

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
March 4, 2014**

Presentation

Operator

All lines are bridged with the public.

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

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

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

Here.

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

Hi, Paul. George Hripcsak?

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

Here.

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

Hi, George. Amy Zimmerman?

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

Here.

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

Art Davidson?

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

Here.

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

Charlene Underwood?

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

Here.

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

Christine Bechtel?

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

I'm here.

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

David Lansky? David Bates?

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

Here.

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

Hi, David. Deven McGraw? John McGing for Greg Pace?

John McGing – Senior Advisor – Social Security Administration

Here.

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

Mark Overhage? Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Hi, Leslie. Marty Rice?

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

Here.

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

Marty Fattig?

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Here.

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

Matthew Greene? Mike Zaroukian?

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

Here.

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

Neil Calman?

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

Here.

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

Patty Sengstack?

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Here.

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

Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Rob Tagalicod? And Stephanie Klepacki? Are there any ONC staff members on the line?

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

Hey Michelle, Elise Anthony.

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

Hi, Elise. And with that, I'll turn it back to you Paul.

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

Great, thank you. Thanks Michelle. So this is our final call before presenting our final recommendations to the Policy Committee next week. And last time, thank you, we went through, looked at our voting matrix, and recommended removing nine objectives from the draft that we had last time. Since then, since we've last talked about these other objectives, there has been some minor editing basically to try to clarify the objectives, the intended concept and objectives that we had, based on feedback we got either from the Policy Committee or sometimes it came from other parties – looking at the clarity of these things – these objectives as well. So anyway, we tried to take the best input so we put our best foot forward in terms of the clarity of what we're trying to propose for next week. And what we're doing this week, then, is reviewing essentially the wording changes, just to make sure that everybody has full transparency on the wording that we're going to be presenting. And any final discussion, questions on that, or other agenda items?

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

Paul, its Christine. We've received a lot of letters – different criteria that we had proposed to remove. How are we thinking of approaching that?

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

I think they all have a common theme, I could make a comment about that, at least my read and other people's reading of it, maybe at the time, there's a slide that has the list of objectives that we removed, and maybe make a comment. I think most of it – some of it's from misunderstanding of the Meaningful Use Program, but why don't we comment on it there, how does that sound?

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

Okay.

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

I don't remember what slide that is, but there is a slide that talks about the object – it's actually about three slides in. Does that sound fair?

M

Sure.

Paul Egerman – Businessman/Software Entrepreneur

Paul, this is Paul Egerman. I had a minor issue. I looked at the slides briefly and then I looked at the other documents, the spreadsheet and there are some inconsistencies there.

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

Okay.

Paul Egerman – Businessman/Software Entrepreneur

Is that something that we should just go through when we go through the slides?

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

Yeah, why don't we do that.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

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

It's probably pretty hard to keep these things totally consistent, but it's helpful to know so that we – for next week. Okay, anything else? All right, so this is a list of our fearless workgroup members, most of whom, thank you, have been with us for a long time. Next slide please. So, to remind us of where we are, these are the current objectives in our draft, in the four plus categories. It looks like the three – it has the ones that we removed last time removed from this slide. So we still have a total of 17 objectives. Next slide please.

Actually one, go back one slide please and I'll go ahead and remind us of the four focal areas that we had, that the Privac – that the Policy Committee wanted us to concentrate on. One is clinical decision support, two is patient engagement, three is care coordination and four is population and public health. And you can see that they're pretty well represented here.

Paul Egerman – Businessman/Software Entrepreneur

And Paul, I had a question about that also, is that the focus of Meaningful Use Stage 3 now, as opposed to what we had said earlier, where we just said outcomes? Or –

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

I wouldn't interpret it – I wouldn't say it's a reinterpretation of outcomes, it's clearly driven by outcomes, but from a functionality point of view, we wanted to concentrate on those four areas in order – because we felt those were closely linked to the outcomes that we're trying to achieve.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

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

That would say they're complimentary. Next slide please. Okay, in our work last time, we agreed to remove these objectives, and vis-à-vis what Christine mentioned, I – we didn't really have much feedback – additional feedback from the public, except for electronic lab reporting and syndromic surveillance. Let me – I'll try to summarize and welcome certainly Art to chime in and anyone else.

I think one of the big things people were saying is, let's talk about electronic lab reporting, is a lot of work has been done, and I think public health departments are very appreciative of the work that's been done in ELR in Stages 1 and particularly in Stage 2. And their concern was that if we remove it from Stage 3, now you'll recall that actually we proposed no change for Stage 3, it was basically a continuation of Stage 2, is that if it's missing from Stage 3, and then I think some people were concerned that people would just stop doing it.

So our rationale as we described how we were thinking about the stages and objectives and trying to be very careful about both the burden of development and testing and certifying and the burden of use, is that we wanted to try to, as we add more things, and we are adding some new functions – functional objectives, that we want to make sure that we don't continue to pile on and add more burden. Because doing it – reporting, documenting, auditing what you do sometimes is as much work and effort and cost as actually doing it. So we wanted to try to relieve the burden of that documentation and reporting, especially since if we're not changing anything about it, we have no evidence that people turn any functionality off once they have implemented it, even from one stage to – one year to another in the same stage.

