, please.

And here's the similar look with an EP focus. So, the good news is that there is a fair amount of green but it's still going to be somewhat of a challenge to look for things where you have a reasonably clear connection between what you're measuring and its HIT sensitivity. So, that's some of the discussion that was had at the Quality Measure, I mean at the HIT Policy Committee.

So, that comes back to challenge – you know, we should – you know, re-examine and reconfirm whether our idea about the deeming program is a healthy one and some of it I think is related to not understanding what are all the attributes of the deeming program. So what I tried to reinforce that one, this is absolutely optional, it doesn't replace the traditional Meaningful Use Program.

Second, it already means they've successfully, by Stage 3, for whatever stage they're in they've already successfully passed the prior stages. So, they've already used the functionality. We continue to see them both blow past the 90% threshold and maintain it from year to year. There are three years' worth of data now.

We are assuming that whatever their scoring well at is HIT sensitive to the best of our ability but that is a critical assumption for the deeming program and so that's sort of the answer and I think that addressed some of the questions that were raised. Would you say, for the people who are on the call, would you say that's true or do you think there are unanswered questions that undermine the rationale of the deeming program? What are your thoughts?

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

Well, it's Christine, I think you're right that there – you know, they didn't have the slides that said some functions won't be deemed and this is voluntary and all.

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

Right.

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

So, it was difficult I think to remember for –

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

Sure.

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

Particularly for folks who weren't part of this Workgroup. So, and I'm not ready to give up on the deeming concept until we see what, you know, the measure set or sets are that this group comes back with.

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

Okay.

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

It may not be a workable approach but I don't think we know completely yet.

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

Okay. Other comments?

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

You know, Paul, its Neil, after the meeting yesterday I was struggling with this deeming stuff all over again because the idea of deeming, if I remember correctly from the very first conversations, was sort of around simplification for people.

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

Yes.

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

That we would stop sort of requiring people to report on the sort of individual things that they're doing in favor of sort of moving people to sort of some greater functionalities that we think are EHR dependent. So, I'm totally with you on column one. I think if it's not green in column one it probably doesn't belong in this process of deeming, it might belong in good practice.

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

Right.

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

But it doesn't belong in the process of deeming. But on the other hand I'm trying to think that if what we're really saying is you have to do all the things we told you before in order to be able to do this stuff and people have already created the mechanisms to report on all the stuff that we asked them to do before.

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

Yeah, yeah.

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

Isn't it more – isn't it more confusing to sort of – this is an add on no matter how we slice it, because we're not really taking anything away, we're really just saying, don't tell us about this other stuff, you still have to do it all because we're creating a set of deeming criteria that really are going to make sure that you're still doing all of this other stuff, otherwise we're not going to deem you free of those particular obligations.

So, as long as they're doing it anyway and as long as they've been reporting on it anyway I'm kind of losing the Gestalt here. I think we're trying to move people forward to understand that integrating these functions gives you higher power to do things that are more globally important in healthcare, but I'm not sure that the concept of deeming is doing what we originally anticipated.

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

You know, Neil, I like your step back approach and as you talk it really is ringing true and the other piece is we've always said this is a handoff so in a sense someone else is going to reward people for high performance like –

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

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

The ACO kind of world, the whole pay for value. So, I think there's a lot of merit to what you say.

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

I mean, it just – sometimes you need a chart like this to –

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

Right.

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

And realize like so how did we get here.

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

Yeah, other comments? Art was that you that was –

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

No, no I didn't have a comment. I mean, I thought I agreed with the concept to deem and Neil is now making us question whether this is the right path forward. Do you actually, in Neil's comments, he said you still have to report everything and I thought the way that you had described it Paul is that you're actually reporting some different things and we're trying to move Meaningful Use in those that are more advanced to a different concept.

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

Right.

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

No I didn't say that you still have to report it, I said that you have to have had already developed a methodology to do this in Stage 1, right?

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

Right.

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

So, it's all there already, the processes, the reporting mechanisms and everything else. And so while we were thinking of this as a simplification function in fact no matter how you look at it it's something new that we're asking people to do above and beyond what they did before and they're still – and we're basically still getting – we're still requiring by the way we're setting up the deeming them to do all of the things that we did before even if they reported on them or not that's not really the issue, that's not really the burden –

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

I think –

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

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health
Because they're still doing it.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Paul, this is George, so there are two possible purposes for deeming one is if an organization gets to high quality we don't care if they do the objective because the real goal was high quality. The other is what Neil just said the presumption and that's really what we focused on the second one that they have to do the objectives to get to where we're picking indicators that make sure they do the objectives anyway, which is different from the first deeming which is an organization that has perfect care maybe we don't need to be doing Meaningful Use for them.

