



HIT Policy Committee Consumer Workgroup Final Transcript April 30, 2015

Presentation

Operator

All lines are now bridged.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning everyone, this is Kimberly Wilson with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Consumer 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 will now take roll. Christine Bechtel?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Good morning.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Clarke Ross?

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

Good morning.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. Kim Schofield?

Kim J. Schofield – Advocacy Chair – Lupus Foundation of America

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. MaryAnne Sterling?

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

I'm here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. Luis Belen? Will Rice? Ivor Horn?

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

I'm here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. Philip Marshall? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. Nick Terry? Erin Mackay?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. Dana Alexander? Wally Patawaran? Amy Berman? Theresa Hancock? Teresa Zayas Caban?

Teresa Zayas Caban, MS, PhD – Chief of Health IT Research – Agency for Healthcare Research and Quality

Here, good morning.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. Danielle Tarino? Cynthia Baur?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

I'm here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. Bradford Hesse? And Wendy Nilsen? And from ONC do we have Chitra Mohla?

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning. And Dan Chaput?

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

I'm here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Anyone else from ONC on the line? And Christine, I'll turn it over to you. Thank you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great, well good morning everybody and again, apologies to our West Coast friends out there for the early morning nature of this call. So here we go, continuing our Stage 3 discussion. So what we are going to do today is try to get through mostly objective 6. We also have some slides on the certification criteria; those were sent out to you in a Word document actually; so, I'm not sure we're going to get to those today in terms of slides and discussion, so we want to just remind you all that if you've got comments on the certification criteria that you go ahead and submit those electronically.

So, what we really want to try to get through here is objective 6, so let's go to the next slide; keep going. Umm, keep going. Okay. So this is the kind of overall measure that constitutes objective 6, which is care coordination through patient engagement. So basically, under the proposed rule the provider would have to do two of these three things. So the first is essentially view, download, transmit, which we now know in Stage 2 as having a 5% threshold requirement although CMS did release a proposed rule to change that to just 1 patient; so we may want to consider that. But the Stage 2 threshold for view, download, transmit was 5%.

We agreed on our last call that that view, download or transmit could happen through both a portal and an API. So we are suggesting that providers essentially offer both options and that both...that downloads, views, transmittals, whatever through either mechanism would count automatically towards the threshold. Okay, so that's measure 1. Do people feel like, actually, let's go to the next slide, let's do this; I'm going to walk through each of the three measures and then we're going to come back. Next slide.

Okay, so this is essentially what I was just explaining that the numerator is this, you know, either/or option, so providers have more flexibility which we did talk briefly last time and we want to maybe come back to that about the idea that perhaps not all providers, since some of them don't have very much data about the patient or maybe don't really have any kind of a visit with the patient but they might be able to do just an API. But regardless, what we're going to talk about here is the threshold, so this is a 25% threshold. Next slide.

So let's keep going, we're going to have to come back to this; I'm just going to give you a quick overview of the measure. So the second option, again you've got to pick two out of three, is secure messaging. The threshold here is 35%; it says Stage 2 was 5%, but that was actually 5% of patients having to send a secure message. The change that's been proposed for secure messaging here is that it has nothing to do with patients actually sending a message, it has to...it is provider initiated.

So this is...it starts out sort of a little bit deceivingly, the number of patients in the denominator for whom a secure electronic message is sent. So there are some questions about what happens if...it's just provider to provider messaging but the patient gets copied, should that count; things like that. But in this case, the 35% is not patients sending a message; it is a message gets sent to patients. Next slide. Okay, and then next slide; we're going to...the poor slide people are going to hate me today.

All right, so then the third, so again, pick two of three, so here's the third option is patient-generated health data, and again, it's not exactly completely patient-generated health data. So this is basically either you have 15% of patients for whom they either, you have included patient-generated health data in your EHR or you've gotten information from them from what they call a non-clinical setting, which is absolutely a total misnomer, it's not non-clinical, it just means a not MU eligible provider. So, physical therapy, nutrition, those are clearly clinical settings; if you were to get...if the provider was to get patient data fro...not patient-generated, but just patient data from another setting like that, outside MU, then that would count also towards this threshold.

So what I wanted to do here is just give you quick overview, so now we're going to go...let's go back to slide 6...I'm sorry, 4; okay, great. So let's maybe...my suggestion would be, let's talk first about the structure; the whole idea of two out of three and then we'll take the measures from there. What do you guys think about this?

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

Christine, this is MaryAnne and I just want to make a general comment that, as you pointed out, when you start to pick these apart none of these sound like they're very collaborative between patients and providers or family caregivers and providers. And that to me raises a huge red flag right off the bat.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

Now mind you, I don't know what to do about it quite yet, gotta think through that, but...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

...it just raises all kinds of red flags for me.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah and I share those red flags. I agree, I have some other thoughts as well, but let's see what other folks have on their minds.

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

This is Clarke Ross. I agree, giving people the benefit of the doubt, if we engage patients, persons in a variety of ways as proposed, in theory we're setting the groundwork for better and more effective collaboration; but that's giving everybody the benefit. But it's important, for me, that these concepts that we're talking about are being talked about and ultimately included.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. I agree with Clarke, I think these are very important concepts. Perhaps what we need to do is if there are red flags, point out how these could be interpreted in a way that wouldn't be positive and articulate how these could be interpreted in a positive way so that there isn't room for moving to those red flags, because this is very much a great infrastructure to start setting.

Christine Bechtel, MA – President – Bechtel Health Advisor Group

Yeah, so I think part of what MaryAnne's reacting to and certainly what I'm reacting to is, you know, like for example in measure 2, which is secure messaging, you have a huge jump in threshold, 5-35% but, it actually has nothing to do with patients. And so I worry a little bit about this one because I think well, you have to send a message to 35% of your patients. Now we're assuming that the 12-month reporting period holds true, but it has historically almost always in every stage, in the first year then cut back to 90 days.