So by Stage 2, that's a total – in some cases, it's a total of six years of doing something, it seems to us unlikely that someone would turn something off. Let me – and that's a big reason, for example, why we did not continue, and it really is just a continue the same requirements in Stage 3 as existed in Stage 2 for both, so it's electronic lab reporting and syndromic surveillance. Let me invite Art to make any comments that may reflect some of the concerns people have, and maybe try to rationalize that – reconcile that with the rationale that I just presented.

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

Thank you, Paul. So I think the main concern from the public health community is that as this group and the Policy Committee have been evidence-based in its recommendations, like deciding to retire things from Stages 1 to 2 or 2 to 3, we actually don't have much evidence that this is working yet. It didn't – wasn't required to do anything more than attest in Stage 1 and in Stage 2, we've only got a couple of months of experience so that we don't know whether this is working yet in stage 2. That's one piece of data that I think our group has traditionally been looking for before retiring an objective.

I think the second thing that is concerning to the public health community is the fact that thousands of hospitals need to connect to state health departments that weren't funded to do this. They're very happy to get the data stream, but some states are well out in front and other states are behind so that if in Stage 2 a state is still not able to get someone or an institution, an eligible hospital, signed up, that opportunity is lost if in Stage 3 it's not listed as a Meaningful Use objective. So I think those two pieces operationally are important for us as public health entities to see if we can get electronic lab reporting and syndromic surveillance to be the expected state of operations in each of the jurisdictions.

I think lastly, the fact that electronic lab reporting is – well, lab reporting is required in many, many states, it's all states, and there are variations there. And the fact that in several articles it's been proven that you can reduce the time to reporting and you can multiply by several factors the number of reports made when you do it electronically versus a lab sends it when the remember to send it on paper or calling it to the state health department. I think the efficiency there really speaks to what Paul Egerman was talking about, these outcomes that we expect to happen in Stage 3 to improve our ability to track outbreaks – a variety of outbreaks, that happen nationwide that could be identified better by more comprehensive and more timely reporting to state health departments. So the inability of state health departments to achieve that goal in Stage 2 and then dropping it from Stage 3 is of most concern to my colleagues.

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

Any other comments? Now recall Art that all of the justification of the benefits is the very reason why they showed up in Stage 1 and Stage 2 and that everybody has to do three years of Stage 2 before they even go to Stage 3. So that's –

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

So I agree with that Paul; however, if the state has not gotten all the hospitals lined up, if they got a pass in Stage 2 because they – let's say this year, a hospital wants to do ELR and the state health department is not ready this year. They apply for their Stage 2 and they get a pass. They're allowed to apply and receive Meaningful Use funds because the state gave them this pass, it was unable to do that. When Stage 3 comes around, they have no incentive to then make up for the pass.

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

So can I – this is Amy. I have a question because I'm so confused and I'm looking at the chart. On the one hand I hear we're eliminating it, on the other hand I think I heard Paul say, we're just not changing it and adding to it and making it more stringent.

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

Yeah.

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

So, can we like clarify that, because I think that's very relevant.

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

Okay. So it is really based on the fact that we were not proposing to make any changes in Stage 3 for this requirement that we said we would drop it as – drop it from being a part of Stage 3. Which in our terms that means that we're reducing the burden of having to comply with something you've already been doing for three years.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, so I'm not understanding what Art is suggesting. Are you suggesting that we simply repeat it in Stage 3, identical to what it was in Stage 2?

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

Yes Paul.

Paul Egerman – Businessman/Software Entrepreneur

And that was a menu or a core –

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

That's a core item in Stage 2, but if the state is not ready when that hospital is applying, they get a dispensation for meeting that core objective.

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

No Art, I –

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

And then – and when they apply for Stage 3, they have no incentive to make that happen.

Paul Egerman – Businessman/Software Entrepreneur

And so – this is Paul, I understand what you're saying, but I also heard you say something else important is, we don't have experience from Stage 2, and I think that was a valuable comment, it applies here and applies in a few other places also. So, couldn't you make the argument that since we don't have that experience, we don't know if it's a good thing to continue in Stage 3. We really don't know if it was effective at all in Stage 2 yet, if this helped at all.

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

I guess you could make that argument. We need more evidence, that's correct.

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

It's Christine, if I could –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Art, this is Leslie –

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

– jump in – sorry Leslie. Thanks. Just to say I think – to Paul Egerman’s argument, I think there’s another way to view it though, which is do you do more harm than good by removing it, because I know I just heard Paul Tang say, you’re not likely to stop doing something you’ve been doing for a couple of years. So if you already know how to do it and you’ve been doing it, I think it’s – for those who can, it’s easier for them to continue to do that, because they’ve got the system, they’ve got the workflow. But what I think Art is proposing captures a new realm of people who we would lose, frankly, if we didn’t have it in.

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

Art –

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

Right so Art, this is Amy. If I’m understanding you, the concern about taking out the requirement for documentation is that there’s no incentive on the public health agency side to continue to onboard providers. So those that are doing it may still do it, we’re not concerned about losing them, but the onboarding on the public health side, since they’re not going to keep their providers and their hospitals from getting money, may not have as much incentive if they are – if they’ve got competing priorities. That’s what you’re saying, am I correct in that?

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

No, it’s not about the public health side, it’s that – the public health agencies are trying to onboard as quickly and as efficiently as possible.

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

Right.