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

Right.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
If we're doing the second one, we tried it out and what's happening is I think what you're reacting – you're positive reaction to Neil's comment is that we keep going at it and trying to get it right and it feels like it's getting more and more complicated and therefore not simplifying but in fact just being a second program which is even more complex than the first.

So, certainly if we could look at our objectives or if CMS looks at our recommendations and says let's cut down the number of objectives to only the essential ones that are really used for outcomes and not even just deem for everybody regardless of performance everything else as the program focuses like that would be a better solution than having two very complex programs for people to figure out.

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

I really resonate with what you just said George and the other piece just to say what other people have reacted to this whole concept of deeming for high performance or improvement means you have to have benchmarks and you have to have a track record with the measure and we're almost relying on new measures – so there's a lot of complications that have come up. We gave it our best shot, but at any rate – somebody else wanted to say something?

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

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

Yeah, this is –

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

Just the framework they came up with how does that relate – and if we're going to drop it maybe that's not relevant, it was good, but how does that relate to like the 6 domains of quality? Was that thought through when they did the work?

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

No, they came up with this somewhat de novo.

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

Yeah, okay, it just felt like – so we need another framework, you know?

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

Yeah, I know, I know.

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

All right, okay, so, that's not relevant is what you're saying.

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

So, this is Mike, can I – it's going to sound awfully simplistic and it may – and it probably is, but let me just try to reflect what the discussion at the American College of Physicians Medical Informatics Committee was when we looked at this and made this suggestion and it really speaks to I think both Paul and George's comments, but the notion was that some of the burden of functional measures for Stage 3 was seen to be an ongoing escalation of doing more clicks and figuring out more things that are basically meeting the letter but not necessarily the spirit of the rule.

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

And if we could instead waive some number of them –

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

Yeah.

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

Especially those that are burdensome and instead be held accountable for nailing the quality measures that exist in Stage 3 and demonstrate that we're likely to do that because of how we did with the quality measures in Stage 2 that would give people the inspiration of improving quality, safety, efficiency, value, etcetera, etcetera and not focusing on how to hammer doctors and nurses into doing what they almost certainly had to do already which is use the system well to get to that point.

And I want to try to make sure if there is a way not to lose that possibility in a framework that, at least for me, I'm sure the devil is in the details, but that would be the simpler approach is to say, here are your quality measures you'd have to nail them but we're going to take away the concern about you actually reporting to us back on these "x" number of measures some of which are new, some of which would require changes in workflow and based on your performance with quality measures in Stage 2 you probably don't need to follow them to get to the goal that you have.

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

So, we're at the end of our time I want to have some time for public comment. But let me summarize what George and Mike just said to carry over to our next conversation that is regarding the original thoughts for deeming, the original motivations we might have – we tested it out for sure and we need to rethink that but an alternative to that has been just proposed is use the same approach to simplify but go back to the functions and the measure objectives and start reducing them to the ones that are more outcome sensitive and do a good job of getting better quality measures.

And actually the second part of the charge to the Quality Measure Workgroup was to do that latter, we put them on deeming first because that was a critical need for us, but the other thing is to get better – start getting better measures in the pipeline that are more meaningful to consumers, more meaningful to providers and achieve – helping us get better outcomes. So, let's put that on the table for raising that again in our next conversation, we'll add that to our agenda for the next call and see if we can't come to some conclusion about the deeming program itself. Can we open to public comment please?

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

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 one public comment. David, go ahead.

David Tao – Technical Advisor - ICSA Labs

Hi, this is David Tao from ICSA Labs, I appreciate the in depth discussion of advance directives and the desire to promote their access but I suggest that having a statement “if the capability exists” regarding accessing electronic directives maybe redundant and unnecessary for certification criteria if the source of an AD or a POLST can be a PHR like HealthVault or a web-based application like MyDirectives that anyone can sign up for then it seems like the capability of accessing the directives always exists regardless of whether people take advantage of it. Thank you for the opportunity to comment.

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

Thank you, any other public comments?

Ashley Griffin – Management Assistant – Altarum Institute

There are no further public comments.

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

Well, thank you everyone for a very hearty and robust discussion. These are important topics and I think we're getting to do some good recommendations. We're pressed for time so please try to do your best to join the subsequent calls we have before our December meeting and presentation and recommendations. So, thank you everyone and talk to you next time.

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

Thank you.

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

Take care.

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

Bye.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you.

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

Thanks, all.

Public Comment Received During the Meeting

1. As an EHR Developer, are we not adding more cycles, more cause for pause and criteria matching with the proposed approach for Improving Population Health. External Data to prompt end user? Does this not fly in the face of usability? Wouldn't it be better to have the state public health agencies be the ones prompting/searching/culling through data submitted for cases to report. Please consider this perspective. Thank you.