So if you had to send a message to a third of your patients in that 90-day period, I mean I worry about getting spammed and no...it doesn't really have anything to do with what Stage 2 is, which is about patient initiated messages, so you really know that they're online and engaged as opposed to just there's a message that is sitting in my inbox somewhere. So, we've seen some gaming of the system here so I think that part of that change in measure 2 is, I think, less collaborative. And the other component of it is, I think if you step back and you think about what two are the easiest of these three, on...you know that two of them can really be pretty much, I think, 100% controlled by the provider and one of them can't. So it's not probably hard to figure out what's going to happen when you give that kind of flexibility. Do folks have other thoughts?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I...maybe I'm Pollyanna...this is Leslie, but I think it would be harder for them to distinguish who they were leaving in the inbox and who they weren't and which...what we're sending back and what they're sending. I think it's going to be harder to game than to just do it well.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Oh no, no, Leslie, all I'm saying is because you just have to send one message, that you can just send your one message to your patients and you're done; you don't have to have them respond, you don't have to look at whether they've read it, you just have to send them a patien...a message.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I gotcha.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

So Christine...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And so I just don't know how meaningful that is all I'm...that's what I question is like, is it really worth the work? Is that Erin trying to speak up?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Yeah, thank you, it is Erin. I mean I was going to say that I know, who is this, CMS is requesting comment on how to define, you know, I think they acknowledge that that could be an issue that patient's, you know, just cc'ing patients or just sending messages to patients might not be getting us to the meaningful engagement we want, but they do specifically ask a question about how to define or determine meaningful patient engagement if they're just being cc'd on the emails. And I don't have any brilliant ideas about how to do that, but I think at least it's a positive step that they seem to understand...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yup.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

...the potential impact of their change.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

Hi, this is Ivor and I...on the call last time we talked about the sort of pushback that we're getting from providers and, you know, like the other caller, I'm being sort of Pollyannaish, I at least see this as a step in the right direction of moving providers to the place where they're at least prepared for those who may be a little bit further behind, at least moving in the direction of where they're creating the process so that they can communicate back and forth with patients as opposed to not doing anything. So, I do...I hear how problematic it is and I agree, but I'm at least being positive in saying at least it's a step in the right direction.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So Ivor, the only clarification I would make is that this is Stage 3 not Stage 2, because Stage 2 already has a lot of requirements around it that are more engagement collaboration oriented. So, right, because the patient has to send a secure message; so that means you actually have to work with and understand how do you use the system? Why would you want to do that? Things like that; so, I think that no...you know, recognizing that this is supposed to be a building block; Stage 2 is a building block, so I think they kind of got off on that and we're started on the right path component.

I think the...if CMS is going to keep this optionality, they're making one of these completely optional, so they're basically making one of these three measures a menu item that you can ignore. So what I'd like to suggest and see how people think about this is we could take a couple of approaches. One is to say, all three of these are so essential, there should not be optionality, you should have to do all of them; but, we might...if you have to do all of them, then you might, for example say, okay, it's fine if secure messaging is just sort of there, right? But, you know, you really do want people to also have to engage their patients in the view, download, transmit or use of an API. But I would suggest that 25% as a threshold is probably too high, I think it's going to scare people since they're kind of freaking out about 5% as it is, although they're performing decently.

So one option, so I'm just throwing this out as...one option would be to say, nope, you've got to do all three. The other option would be to suggest that you can do two out of the three, but we make the...we make sure...we suggest ways that each of the three is...are far more meaningful and also appealing, right? You have to think from a policy perspective, which is the hardest one and the one people are the most worried about will be the one that is least selected, which right now in my opinion is definitely measure 1 VDT. So we could say, okay, two out of three is alright, but we're going to make...we're going to suggest some ways that these are actually achievable and yet more collaborative and meaningful. So those are two pathways that I'll throw out there for folks to react to.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Christine, so you're suggesting that it's the patient-generated is the toughest one, correct?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No, I think...I'm not sure about that. I'm concerned more about the first one which is VDT because the threshold, as you know, is 5% right now and people are really worried about it, CMS has proposed a dramatic change, people are up in arms, there's like a whole consumer...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...movement around it; they're furious. But on the other hand, the providers are like, look, it's not easy for me to convince 5% of my patients to get online. And I'll say that I think that's a particular problem because the reporting period in Stage 2 got changed to 90 days, right? So that makes...you don't have 12 months, you have 90 day...so, it's a little bit harder. But, I think that's the one that people are the most vocally complaining about, along with secure messaging. So they've clearly changed secure messaging in a way that would definitely work for providers, not commenting on whether it works for patients; but going from 5 to...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The patient-generated health data is brand new.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

It's brand new, but also...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...going from 5% to 25% VDT when people are really worried about 5% today, I'm really worried that they're going to be like, well that's impossible so we're not going to do that, we're just going to do patient-generated health data, but it's actually because we can do either patient generated data or we can just get data from...about the patient from another system. So, not to say that either one of them is easy by any stretch, so, you know, that's for sure. Does that make sense, more sense, Leslie?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah it does. I think that technically the patient-generated health data is going to get more pushback from the vendors, but because they've already had to deliver the solutions in option 1 and number 2, we won't get as much pushback there. The hospitals I've talked to that are meeting the threshold and way beyond the thresholds on 1 and 2 are doing it as part of their pre-admission process at the hospitals, getting people ready and onboard. So...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...I think that your points are right on, I'm just not sure I have a good suggestion, so I'll defer to the group.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. Well why don't we do this, let's come back to the structural question here as two out of three, because I think folks are struggling with it. So let's maybe take measure by measure so we get a deeper understanding of what each means, does that...and if anybody wants to continue to comment on the structure of the two out of three or three out of three, then speak up and if not, we'll come back to it. So any last comments on that before we keep going?

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

Christine, this is MaryAnne.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

I'll jump in into the fray and say, as far as I'm concerned, it's three out of three because I think we have to push the envelope that way. Now I'm not sold perhaps as others are, on the exact thresholds, the exact percentages of patients. I'm not sure about that yet, but I...for me, it's a three for three.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

This is Clarke Ross; I agree with MaryAnne. I don't appreciate or understand the meaning of certain thresholds; they're symbolic in some ways. But, the three messages, the three components and of course one of those are much higher in my area, in disability, I don't want one sacrificed for the other two so I like the message. The beginning message, these are three initiatives, they're all very important, they would improve health, wellness and person engagement.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great, thanks Clarke. Any other comments? Okay, so let's go to the next slide, or actually, we'll probably go onto two slides; yep, one more. Okay, so just to, I think everybody understands this but just to make sure, so this is option 1 of 3, view, download, transmit, which could also be done through an API. And it is essentially the same as what is in Stage 2, but it's going from 5% of patients have to actually go online and either view, download or send their health information somewhere else, one time during the reporting period, which in the proposed rule is 12 months.

So that is going to...and under our...per our last discussion, if our recommendations were accepted, then the providers would be essentially both offering a portal and an AP...using an API in their EHR so that if I had an application, I could download through that application using the ONC certified API that is part of the EHR. So the big change here is really going from 5% to 25%. The rule talks about the fact that today I think...let me just pull up the data.

So, in provider attestation they have reason to essentially believe that that number is potentially achievable. What we know from...so, I think the latest data tells us that for hospitals attesting to Stage 2, they've been able to achieve 18% and I'll pull up the EP in a second here. So there's some reason to believe that they think that's achievable, although I definitely think it's a major kind of stretch for them, so I wanted to flag that for folks. My own thought, and I think this is going to become somewhat controversial for folks is to say the 25% is actually a little bit high, I think it's going to cause a lot of provider pushback because they're already pushing back, not all of them, but several are pushing back already on the 5%.