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

It’s just that if a hospital in your jurisdiction decides to apply for Meaningful Use dollars at present and you don’t have a way to allow them to send electronic lab reporting at this moment to your hos – to your agency, you give them a letter saying –

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

Right.

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

– you get a pass this time, and the next time it comes around is when Stage 3 dollars are applied for, and that’s not a requirement at that time.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Art, this is Leslie.

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

That’s the problem.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Is there an obligation that states, if you’ve accepted Meaningful Use dollars, and although you couldn’t deliver on the promise because the agencies weren’t ready, is there a requirement that at an available time in the future you are required to do this because you have accepted the funds already? Do we know?

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

I don’t believe that’s written into the rule.

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

But Art, if you have to do Stage 2 before – oh, you’re saying if you have to do Stage 2 before Stage 3 and you got a pass, but you don’t get a pass for all three years of Stage 2, do you?

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

You have to do it three years it’s like –

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

So as people were – as I was talking, I had a similar idea to Leslie’s is, another approach is to, because I think that’s something that HHS could do, is to – is when the grant an exception, that the exception expires when the public health agency can accept the information so that it carries on. Because what you’re – to do it the way that you’re suggesting Art would cause everybody to have to report everything all the time to pick up the stragglers, and that doesn’t seem fair. Whereas maybe to address the concern that you have is to change the exception, the waiver, to say that it expires when the department can accept it. Does that make sense?

Paul Egerman – Businessman/Software Entrepreneur

Yeah, this is Paul. That – I have a problem with that, which is it appears to be operationally that would be difficult. I mean, if you’ve already qualified for Stage 2 and you’re getting your incentive payments, and then somehow the state – your state gets its act together, it seems odd all of a sudden now you’ve got to like hustle, otherwise you’re going to lose money. It just –

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

Well, I don’t –

Paul Egerman – Businessman/Software Entrepreneur

– seems operationally – I don’t understand how that works.

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

It would kick in at your next application. So you’re applying for the following year of Stage 2 or you’re even applying in Stage 3 if the state’s that far behind, then to collect the next amount or to avoid the next penalty, you would have to make up for it. All these –

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

In effect, Paul, isn’t that just saying –

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

– things are trade-offs.

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

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

– that it continues into Stage 3, and I think that’s what the public health colleagues are asking for.

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

No, the difference is, instead of making everybody do all the documentation and administrative burden of proving that once again, for the sixth year in a row, they’re complying with this objective that was started in year one of Stage 2. It just applies to the folks who were granted waivers, and that hopefully diminishes over time.

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

So Paul – this is Amy. Is there a way – so I think what you're trying to say, and I'm just clarifying for myself, is there a way to say that if – when – so let's say your three years of Stage 2, your health department still wasn't able to get you onboarded –

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

Right.

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

– and then Stage 3 comes. Are we saying that if you've had an exemption previously for Stage 2, then for Stage 3 you have to report and say whether you still have an exemption or you've met it. Can we like do that, like a partial?

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

I don't know. It certainly hasn't been done in the past, and it does have the wrinkle that Paul Egerman was describing, but I'm trying – I'm suggesting we try to avoid not penalizing everybody else for the folks that are behind. Art, do you know what –

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

I don't see the wrinkle because they wouldn't have to give money back, it just means, it doesn't become – it doesn't go away for you in Stage 3 –

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

Correct.

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

– if you were never able to achieve it before because your health department couldn't onboard you.

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

Correct.

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

And if they still can't onboard you, you're not going to be held up from your payment, but if they can, then you do have to require to report. And it's a little bit tricky –

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

Right.

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

– there, but it's – from an attestation point of view, it's a little confusing, even from an audit perspective, from a state health department, but it might be a happy medium.

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

So Paul, let me just bring up one other point of concern that my public health colleagues have been – also been pointing out is that as we know, each version of Meaningful Use criteria requires modifications to the certified EHR technology. So the 2014 version is coming out now, there's actually a Notice of Proposed Rulemaking for 2015 certification criteria. When 2017 comes out, a new version will likely be installed in most hospitals and those hospitals will likely need to be rebuilding some of the interfaces from that new version. And one of the concerns of my colleagues is that as the new version gets installed and there's no Meaningful Use Incentive Payment tied to it, that that might fall at a lower priority and may actually be dropped, even though I know we said, why would they drop it. Well, because it requires effort and resources to reestablish in many cases, when there's a new version installed, it takes effort and resources to reestablish the ELR and syndromic surveillance feeds.

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

Art, do you know what percent you anticipate will not be able to do this by the end of 2016, by 2017?

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

I don't have that answer, but I know that my public health colleagues again are trying to collect some of that information. The Association of State and Territorial –

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

Yeah, my – this is Amy, yeah, my sense is there still may be a fair number of places that haven't done that –

Paul Egerman – Businessman/Software Entrepreneur

Yeah, so this is Paul –

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

– haven't been able to do that. So I think it is a reasonable issue, a very reasonable issue.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul. I'm still concerned that – I mean, I hear what you're saying, Art and I'm still concerned though that we don't have any evidence, any data that this is working – working well and – which I –

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

We have several states where it is working now, very well, Paul.

Paul Egerman – Businessman/Software Entrepreneur

Okay, that's part of Stage 2?