So maybe we take something that we really know is achievable that's 10 or 15% although I'm not sure a 5% increase in a threshold really matters, right, I mean like somebody could argue that in fact 5% is no different than 10 or 15%; and I think we've seen that before in our Meaningful Use experience, but I do think that there is some...there's just a real flashpoint around that 25% that we will see if we're...if it goes through. Oh by the way, I think the third quarter data that I'm looking at for EPs is actually 48%; so, EPs have been far more successful, even though they're saying I can't get to the 5% threshold, they're actually averaging 48%, I think or...I may...we have to double check that, but.

So, I know I just talked a lot, what do folks think about my comments and the threshold is at potential flashpoint?

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Hey Christine, it's Phil. Good morning.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Hi.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

I'm wondering, is the 25% an adjusted percentage. The Meaningful Use Stage 2 percentage was ratcheted down, but I think it was after the Meaningful Use Stage 3 proposal came out. Is the 25% sort of adjusted downward as well or was it left the same? I can't recall.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Umm, I'm not sure which point in time you're talking about. So do you mea...so the Stage 2 original Policy Committee proposal was 10%. In the final NPRM, which is currently governing today, it's 5%. Then a couple of weeks ago, CMS proposed, but it is not final, that that 5% become one patient, which I think...

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...in my humble opinion is totally meaningless. So...but that's not final. So it is a little bit of a disconnect that on one hand CMS is saying, oh we just need one patient to do it and on the other hand, they're saying 25%. Does that answer your question?

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yeah basically all they're saying is...yeah, basically all they're saying now is, you just need to make it available, right?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

There's no cause to verify that a certain percentage used it, which does make some sense because it's hard to bring...it's easier bringing a horse to water than make him drink, right? But I was just wondering if there's been any adjustment to the Stage 3 proposal...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

...as a result of that action? It doesn't sound like it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No. Um umm.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Okay, that was my question. Thanks.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Gotcha.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Christine, this is Cyn...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Christine, this is Erin...oh, go ahead.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Oh, sorry. This is Cynthia. I guess as I think about all the comments, I'm wondering, what do we think has changed among the eligible providers, in terms of their ability to engage patients, right? So whether it's one patient, 5%, 25%, you know, moving from any...along that continuum, whatever the numbers are, it implies that something...the providers are doing something different at each of those points so that they can get to those higher numbers.

And so I guess to this point about kind of commenting about kind of the...both these being kind of foundational elements, but sort of the structural conditions, is it also making some comment about what providers might have to do differently so that they can get to whatever the higher numbers are? Does that make sense? Because I think that what I'm...from what I know of the literature and what I'm hearing in the comments, there's some fairly sizeable gap between what providers have been doing and what they need to do to get to a higher number, whatever the actual number is.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

You mean the number in terms of achieving the threshold?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Right. So I'm saying, whether it is 5% of patients, 10% of patients, 25% of patients, 80% of patients; it...what I'm hearing and what I know from what's been published on, you know, studies of getting people enrolled in portals, getting them to use them in a continuous way, getting them to use a variety of functions there's a lot that has to be done from a kind of communication, marketing, engagement, outreach strategy side. And I'm saying that seems to me kind of a fairly sizeable gap that needs to be commented on if...regardless of what the actual numbers are, you know.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Gotcha.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

So I think the numbers are important, but I think it's like what are we expecting providers to do differently to get from 5-10 or 10-15 or 15-25 or 25-80? Does that make sense?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Gotcha. Yeah, um hmm.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Because I think that's what I'm hearing is like, we probably have to provide some direction on what providers need to do differently so that the outreach and engagement actually happens, regardless of what the specific numbers are.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, I mean, I totally agree with that and I think it makes me a little bit sad that the REC Program has been winding down and/or isn't available to everybody. But I think a comment about some technical help from ONC and CMS is a good idea because we've seen many providers do this very successfully, mostly because it's not just education and outreach. But if they actually think about their workflow and how they can create efficiencies in their own practice or at their...at the hospital level and they will think about the workflow of patients and families and what's the right time and right purpose, what are the right purposes an IGE...e.g. functionalities that they will use and then they, you know, the 5% is like ridiculously low because they can really exceed that.

So I think it's a really good comment to say, regardless of what the number ends up being, help them succeed by understanding these key factors. Did I get that right?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Yeah, that makes total sense because if you've seen organizations go far beyond these very minimal thresholds; that seems to me very valuable to help those that seem to think 5% is even too high.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah. Right, exactly.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. So maybe what we can do is ask in our comments that also best practices are identified or some formal process to identify best practices in the field and communicate that more broadly.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes, exactly, yup. Erin, you were...you had some thoughts?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

No, I don't. I mean, I will...I take it back.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. All right. Okay, so any last comments on this before we keep going through the three measures? Okay, next slide. Okay, so this actually is related to measure 1, and I think we do have our good friend Dan on the phone for a little bit in case we need him, although he can't be on for the whole call. So the interesting piece here is that there is a question in the rule, the proposed rule about APIs an...you know, what are the challenges and solutions? There are a couple of particular questions that I think to me don't make a ton of sense.

So, they all surround how you measure the actual downloads or transmissions. So they've got some comments on alternative proposals, pros and cons of measuring the minimum number of patients who have to access to...and I think the way the rule reads, it misunderstands what an API is and that the API is actually part of the electronic health record and therefore it can measure both...it can create both an access log, right, because that's what the EHR can do, so how many times information has been accessed and successfully transmitted to a third party application.

So I think we kind of want to, in this case just say, look API is part of EHR already and clarify that this is a very doable thing to have the number of essentially downloads and transmissions, or at least the download component would be automatically measured through the electronic health record and not through the, so let's say a third-party App that sits on my phone. So I think we're just going to clarify that here, unless folks have any comments or questions on that. Okay, great. Next slide.

Okay, so this is secure messaging. So again, this is...the change from Stage 2 here. So basically if you sent a secure message, it doesn't, you know, actually it doesn't appear that you have to really guarantee it was received. But if you send a secure message to the patient or the patient's authorized representative, it counts. Or, if you respond to a patient message, it counts. Let's go to the next slide.

Okay. So what they've got here for questions is should it count towards the 35% measure if the provider sends an email to another provider or care team members and the patient is an active participant in the conversation? Now I'm not sure and I don't know if anybody knows if it's, you know, is it just a CC or do I actually have to weigh in to be considered an active participant? But, there are two things we're really commenting on here; first is this real change of what is in the numerator between Stage 2 and 3, which is it's not patients that actually have to do anything here, it's now just providers, that's the first thing; so any comments on that?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

So, this is Erin. I mean, this is a real head scratcher to me because when we hear pushback from the provider associations about these patient and family engagement measures, I've sort of been more understanding of their difficulty achieving the secure messaging threshold, particularly hospitals. Leslie, your comment about how hospitals are sort of using it as part of their pre-admission or intake process is genius, I hadn't thought about that. But I understand that if you are admitted to the ER, there might not be a reason for you to need to email that ER doc or whatever it is. And I also understand that we've done research that says that what consumers want in healthcare is they want their doctors to talk to each other. And so, either being included or maybe not being included just talking to each other, so the part about if a provider is sending an email to another provider, as long as the patient is part of the communication, that has...that rings true to me as something that I think patients would want.