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

No – this is – states that have been doing this for years already and that are now –

Paul Egerman – Businessman/Software Entrepreneur

I understand, so what –

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

– catching up as part of Stage 2, that's what I'm saying. We will – we do have some data from some of the member organizations, they're trying to collect that as we speak.

Paul Egerman – Businessman/Software Entrepreneur

So my question is, do we have evidence that whatever we said in Stage 2 is somehow effective, that the health – the providers are able to do it, the state agencies are able to receive the data and everybody is like a happy camper?

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

Yeah, I think what Art is saying is that that is in place in a number of places, whether it – and it's the same as what we've put in Stage 2. Like I know our hospitals are all doing syndromic surveillance.

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

Right and there's entire states like North Carolina, that's been doing syndromic surveillance for years.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah, but I'm specifically asking the Stage 2 objective, is that in place? I'm not saying –

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

If you're a hospital in North Carolina, you're meeting Stage 2 objectives, yes.

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

And Paul, the other Paul, you asked – I mean, in our state, like we haven't had a lot of hospitals – we haven't had almost anyone come in for Stage 2 yet. So, I think what I'm trying to say, and I think Art is saying the same thing is, there are hospitals that for that one objective would be able to meet it, they haven't come in on Stage 2 period, because they're still trying to meet a bunch of other things on Stage 2 that are very difficult for them. This one, these two, at least the syndromic surveillance, I don't think is super hard and the electronic lab reporting, my guess is, isn't as difficult either, as some of the other ones. So we haven't, from my perspective, we haven't had states come in ready for Stage 2 yet, but it's not because of the public health one.

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

Can I – this is Neil, can I ask a question. So what are we trying to accomplish by dropping it?

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

A redu – keep – reduce the overall burden of complying with the program, when –

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

Right, but if you've already – if the purpose is to get everybody to comply, the people that are already complying don't have any added burden reporting, right, I –

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

Well, they still have to report – like CPO – like any of these objectives, every year you have to report, every year you have to make sure every physician is – every provider is doing each at the then current threshold, for example. The point –

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

But Paul, for this – for these two objectives, it's a simple thing of getting a letter from the state health department saying you're having ongoing submission of these electronic lab reports and syndromic surveillance, it's not a burden.

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

Right, that's my point. My point is, it sounds to me – for some of the drops, there's a substantial burden that we're reducing, but for this, it doesn't sound like – it sounds to me like we're not really reducing much of a burden to begin with and there's concern that it's going to create an impediment to further progress in this area. It sounds to me like this is an easy one to sort of say, well let's just keep it. I mean, if there was a substantial reporting burden, then I would agree, but since it doesn't really work for these objectives, I'm not sure why we're struggling to drop them.

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

Art, this is George. Is there a difference between electronic lab reporting and syndromic surveillance in importance to keep?

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

I would not suggest that there's any difference – they're different, but there are pieces of – sections of the public health community that have been very vocal about both of these, so I wouldn't want to put one up for the chopping block, George.

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

You know –

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

I have heard that most of the people who have been suggesting we keep syndromic surveillance for hospitals were willing and some even recommending that we drop it for EPs.

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

That indeed is true, that is something I believe that we've all received letters in the last several days in the member organizations. I believe it was CSTE had one and I believe JFID another, suggested that maybe that one, since there aren't good standards there, it hasn't been used much, that that might be a menu item to be dropped, that's correct.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul Egerman. I'm listening to this and I'm looking at the matrix and if what we do is keep it exactly as it is in Stage 2, in other words, do not add EPs, then I'd be in favor of it. I kind of want to ask to remove something else in the trade, but it seems like Art's made a good point and if there is value and if it's working right, we can just keep it as it is in Stage 2.

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

Let me hear –

Paul Egerman – Businessman/Software Entrepreneur

But exactly as Stage 2, not add anything new to it, in other words, not add EPs or anything new, just exactly as what it was in Stage 2.

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

So let me hear from some of the other folks who haven't spoken up yet.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Yeah, this is Marty. First of all – there are a couple of things. First of all, I'd be in favor of keeping both of these, but before that, our state was one of those who was not ready when we ran our test for Stage 1, we ran the test and therefore we got an exemption for the 90-day attestation period. But for year 2 of Stage 1, we – our state was ready, so then we had to acknowledge that we had an interface in place and we could, in fact, share data on one of the public health measures. So I assume the same thing will happen with Stage 2.

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

I do, too.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

But for this discussion, everybody's going to be doing these things, just leave them exactly as they are and move them to Stage 3.

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

Anyone else want to comment? Okay, so let me summarize where I think we have ended up in the comments is to keep electronic lab reporting core, as it was in Stage 2, in Stage 3, unchanged. And that for syndromic surveillance, keep it core for hospitals, unchanged, but have no requirement for EPs in Stage 3.

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

Right, electronic lab reporting, is that both or just EH?

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

Just EH.

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

I think that's EH, yeah.

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

In Stage 2, yeah, okay, because it's not online, I'm looking at the – okay.

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

And then our Stage 3 proposal was also just EH.

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

Okay, so EH for both.

Paul Eggerman – Businessman/Software Entrepreneur

And so the way – this is Paul. The way I'm understanding it, we're taking these two things from Stage 2 to Stage 3 identical, as they were before, and there's a reason why we're doing that as opposed to doing that for anything else, and it's because of the issue of the variability of the readiness in different states.