I really am confused about this change in terms of the provider initiated messages because I...as everybody has said; I worry that that is sort of tamping down the intent of the measure. So I'm wondering if it would be possible to request something like, you know, you had to submit data not only on provider initiated messages, but also the...how many of those messages were responding to patients? Just to b...and maybe this won't work because I know in Stage 1 many people just attested that zero patients had asked for their data and so maybe people would do the same thing.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

But, it would be interesting to know, you know, is are you achieving this measure because you are just blasting out reminders for flu shots based on whatever health records or how many of those messages or are you responding to pa...because they wouldn't have to respond to any patient message to meet this measure. So is there a way we could sort of bifurcate the data that has to be attested or contributed?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, let me...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Does that make sense?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

(Indiscernible)

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I think that's a...yeah, it does. Sorry, who's trying to speak?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I just wanted to comment that even if the patient...if the doctor receives an email from the patient that's material to care, they are obligated to accept and record that in the chart under just medical law. So there is some protection there. I also agree with Erin on the CC thing, I think that even though it could be passive, it's still knowing that they're talking about you and having the ability to know that things are being coordinated where right now it's just a black hole.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Um hmm.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And at least you'd be able to respond and say, hey, yeah I see you sent that to my dermatologist, but it was really about the pathologist that we need to talk about. There's just a new opportunity for dialogue having that information. So I want to make sure we do support that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Umm, I have a fairly basic question and I'm not able to pull up my answer right now but, my question is, did secure...I should know this and I just can't remember, does secure messaging apply to the hospital setting or was it physician only? I know VDT did.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's both.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Yeah, I think it was both.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...both because you're to sign them up to the portal, show them how to do an email, show them how to view, download, transmit, respond to an email.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well none of that was technically in, you may have had to do that to hit your 5% threshold, but I'm just looking at the strict requirement for Stage 2.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Maybe...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

We'll double check that. But anyway, okay, so other thoughts on this? And I just, here's the...I'll throw something fairly radical out here on secure messaging. Since Stage...if Stage 2 maintains its structure, which I...if it does and I personally hope it does, that they...that the patient sends a secure message, then by Stage 3, what is the point if we've shown for two years or three years, however long Stage 2 ends up being, that you've actually done patient engagement and secure messaging, then if it's useful to the practice, wouldn't they just keep using it?

I mean, why do we have to measure 35% that they're sending it, particularly if you just had...so one alternative might be, only do measures 1 and 3, which actually takes secure messaging out of Stage 3 because if your patients are online, whether it's 5% or 25%, if your patients are online with you through a portal or using an API, and they've done that now with you and used secure messaging for a couple of preceding years, then is there really a policy requirement that is a useful one, that drives the practice or the hospital to have to send something which may or may not be meaningful to them. Or should we assume that by now they've got some experience and they'll keep using it if they've found ways to make it useful to themselves or to patients. I'm not saying...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

This is Erin...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...it's the right answer, but...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Well what about those people who don't think it's useful, then we're just letting them off the hook. And my other concern is, I mean, what if the po...maybe the policy incentive is to get doctors who work in unaffiliated practices to talk to each other?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree that talking to each other is a big deal.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. Right, so that I think you're right on that, but this also feels like this is almost less about patient engagement and more about care coordination that's provider-to-provider. I can do...I could...I'm happy to be wrong on that, but that's a little bit more what it feels like because people who don't find it useful already, then they're going to find a useless way to use it with patients, they are just going to blast out one, you know, global reminder a year on a healthcare issue and that's going to be it and they'll meet their measure as it's constructed. So I'm just trying to think of how do you make this actually meaningful and I think it's a great idea to focus on other care team members.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yeah Christine, it's Phil. I agree with your point and I think it's actually an unnecessary flashpoint for providers and so, I agree with the point that you were making.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Christine, this is Cynthia. I mean it seems to me what you're asking or potentially suggesting should be documented by this stage of development is the conversation as opposed to a message, right? Because it seems like the sending of a message has been surpassed potentially in these other stages and by Stage 3, it seems like people are suggesting there should be some way to document an actual conversation about something.

Theresa Hancock – Director, Veterans/Consumer Health Informatics – Department of Veterans Affairs

So this is Theresa from the VA. One of the things we're looking at based on some experience within the VA using secure messaging going back and forth, we started out with unique patient's sending messages to the provider and the provider sending messages to the patient and now we're looking at well, what next? And so we're going to start to look at use of, what you mentioned earlier. Does it decrease virtual care...oh, I'm sorry, does it increase virtual care rather than face-to-face office visits because of this messaging and data being sent back and forth? And so our measure that we're going to be looking at going forward is the use of the data or use of the message.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And you mi...you're...I like this idea, it's very interesting. So you might measure use of the message, and the VA can do that in terms of like did it increase virtual care; joe provider probably can't do that because they're not set up for that, but are there other kind of outcomes of secure messaging that we should be thinking about here? I think it's a good idea.

Theresa Hancock – Director, Veterans/Consumer Health Informatics – Department of Veterans Affairs

Well, so the other way we're looking at it with VDT is, what problem are we trying to solve? The problem from internal to ex...non-VA providers is ensuring that consults and referrals are received and the information is sent and closing that loop. And so you may take individual projects or individual initiatives or a problem that you're having and try to solve it with this, and that's use of; so that's another way we're looking at it as well.

Christine Bechtel, President – Bechtel MA –Health Advisory Group

Gotcha. By the way, just to clarify, secure messaging is not a hospital requirement in Stage 2, so it would be EP only; I'm looking at the tip sheet right now and I don't see it, which makes sense, right? Securely messaging my hospital; so, we should probably double check that that is still true here in Stage 3. Other thoughts on this? Yeah, this is only EPs, so, okay.