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

Minus the EP.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah, but the minus EP, that was not in Stage 2 anyway, right?

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

Correct.

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

No, it was –

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

It was a menu item in Stage 2, I think.

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

– menu in – yeah, menu for syndromic surveillance in Stage 2.

Paul Eggerman – Businessman/Software Entrepreneur

Okay.

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

So is there – oh, it is a menu in Stage 2, right, yeah. I was going to say, I wouldn't want to drop the menu option if EPs want to do it, and a state has that in place, I wouldn't say drop it, but as long as it's –

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

Well, there was some argument for dropping it because of some of the other – like standards and not enough experience showing that it does work, etcetera.

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

Okay. But it already –

Paul Egerman – Businessman/Software Entrepreneur

Yeah. And then if that argument's there, I would be in favor of dropping it. I asked the question, is this operational and people are happy with it and the answer was yes. But if the answer is yes on the hospital side, then I would say let's keep it on the hospital side, it's frustrating to people when we try to implement things that really don't work, and so we shouldn't do that.

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

Well we have – okay, so currently Stage 2, am I correct, EP – for syndromic surveillance, EP its menu and hospital its core and we're keeping it that way.

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

Correct.

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

Okay, I'm in favor of that.

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

You mean keeping it menu? I mean, I –

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

If we're keeping it the same as Stage 2, and we're doing no change from Stage 2, that's how it would be, it would be menu for EPs and core for hospitals. If I'm reading the chart right, the matrix right.

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

No, yeah, I was just responding to some people are literally recommending to not have it because it's one, I'm pretty sure that the uptake was not high, but it was not high for a reason –

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

Oh, all right, so you're saying, make it – you're saying, just make it Stage 3 take out any reference to EPs, and just – .

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

– EPs –

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

– make it core for EHs.

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

That's part of my reading of the comments we got and the uptake sort of consistent with that. I guess – if there is something that is not ready for being a Meaningful Use objective and then it's – this is almost a correction for that.

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

Yeah, that's fine for me. Art, do you know how many states even ask for EPs to report syndromic surveillance or want that?

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

I don't know that.

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

I know our state isn't ready and has no interest in it from – they want it from hospitals, not from providers, for syndromic –

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

As I understand it, it's relatively rare.

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

Yeah.

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

Yeah so –

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

So take it out, yes, I'm sorry. I'll changed that.

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

– I'm almost saying let's do a correction here.

Paul Egerman – Businessman/Software Entrepreneur

So it seems like if we do it with hospitals it's a step forward for what Art wants to do and it's consistent with what we've done before and it's using standards and technology that we know will work. So that seems like a reasonable step.

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

Art, do you think the public health community will be happy with that? This is David Bates.

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

I do, David.

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

Okay, so let me summarize again and see if we can get a vote here. So it is for electronic lab reporting to keep it the same as in Stage 2. For syndromic surveillance, keep it the same as in Stage 2 for hospitals and to remove it as an objective for EPs that is for syndromic surveillance. All in favor of that?

Multiple respondents

Aye.

Paul Egerman – Businessman/Software Entrepreneur

Yes.

Multiple respondents

Aye.

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

Any opposed? Okay, good, thank you for the discussion. Next slide please. Okay, so now what we're going through are the objectives, the ones we've approved, there are some wording changes to accommodate or to respond – to increase the clarity really, of some of the objectives and this is just for our review. Next slide please.

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

Paul, we were going to also go over the other comments that we got, aside from public health, I thought that was on the last slide, but maybe I misunderstood you.

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

No, I didn't – what other comments are you referring to?

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

We got a letter from several members of Congress around health disparities and then we had the public health letter and I think there was one more that I'm not remembering off the top of my head.

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

Disparities, we haven't – well, if you want to bring it up.

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

Well, so their essential request was for more detailed standards with respect to demographic data.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, can I make – why don't we just get through that when we get to that slide?

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

Is that o – I don't know that is one of our slides though.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, there's a slide on demographics, isn't there?

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

Yeah, I think so.

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

So, and then they had – well, okay so I mean that's fine, but there are – they raised stratification of quality measures, which we don't have a slide on. They raised reading levels. They raised I think it was access for people with visual, hearing and cognitive impairments and then they raised mobile platforms.

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

I'm a little nervous about reopening the whole discussion. I think this public health concern was over a decision we made last time, but I'm not sure we want to raise – that's a lot of topics and I don't know that – remember, we're just – we still have many stages, we have the Policy Committee next week, the NPRM. There's a response to the NPRM, so there's plenty of time for input, I mean it's basically going back to your suggestion from a couple of calls ago. I don't know that we're reopening all of the topics.

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

Well, my suggestion from a couple of calls ago was with respect to the fact that we as a workgroup have gone over things many a time. This is a letter signed by 24 members of Congress, so, to me that brings a little bit different weight. If you don't want to work with it on this call, I think that's okay, although there are some relevant things, like demographics, to the slides that we do have. But I would be extremely cautious about ignoring 24 members of Congress on this.

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

I'm just –

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

So let's – go ahead.

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

I was just curious. It sounds – I would agree in a way that whether we do it on this call or later at the full meeting. I think we need to take up some of these issues only because there's really no other mechanism except in the backroom of CMS where somebody's going to figure out what these requirements should be if people decide to respond to this Congressional letter.

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

Well, keep one thing in mind for the social determinants of health part – this is George – part of it, that IOM is publishing a report on exactly this topic. And based on evidence, and eventually the second report will have the metrics and everything – the measures, so rather than just dreaming up what might be useful, they actually are looking hard at what's the right answer. So we might want to – we included the demographics objective, let's talk about it and look at the letter, sure. But I think the answer is going to – will end up getting pushed a little bit to CMS and ONC, since the report won't be out in time for our presentation.

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

But these are – George, I don't know if you read the letter, I know you were on the list, because I think all of us on the workgroup and the Policy Committee and the Standards Committee received it, but it –

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

Can you just point us to the – what's the date of the letter, to make sure we're –

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

Yeah, it came – Michelle.

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

You should have received it on Friday morning. I have at 8:42 Eastern Time.

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

Wait, Friday, what's the date of Friday?

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

The 28th.

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

The 28th at what time?

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

At 8:42 Eastern.

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

What was the name of the file?

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

The subject of the email is 2/21 Meaningful Use EHR Incentive Program.

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

And who did it come from, because didn't it come from Altarum?

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

It came from the Altarum, which is the ONC's FACA meeting.

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

You know what, if someone has it and can send it around, because I'm not finding it.

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

Michelle, do you want to do that?

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

Caitlin – yeah. Caitlin, do you mind re-distributing to the Meaningful Use Workgroup?

Caitlin Collins – Project Coordinator, Altarum Institute

I'm looking for it – was it –

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

I'll forward it.

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

What's the subject again?

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

2/21 Meaningful Use EHR Incentive Program, I'll forward it to everyone.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The file's called leverage Health IT.

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

And then Michelle, I know we had all the public health letters, we had this one, was there one more that I am – for some reason I think there was?

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

There was one on advanced directives, I know I – I can't find the Altarum one, but I was going to say that – I was actually going to ask a process question which is, when we get these letters, does anyone respond to them or is it just a one-way communication to us? Do we ever – what's – Michelle, do you know what the process is, because some of them come to you and – are we out? Do we – I guess I'm asking process, do we typically respond? Is it like a public comment, people just write it, send it and that's the end of it and then we don't need to respond?

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

Yes, exactly. This one that we're speaking of, ONC may respond to, but that would be separately on their own. If the committee wants to respond, we can. I think we responded to the public health letters by discussing them today.

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

Yup.

Paul Egerman – Businessman/Software Entrepreneur

So this is Paul, I just have a couple of quick comments. One, with regard to the Congressional – this letter, I've been involved on the other side, like writing and getting signatures on those letters. And what tends to happen is when you get a lot of letters, I don't know – to get people – a lot of signatures, in order to get people to sign, you end up adding additional items to the letter. So it's not a surprise to me that that letter covers a large number of topics, that was sort of like the price of getting a lot of signatures, people would say, I'll sign if you add this one special thing that interests me.

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

Yeah but Paul, they all agree to sign to all the content, they never – I don't think that takes away from its import.

Paul Egerman – Businessman/Software Entrepreneur

No, it's just an observation as to why you get a letter with a wide range of issues, which is what is happening here. So, that's just my observation, I'm not saying that there's anything wrong there, but it's a difficult letter to read only from the context of it's not one single topic or two topics.

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

Well, it's all on disparities.

Paul Egerman – Businessman/Software Entrepreneur

Umm –

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

They did not go outside, the whole letter is on health disparities and the different functions that they think will help reduce health disparities.

Paul Egerman – Businessman/Software Entrepreneur

Right, I understand that. And my other comment, though is, I'm still looking at the clock, we have a lot to do. One is, we can go on through some of the slides.

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

So, may I suggest what we do is to go through the rest of the slides and the wording changes and then we – and we certainly can pick up the disparity variables under demographics as it occurs there and then we'll go through these other comments, time permitting. How does that sound?

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

Yes.

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

Sounds good.

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

Okay.

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

And Paul, this is Michelle, I just want to note one more thing, I'm sorry.

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

Okay.

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

I think somebody mentioned that there was a demographic slide, there isn't a slide, so when we get there, we could possibly bring up the matrix, just to note that.

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

Okay. Thank you.

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

Yup.

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

Okay, so hopefully these wording changes are fairly straightforward. On slide 5 that you see in front of you, it's just changing chronic disease to chronic condition.

Paul Egerman – Businessman/Software Entrepreneur

Yes and Paul, I had a question, I'm sorry, I didn't mean to interrupt you.

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

Yes, go ahead.

Paul Egerman – Businessman/Software Entrepreneur

On this slide, there's a difference between it and the matrix, on the certification criteria –

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

Okay.

Paul Egerman – Businessman/Software Entrepreneur

– which on the slide it says consume external CDS rules, that's not on the matrix and I believe in our last conversation –

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

So, okay –

Paul Egerman – Businessman/Software Entrepreneur

That was –

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

– so, correct, so that no longer exists on this slide that was moved to immunization so thanks for the correction.

Paul Egerman – Businessman/Software Entrepreneur

So that needs to be deleted here –

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

Correct.

Paul Egerman – Businessman/Software Entrepreneur

– because that'll cause a lot of people's blood pressure to go up.