So actually, I don't know if that's a new addition here or not on the denominator, because I'm looking at this...the...it does say...so I guess, does that make sense for folks to...if we go back a slide, yeah. So this does talk about EH, and I want to make sure that's actually true and not a copy and paste holdover, because I don't see that in Stage 2. Okay. Sorry guys, there's a little confusion on this one, but maybe Chitra can help us here.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

It's definitely required secure messaging is definitely for both professionals and hospitals, proposed for Stage 3. But I think it may have been menu for hospitals in Stage 2.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. I think I only looked at core, so that may be; that's helpful. I don't even see it as a menu.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Well then why is everybody...why is there so much pushback?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well I think it's on VDT, I mean, unless I'm missing it. So maybe Chitra can help us clarify that because I'm only seeing VDT on the Stage 2 tip sheet for eligible hospitals, so I'm not...so it's sort of a) a surprise to me to...because I didn't think it was eligible hospitals but, umm, so we need to clarify this for sure. Does it make sense, you guys, to do secure messaging from hospitals? I'm not sure it does, if we didn't do it in Stage 2. Thoughts?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well this is Leslie, secure messaging can help with discharge planning, can help with transitions of care and I think we should keep it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

As opposed to ju...I mean remember too that it's not...it's...hospitals also have view, download, transmit requirements for sure. So they may use secure messaging already if it's helpful to them, but I don't know that that's, you know, is it essential to require that?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well it can certainly help to prevent readmissions and the patients reporting their current status, whether they've been able to get to their appointment, whether they've been able to follow instructions given to them by the nurse and the social worker.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yup. I guess the question that the Policy Committee will ask is yes, if the market will drive its use, then do we really need a policy lever? That's the fundamental question the committee will always ask us, and I'm not sure I know...I have the answer to that, but I do...I want to make sure we re-discuss it. Okay.

So there's not really a clear consensus here that I'm sensing that's emerging, so it does sound like you guys are okay or, I'm not sure. I mean some folks seem to be comfortable with the shift in you just have to send; I'm not sure I am, but I want to just kind of get a pulse check on folks who are okay with the fact that this is really about providers sending and even provider-to-provider. We started to kind of come to a place where we're thinking is it meaningful for this to mostly be provider-to-patient send or should we suggest that in fact we have enough experience in Stage 2 that that will continue if both parties, both patients and providers are finding it useful. But what this should really be focused on is care coordination and messaging doc-to-doc with patients included on that, where possible. What do you guys think of that?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Christine is there also not a third option though in terms of the kind of extended exchange between the provider and the patient, right? So if Stage 2 was about kind of initiating that behavior, then you could think about Stage 3 trying to create it as a repetitive or routine behavior.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Um hmm. Right, but that would mean going...that would mean, I think, flipping it back to the way the numerator was counted in Stage 2, which was the number of patients who actually sent a message as opposed to the number of providers...or the number of messages that were sent by providers. Is that what you're suggesting? Was that Cynthia?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Well, I'm suggesting potentially something that might be a little bit more umm, I guess challenging based on the conversation we've had so far is that thinking about a way to potentially measure that exchange between the provider and the patient, right? So if part of the challenge with the way it's phrased now is that it's much more provider-centered than patient-centered or even on that relationship. I'm suggesting that there's something that has an even...that's emerged in this conversation we've had, but isn't reflected yet in Stage 2 or in the proposed Stage 3 which is, trying to measure what that exchange would look like or even as Theresa was saying, something about what happens as a result of that exchange, right, the outcome of that, the impact of that exchange.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right. I would love to do that...

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

(Indiscernible)

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...any ideas on how?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Well, yeah, I would sort of defer to people who are more kind of on the ground in terms of the pragmatics of that, like what...how that might actually work. But I think if...I'm coming back to some of the comments you've made so far is that if we're really trying to move people down a pathway, it seems like the two options of just continuing to document that patients are sending messages or focusing just on providers sending messages is not really, you know...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

...making progress.

Theresa Hancock – Director, Veterans/Consumer Health Informatics – Department of Veterans Affairs

Right, and from the VA perspective, we had to first do a couple of things to get to this point. One is, we had to get leader...executive leadership buy in and put directives out, because obviously in the beginning providers thought it was extra work. And so we had to get them to put directives out to say, this is expected from the organization.

Then two, we had to actually focus on numbers and getting the PACT teams and the patient to be able to communicate to get the unique registrants up, the numbers up just in sending a message back and forth. And then as I said, the third stage or the third thing we're concentrating on, and we haven't figured it out yet, we're going to just start meetings to talk about use of, and I'm sure we'll be able to contribute once we have those meetings, to say what does that mean? How can you measure that and what are some examples? So we'll be sharing that with you as we learn ourselves from those on the ground.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

That's really helpful because I think kind of what you've outlined is the...is what was intended to be the outcome of Stage 2 which is, there's a directive out there which is the Stage 2 requirement, that says you've got to get 5% of your patients to send a message and providers definitely don't like it because they think it's extra work, or not all providers but some providers, and so how do you focus on getting the numbers? That's kind of where Stage 2 folks are at right now. So I do think it's going to be important to maintain the Stage 2 requirement, and I'd like to check with you guys if you agree on that. And just based on what you're saying Theresa, that's really good practical lessons there.

And then the third piece is where you guys are trying to figure it out, and it's the same thing that we're trying to figure out is what makes sense for Stage 3? And you're trying to figure out, okay now we're getting some secure messaging out, how do we measure the impact of it? Is that...did I get that right, Theresa? Okay, so, all right. So I think what I'll suggest at this point is Chitra and I can put together some options based on the discussion and since there isn't quite a clear consensus or clear idea that everybody is coalescing around, we'll create some options and send those out and then folks are welcome to come back with a new thought that they have or whatever, but we'll try to come back to this component on our next call. Anybody have any other comments on the secure messaging component here?

Okay, so next slide. We talked about...let's see, oh, okay; I understand. Um, okay, so we'll...I'll...this is looking at the slide on the screen; I'll include some of these in the options that Chitra and I develop for you to think about. Next slide. All right, so patient-generated health data; let's talk about what this is. So this is again would apply to both hospitals and EPs. This would be the number of patients where you're getting data from another "non-clinical setting" or you're...here in fact, let's go to the next slide, that'll help us a lot.

Thanks. Okay, so information...so patient-generated health data would be either or both; number 1, info received from what they're calling a non-clinical setting which again is that non-MU eligible provider, so...who doesn't have access to your same EHR system. So the example they give in the rule is like nutritionists, physical therapists, psychologists, home health providers.

So if the provider gets information from the home health agency, for example, then that in fact, because home health agencies are not Meaningful Use eligible, that would count towards this patient-generated health data measure. And then second of all, information received from the patient; so it could be "also" or could be an "or." So examples here that they give are recording vital signs, activity and exercise, medication intake, nutrition, advance directives, device data, things like that. Those would all count here.

So I do...I will make one observation and then I'm going to open up for folks reactions. I do think that part of what we're struggling with is that they've sandwiched together patient and family engagement and care coordination, right? So the left half of this slide is care coordination; the right half is patient and family engagement. On secure messaging, sending to another provider is care coordination; sending a secure message to patients is more patient engagement. So I think that's part of what we're struggling with and part of what's conflating our issues here. So I'll make that observation but let you guys respond here to thoughts on this measure; so the measure is 15%.