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

I understand. I understand. I understand, I thought I gave you the pill ahead of time Paul, but – okay. Yeah, thanks for catching that. Agree Michelle?

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

Yup, got it. Thank you.

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

Got it. Okay, next slide. This was the famous track changes. So, I talked to some people who were both asking questions and had concerns about it and tried to revise it to reflect their concerns, because their concern was unintentional. So by referring to Microsoft track changes, it appeared to suggest that everybody had to do that and it was only supposed to be an example of what the end product – an example of how being able to see the provenance is helpful. And the analogy was in the collaborative document, it's really helpful to show who entered what and what changed. In the same way, you can look at when you do a copy paste or essentially use a system template, which of course is not – generally is not yours, it truly is a collaborative document. And the same issues, well like what is the provenance, and that helps me assess the accuracy, the up-to-dateness, etcetera.

So that's the purpose, that's the intent and so in the way it's stated now is there are some example methods. Now really the only goal is that the reader has the ability to see previous versions. Now obviously there are convenient, more transparent ways of looking at previous versions and less so. And it depends on the level of effort, etcetera. So, even if you had a link, so you're looking at a document, and you had a link that says, here's the previous version, and you click that, that would satisfy this need of being able to discern what is copied forward and it can be either imported from a template or copied from another note. The difference between something that you physically may change an entry you made today for something from some other source, that's the whole purpose. So any way that you make that available would qualify, track changes only an example and I went and listed other examples to make sure that it looked like an example and not a prescription.

Paul Egerman – Businessman/Software Entrepreneur

And so a process question, can we discuss this now or –

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

Umm, yes.

Paul Egerman – Businessman/Software Entrepreneur

So, I don't quite – I understand what you're saying about previous versions of a note, but I don't understand the part where it says, helps the reader understand the origin of any copied text.

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

Right. Okay, so first –

Paul Egerman – Businessman/Software Entrepreneur

That's the origin of the copied text strikes me as a particularly hard thing to do in some technology. I can understand how you could do version changes, but not the same as an origin of copied text.

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

Okay, so – and I certainly appreciate any suggestions, not necessarily offline, about how to word it, but it truly is figuring out what a previous version is, and in my mind, if it's a previous version and you understand that, than that's what – that's the intent. The source means it came – it's essentially the pre – the source is not something you entered today, and I'm –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul –

Paul Egerman – Businessman/Software Entrepreneur

This –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– this is Leslie. I have a question or a concern about this because in, I think it was 15 years ago when we started automating in internal medicine areas, there was prohibiting rules that prevented a physician to use something like an existing template. And so they actually had to re-dictate every single thing, because it couldn't copy forward from an existing template. And so my concern would be unintended consequences of something that has created efficiencies where providers are able to pull in templates from existing notes where they see no variants and just simply add material that's unique to that particular visit or experience. And so if the problem we're trying to solve is as things are edited, we have the ability to identify that, I think that's great –

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

That is.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– the concern I have is that the way the language reads, it could be reducing efficiencies that we've gained.

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

No. So, so far I'm hearing that the intent is fine and it's the wording that's a struggle and totally happy with receiving any suggestions. The origin of this whole concept is, let me just remind you, we had an entire hearing on clinical documentation and the concern and dissatisfaction with the text was a very prominent part of that hearing. The other thing this is addressing is the GAO report about the possibility of using certain functionality that would contribute to fraud. So, this has an important role, and we want to try to figure out how to say it in the way that allows innovation to take place, but also improves upon the situation that we heard about.

Paul Egerman – Businessman/Software Entrepreneur

Well, and this Paul. First of all, I'm not sure I understand the intent. I mean, there could be – one intent could be to sort of say, well, I've got this document and this is what it existed on March 1st and I've got another document on March 2nd, I can see what the March 1st one looked like versus March 2nd one.

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

Uh huh.

Paul Egerman – Businessman/Software Entrepreneur

If that's the intent, that's understandable. But if I have to sort of say, well the March 2nd one got changed by getting text inserted and that text came from, somebody copied it from the Wikipedia, well that's like it – that's not going to work. I mean, you can just see – you can just say, here's history of what the document looked like before, and here's what it is today, that could work. But the source say the origins of where the stuff comes from, that's really difficult.

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

So, let me see if I can address that comment. So you're – I guess you're saying that finding out that it was the Wikipedia accessed on this date is hard and that wasn't the intent either. There should be some way that you understand what was entered by the current authenticator, and that's really the intent of this.

Paul Egerman – Businessman/Software Entrepreneur

And I – this is Paul again, I understand that's the intent, but I'm also trying to understand what we're doing, are we trying to design how these systems work?

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

No, we're trying to be able to help the reader appreciate what was changed. It does not say that the things that were imported from somewhere else is inaccurate, it just helps people understand – just like collaborative document, which it truly is.

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

But I don't understand – I guess, I don't unders – I think there are so many different permutations that we're talking about.

W

Agree.

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

It could be copying a lab result into a note, because it's particularly relevant to the note. It could be copying over a physical exam from last year's physical exam, because basically you did it and nothing else changed. It could be copying something from a specialist's note to say, here's what the specialist said about such and such, and you're pasting it. I mean there are so many different permutations of this and I'm just wondering whether this is really going to add any value at all. I mean, if we're – this sounds to me like an issue of educating people about the sanctity of the progress note and how important it is for people to be careful when they cut and copy and paste and do other things. But I just don't see that what's being proposed is actually going to add any value.