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

I...this is Clarke Ross; three obser...four observations. This is very important for this to be recognized as a Meaningful Use item. Two, at least 3 committees of the National Quality Forum are working on measures for both of these elements. Three, the next generation ACO RFP recognizes both of these, a group of us are working on strengthening what it really means.

And four, I sort of agree with you Christine on mixing apples and oranges, but for people with severe disabilities whose daily lives depend on non-clinical, community-based organizations, those organizations and their family members working through those organizations are a conduit to express the individual person's information. So the line gets a little gray when we're talking about people with severe disabilities who depend on community-based organizations every day.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Yeah, this is Erin. I think, building on Clarke's point, I mean Christine, I totally agree, there seems...that this conflation is really making it difficult for me to think through what our recommendations can be because I think both of these things are really important. We want providers to be meaningfully engaging patients and families, but consumers and patients and families also want doctors to be talking to each other and coordinating their care and looping patients in as appropriate.

So what if we did something totally radical and blew up these measures and we made a measure that was more about care coordination that included both PGHD from non-clinical settings and doctors emailing each other? And then we had a pure patient and family engagement measure that was about secure messages from patients and PGHD from patients.

I'm sure CMS is going to hate that suggestion but it's the only way that I can, in my own mind, untangle these things because I just...I want to be helpful and provide constructive recommendations, but I'm totally at a loss for how to move forward on the trajectory of Meaningful Use but not be losing things that are really important to patients and families and quite frankly, aren't yet embedded enough in our culture. I don't think secure messaging is yet embedded enough in our culture; I worry about saying it shouldn't be a requirement. But I also...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

...worry about...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...and I worry too about it's somewhat...I like the conflation of it because it's harder to pick apart and say no to one or the other.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So my concern is that we would lose one of these by splitting them out and I think the community-based information is hugely important, not just for care...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, let me...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...coordination but for...actually to engage in my health, to be able to lead it and drive it and help in coordination.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I guess what...I think what Erin is saying though, Leslie is a little bit different than what you're thinking which is, it's...so think about, I'm going to do this off the top of my head, think about not having optionality, okay? So this objective is both patient and family engagement and care coordination; but there are, instead of this slide, wait hold on a minute, objective 6.

So back on slide 4; instead of these 3 separate measures, we're actually going to take these 3 measures and put apples with apples. And then you can either give optionality or not, but you have to do both the apple and the orange, right? So I think it's worth an exercise and thinking through. Could you, for example, say all right, your patient and family engagement measure is the view, download, transmit or API regard...forget the threshold for now. So it's really kind of that measure 1 plus; we maintain secure messaging from Stage 2 in that construct. And you can do that or you can do PGHD.

Then the second component is, and by PGHD, I mean the right half of that slide that actually is patient generated. And then you also need...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Which you could get by a secure message, sorry to interrupt.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...to do. Wh...I know, that is a little bit confusing. So you could do...I guess you could get kind of a twofer there, right? So...and then we have a separate piece that says you also need to do these care coordination components. Does that make sense? So that you're not...you don't...I agree with you, you don't want to lose either, but I think having providers not, you know, being clear about what we're really trying to achieve; is it care coordination or is it engagement?

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yeah Christine, it's Phil...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And really trying to do both.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yeah, I like the direction that you're going because I think that when providers try to embrace patient-generated health data, they need to do so in a deliberate way and they need to have clear...a clear threshold to hit on Meaningful Use. And this muddies the waters, this particular measure as written.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Um hmm.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

So I like breaking out the care coordination bit, I like focusing on patient-generated health data and so I totally agree with what you've said. And I'm not sure it's true actually, that you can get a twofer with secure messaging. I'm going to guess that the way the specifics are written on how one achieves the PGHD measure, that simply getting it in information by email is not going to be adequate, that the data has to come in and be stored in a different way than in the secure message.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

We can take a look at that. We can certainly take a look at that.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

And this is Erin, I'll just ask, is there value to making a recommendation that would allow for that flexibility?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

I think that might make it more palatable to some providers; the flexibility being that, you know, you could get a twofer. I don't know how others feel about that.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree and you don't want to end up saying, we're not going to take something because it's being transported via an email. So an email can include patient-generated data, both as a payload or inside the email. We want it accepted into the record, that's the issue not how it gets there.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yup.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Well I don't think that...I don't think you can have it inside the email to qualify and I think you've got to have discrete data that's stored as a part of the record that was patient generated and so I would think at the very least it would have to be payload or sorry, an attachment.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It depends on if I have a direct connected portal that's doing secure messaging it's already integrated into the record when I come back. If I'm sending like a Direct message or an individual secure message, then it's the payload that gets attached that gets included in the record. But the issue is that it's included in the record.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So Phil, I think what we're saying though is, so when Leslie and I were on the original, it might have been called a Tiger Team, the subgroup for patient and family engagement for Meaningful Use Stage 3 and when we worked on patient-generated health data it looked very different than this, but one of the options was that you could use secure messaging to send in your patient-generated health data. And so...and the Policy Committee...and we were pretty explicit about saying yes, that would count as kind of a twofer here and the Policy Committee liked that. So, I think regardless of...I mean, I'm looking at it right now and there's nothing in the proposed rule that would...that appears to bar that; but we could also be very explicit about saying, you know, if you do secure messaging and you're using it for patient-generated health data and it's patient-generated health data it's not the clinical care coordination piece, then you're going to get...then you should get a twofer and that makes sense. Right? We can just say that. Does that help?

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

This is Clarke Ross. So the last few minutes we've been focusing on how to do this effectively for those of you who do this for a living, that's great. I just want us to affirm, because if we don't do it, no one else in the ONC structure will do it, that both of these are fundamentally important, both of these would improve health and wellness of individuals and both should be included in the expectations. And then the rest of you can figure out, you know, what method and how to most effectively do that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And when you say both, Clarke, do you mean both the true patient-generated health data and the data from other settings? Or do you mean...

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...both the care coordination and the patient and family engagement?

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

Yes, as the slide has it, information...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

...be from non-clinical setting needs to be happening and information received from the person or patient needs to happen.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And you're saying both should be requirement.

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

Yes, both should be a requirement, it shouldn't be a tradeoff, they are, as I tried to say earlier with people with severe disabilities and CBOs, they're interrelated in some ways. But from a requirement point of view, both should be required. These are...and again, these are things that other entities, National Quality Forum and CMS with next generation ACOs, are working on because they're both very important; foundational.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, got you. Yeah, I agree with that for sure; so, and I think that's a big piece of what we're saying. So does anybody want to disagree with Clarke on that, both sides of this slide need to be required and the way it's currently proposed, it's either/or or both but what Clarke is saying, it should be both, not either/or. Any disagreement with that?

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

No, I agree, PGHD in particular has to have its own focus. So, totally agree with that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes. Okay, great. Okay, so let's...are there any other questions on the PGHD component here because I think what we need to do is play around with the idea that's been proposed which is, we would separate out not just the PGHD and require both sides of the slide, so to speak, the red and the blue. But that we might do the same thing for secure messaging and then look at where VDT might fit in so that there are separate measures around care coordination and patient and family engagement. And then we'll come back to the group with some options for how that might be structured. So any other comments on this slide around PGHD or the proposal I just made?

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Christine, its Phil. So, a couple of things; one is, I'll just go back and reiterate that I don't think a secure message on its own, without an attachment, with at least an attachment of additional information can satisfy PGHD.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

I think it has to be discrete data, I don't mean numeric data, but discrete data that gets stored in the record. Okay, so I'll reiterate that, but...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yup.

Philip Marshall, MD, MPH – Fonder and Chief Product Officer – Conversa Health

...the second question is, PGHD originally was phrased as physician-requested and I'm curious about the history of having gotten rid of that. And while, from a consumer engagement standpoint we can say, hey, providers need to be ready and willing to accommodate whatever the patient wants to give them...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, right, right.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

...there's a lot of problem with that and this is a world I live in. And so by making it physician-requested and actually creating a numerator requirement, what you're saying is that they have embraced the idea of PGHD as a part of their care and how they deliver care, and they are now proactive in asking patients to provide it. And I can tell you, again, I live in this world, I can tell you that that is the only way that this actually works is when clinicians make it a core part of their care delivery as opposed to simply putting some sort of drop box repository out there where patient-generated health data goes to die, which is kind of the way this is written right now.

And so I would strongly recommend that physician-requested be kept in. It looks like it's been removed to me, I could be wrong...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, it kind of has in a way, so let me...let's go to the next slide because that is, in fact, sort of implicit in the questions that they ask in the NPRM. And you can see them on your screen, and I'm looking at the actual NPRM and basically what the NPRM says is, look, patient-generated data could mean a whole bunch of things. They say it could include, but it's not limited to social service data, data generated by a patient or a family caregiver, advance directive, device data, home health monitoring data and fitness monitor data. The sources of data vary and they can include mobile Apps, home health devices with tracking capabilities, wearables, patient reported outcome data, other methods of input for patient and non-clinical setting generated health data.

So these are...then they go on to say, these are examples but it's not limited to it. And while the scope is very broad, it may not include basically administrative data. So you can't consider billing, payment or insurance information as patient-generated health data. So they ask these questions, and I think that there are a couple of these questions like should the data require verification by an authorized provider? Should the incorporation of the data be automated? Should the data be incorporated in the CEHRT with or without provider verification?

Phil, I think you're right, it sort of implicitly assumes that PGHD is just PGHD as opposed to provider selected. So, let me, and Leslie will chime in when needed. Let me give you guys a little bit of the history and then let's talk about how to do this the best way for both providers and for patients.

So when we originally worked on patient-generated health data and Erin Mackay actually served on the technical expert panel that OC...ONC convened as well. We basically said you can't just turn on the firehose. If you just turn on the firehose it creates a lot of liability for practices if you just sort of flip the switch and all of a sudden you're getting my home health monitoring device data. If you don't know it's there and if something comes through that tells you, oh my goodness, I have congestive heart failure and I've had a big weight gain this morning, but you didn't even know that I'm feeding my device data into your EHR and there's no alert that tells you that there's an issue there. Then it would create a lot of liability for providers.

So how we as a workgroup, Meaningful Use Workgroup and the Policy Committee navigated that was to...was, in fact, what Phil is saying which was to say, okay look at...it needs to, until we have real workflows established around it, it needs to be that the providers select it and they work with their patients to select the type of patient-generated data that they're going to work into their record. And that when they do that, if they have a way to get device data then great, but that they have to be sort of the decision point first, because that's the only way to guarantee they'll have a workflow around it. Does that make sense to folks and what do you guys think?

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

This is Clarke Ross. I wanted to ask Phil his thoughts on responding to the following situation. So a few years ago the Depressive and Bipolar Support Alliance, DBSA, a national organization of consumers with bipolar, did a nationwide survey on their experience with their own psychiatrist. And I can't remember the exact numbers, but overwhelmingly consumers felt they were not advised about the side effects of antipsychotics and so many of them experienced so many severe side effects.

And so the consumers want, and this is before electronic health records heated up, it was several years ago but, they wanted a mechanism to be able to immediately get a response from a physician, a psychiatrist; you know, I've gained 22 pounds, the same thing Christine said in the abstract, and this alarming and I need a response. And if it's physician directed and we have studies that a lot of psychiatrists don't really...aren't really overly sensitive to the side effects, they just want to treat the symptom of the mental illness, are we...how does that situation fit in what you're...the limitation or boundary that you're proposing, Phil?

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yeah, so the way I would propose that we think about PGHD is as sort of the perfect balance and analog to secure email. In your situation, a person has a concern; they want to express that concern. Meaningful Use Stage 2 requires the ability for a patient to securely email their provider, right? So that's patient initiated, right, there's a patient initiated concern or question, we have a mechanism for addressing that.

The perfect balance to that is regular inclusion of what's happening in the real world, you know that PGHD, patient-generated health data into the electronic health record. And to Christine's point earlier, the only way that that can be systematized, the only way that that can become a regular part of care is for the clinicians to have prepared for that in their workflow and the whole little two word phrase of physician requested is what would be a critically important part to make sure that that has been the case.

And so I would say, Clarke, in your scenario that the patient initiated email accommodates that use case while regularly pinging the patients on antipsychotics to see if they're having any of the common side effects that might occur is the PGHD angle. And the psychiatrists need to have initiated that and be prepared to accommodate that on all of their patients that are on those drugs. So those two things should work hand in hand and yet another reason why the PGHD item in the Meaningful Use Stage 3 requirement be distinct and focused on, in my opinion.

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

Thank you, I wish all psychiatrists practiced medicine the way you've just described. But, thank you.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Aspirational.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right. So here...so I'm going to suggest that Chitra can send out the patient-generated health data recommendation that this workgroup in its former constitution, when it was the Consumer Engagement Workgroup that we actually put forward. We held a hearing, we did all kinds of good stuff; so let's send those recommendations around because they do address some of these things and they do give you the rationale for why its provider requested.

I think for some of these questions, I'm not sure exactly what they mean. So for example, should the incorporation of data be automated? My instinct is no, if what they mean is should the data just be magically incorporated in the record without some kind of a notification? No. If what they mean is, should the EHR be able to suck the data in in an automated way by the click of a button from a provider practice or a hospital, whatever? Yeah, that would be great. Right, so I'm not sure what they mean.

The other piece is I don't know what they mean about provider verification. So for example, if what they mean is yes, pull the data in and that's the verification, then I think that makes sense. If what they mean is we're not going to treat the data as valid from the patient unless a provider somehow verifies that it's valid, then no, I don't agree with that. Did folks...does anybody have any clue what some of these...questions are?

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

I think...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think it's generally...

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

It...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...that the provider has to accept the data into the record, which I support; I do not...

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...which they have to do for anything, whether it's a lab coming...lab result coming from a lab value, determine whether it's material to care and they add it into the record. It could be a duplicate; it could be something that they want to talk to the patient about first. So I would support that it's not automated and also...but that it is compliant, you know compatible.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Well, so let me give you an example of what we're doing. So, we're now reaching out to all hypertensives in a particular practice and gathering not just their blood pressure data on a monthly or bi-monthly basis for the couple of weeks that they've been out of control, but additional questions as well. And the way the practice has desired that data to come in is if they...if all the values are good, if they're in the green zone, that they automatically go into the record. But if they are out of range, that they actually come in to their task list and not be automatically stored.

And so, it gets into a tricky area and so whether it's automatically included or not automatically included, the main thing is that they are anticipating and expecting patient-generated health data as a part of how they're delivering care. And so I'm very concerned about putting any requirements about automated versus not because some of the data will need to be sort of approved/seen and approved coming into the practice and I'm very concerned about this need to verify. Because Christine, to your actual latter point or latter suggestion is that do providers need to sort of verify that they trust this? If you do the physician requested bit, that...all of that kind of goes out the window because now they know what they're getting because they've asked for it; they know to expect it. And I think the whole verification thing is just weird at that point.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

And when I read this, I had very strong and very negative reactions to the whole needing to verify. And I guess it's because the only way this really works is if its physician requested to begin with. So that's my strong point of view.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

In this...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And I think that...go ahead Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Sorry, this is Leslie again. And as Christine mentioned, this is the kind of testimony that we heard over and over again in response to physician's question, the physician wants to know the answer and so they very much appreciate having the...that request for information. And I agree, verifying gets to the point of things like reconciling it; do I agree with this? Should it be verified to be true? That's just not friendly; we need to get to the idea that a patient has a point of view and that can be included. And to get to that point, we first have to establish trust through a provider asking a question and the patient responding with an answer.

Theresa Hancock – Director, Veterans/Consumer Health Informatics – Department of Veterans Affairs

And this is Theresa from the VA. I have concern because the way we've set up patient-generated data, we have a separate database from our EHR and the patient can upload or send a message to the patient-generated data repository. There will be, and this is what we're working on, there will be conversations with their providers, because right now some of them say they want preferences as to what they pull up from the patient-generated data; some of it's not applicable or clinically relevant. And we need to work through those business rules as an organization on when do you pull from the patient-generated data and upload to the EHR; since we're letting the...allowing the patient to upload whatever they feel is appropriate. But it doesn't mean the provider will use it, it will be accessible to the provider and the healthcare teams. And so because we have two different databases, it doesn't necessarily mean that it's going automatically from one to the other; there will be decision points in there that will make that happen. And we're working through this.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, so I think that's a great point, Theresa, and I think that's consistent with what everybody is essentially saying, although it's...so, which is if we make it provider requested, then they have had to work through the business rules, figure out how they're going to use it. They will be expecting it. So, I think we're o...I think we're all saying the same thing. We do have to, I think open for public comment, right? Do we end at 11? Yes we do; so why don't we go ahead and open for public comment and then I'm going to come back and ask one last quick question of the group on this slide. So Kim, do you want to queue that or, there we go.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Operator, can you please open the lines?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute

Yes. 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. If you are on the telephone and would like to make a public comment, please press *1 at this time.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so there actually is a whole other second slide of questions as well, which is slide 13 and it's asking...well, first of all, some of them we've answered. Should it be divided into two measures? And what we've said is yes, which is patient-generated and everything else. And then, should this measure apply to EPs only or to hospitals? And if...so, what do you guys think of that? And they're also asking if hospitals should be required to do both of the remaining measure options which is VDT and secure messaging, which again I believe to be new, but we'll check.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yeah, it's a good question. What we're seeing with regard to patient-generated data in the hospital setting is that it seems to be just as applicable actually as the ambulatory in the following way. Every discharge that happens from the ER or from the hospital, post-surgically or after a pneumonia admission or CHF or what have you, there is a real need and an emerging desire by hospitals to actually reach out to those patients and gather their outcomes or their progress data and how they're doing; are they recovering? Did they pick up the medication? Are they using the medication they're prescribed after the discharge? And so I would push for, because there are clear use cases around this, I would push for hospitals being a part of the party here.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, I agree and considering most hospital systems own ambulatory practices, they might have already gone through the automation process. So I think if we're trying to avoid readmission and trying to have transitions better, the hospitals need to be included.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. Anybody want to disagree? Okay, we'll come...we'll have a chance to...for you guys to weigh in on this as well once we get something in writing to you guys. Okay, that was very helpful. Are there any other...actually, let me see here...okay. So, I think folks you gu...we'll have to take a stab at the remaining questions on PGHD like should the provenance be included and what not; so...

W

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...should there...right, okay. Good, that's where I was going. And should there be structured data elements available for this data? Well, I think the data is too...the universe of data is too broad, so we need to think about, and Leslie, you and I did this work originally a couple of years ago, how we might either narrow the scope or just say no, not at this time until we figure out what kinds of PGHD are most common. So we'll come back...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I would just add that if it's a questionnaire and a questionnaire response that that should be structured right out the get go.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, perfect. Thanks, that's helpful. Okay, are there any public comments?

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

There is no public comment at this time.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. All right, great you guys, thanks we covered a lot of ground today and I'm going to start to work with Chitra like immediately to get...begin getting some of these things in writing so that you guys can

respond and react to them. So as I have it, our next meeting is Wednesday May 6; good news Phil, it's at 12 p.m. Eastern time.

Philip Marshall, MD, MPH – Founder and Chief Product Officer – Conversa Health

Yay.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So we will talk with you then and we will also aim to get you something to look at in...to cover some of this ground before that meeting...yup.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Hey Christine, this is Erin; I have one last question.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Sure.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Since you raised the Stage 2 modifications, does this group have a role in commenting on those?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Umm, I think we do, so I think it's totally fair game.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Okay, cool.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And Leslie, I have one other question, Christine and I just want to make sure we're aligning our interoperability roadmap comments with this, where applicable.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes we should and I would welcome any help that you want to offer in highlighting the elements where they're applicable. I would more than happy to have some help.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay, I'll highlight that for you and if I can get the latest version, Chitra, from you, our final version on the roadmap comments, I'll do that.

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

Yeah, I'll send it to you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And I know we're over time, but just so you guys know, we're going to meet on May 6 and on May 7, the next day, I've got to present to the Advanced Health Models Workgroup and we've got to get a final really agreement by May 11, for presentation on May 12. So thanks everybody, have a great day.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Thank you.