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

So this is Mike, maybe if I could jump in, since I did this 12 times yesterday in my clinic. So the notion of copying something forward, one of which was from my partner, is the notion of being able to number one, see what somebody else saw last time, number two, not leaving it intact, because that's really unlikely that, for example, that HPI is unchanged now than it was when the person saw them a week before. So to detect fraud, you'd want to be able to detect things like an HPI or a series of assessments and plans that are identical to a previous one, no effort of thought or change. Physical exam could be different, review of systems could be different, but those things are much more standardized. But I think the key is, to Paul's point, it's helpful to me when the nurse interrupts me or a patient or a family member distracts me from completing my documentation, and I've forgotten whether or not I've completed all the modifications of that HPI I need so that it's accurate and up to date. And the other part is to highlight not just what's changed, although that could be helpful to me, it's to highlight what's abnormal, so I can validate whether it's still normal, abnormal or whatever.

So the problem that everyone mentions is this really is complicated, it's tough a priori to say, because this text is unchanged, it's either fraud, wrong, inaccurate, incomplete, etcetera, etcetera, that's why we struggle so much. So I think we have to decide whether we're going to take this by section. So for example an HPI that's unchanged from visit to visit is probably not right. Or if we're going to try to basically say, every time I pull in the template, whether I've modified it or not, the template part of it looks to be plagiaristic or otherwise undesirable, which I think is wrong.

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

Yeah and I –

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

This is George, I think – Neil, I think the problem is we're designing the EHR at this point. I mean that was exactly the right thing, and it's complicated to do this. And so I remain worried, as I said before, that it's just – either you say something vacuous or you design the EHR and it's hard to do anything in between and that's why I favored originally – I understand Paul's motivation. But I agree with Neil.

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

I think we're actually going to create exactly the opposite effect that we want. I think there'll be an assumption that everything that gets copied was basically not done accurately. And I think that what you're going to end up with, and I've done quite a bit of testimony at – in litigations and stuff, and I think that you're going to end up people going like, well, it was just copied over from somewhere else. Well that doesn't make it wrong and also, it doesn't say anything about whether it's accurate or not, whether it's copied. And I think that we real – this is an educational piece. And listening to what came out at the last Policy meeting, where people were so concerned about the technology, how much energy it would take to actually figure out a way to do this. I just think this is a case where the burden far outweighs the value and I think there's going to be a potential negative effect of this.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I remember the one thing that we heard in testimony is that you can't legislate or create rules to eliminate bad behavior, poor behavior. And so I'm concerned also that we end up giving up a lot of efficiencies. I mean I can understand, especially when the record might be edited by someone other than the provider, we'd want to know what that was, and that mechanisms are in place today. But I would see that we may end up causing much more difficulty than benefit.

Paul Egerman – Businessman/Software Entrepreneur

Yes, and this is the other Paul and I agree with Neil and these comments. It seems like we're trying to design a medical record system and it seems like we've talked about this a lot, it feels like a quagmire in terms of trying to figure out something that will work. And I think there's a good possibility here that we're going to be doing more harm than good. I certainly wouldn't want to be the person whose job it is to write this up in the NPRM.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

So, this is Patty. I would agree with what's been said. So my biggest concern is the sentence that has three words, it says "any copied text," and so that's really scary to me. So when I was at NIH, we did a couple of studies. We looked at something like 50,000 records and we looked to see if there was a 100% match on the free-text section that was called the assessment. Because we thought that, well you know, an assessment is where you really are pulling together what you saw and observed with the patient, and so that really shouldn't be the same every day, well, maybe, and that's where it gets sticky.

And so, we looked at it and sure enough, we found 100% match because you know there's software you can use to look at do you want just 80% match, or up to 100%, we said, no, no, no, let's look at 100% match and it was happening. And I can even show you the data, it's not published. And then when we took it to Medical Executive Committee and they mulled it – we showed them some of the issues with it and some of the repeated assessments, they didn't really know what to do with it. The end point of it was, okay, well let's put in place a process where we do a little bit better job of peer review. So people are looking at the quality of the notes and giving feedback to one another, instead of it being a system solution.

The other study that we did, and it's not published either, was to look at the safety impact of this copying – this is copying forward, this is all internal copying forward, not brought in from Wikipedia or a word document or anything. So we looked at the potential for safety, whether it mentions, let's say a laboratory result that was mentioned like three times and it was the same one every single day, and we knew it really wasn't, or the administration of a medication. And we went and looked and found out whether it was true or not and after going through really tediously all of these, we found that the safety impact on this was really relatively small. And I've got that data, too, it's not published either if anyone's interested in it.

So I'm agreeing with this group that this is a really sticky subject and for us to be able to definitively put some rules around it that people can follow and we can say, yes, you met the criteria, I think it'll be really hard.

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

So this is Mike, if I could – could I jump in with one more comment.

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

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

So there is one vendor I'm familiar with that does a really nice job of this that I think speaks to the point. So if I'm copying forward a section of text, like an HPI, it would look in a particular way and as soon as I start changing parts, the parts that I change look in the text translation different. So while I'm doing my work, I can see the difference between what I've changed or added or whatever, and what was copied forward, very helpful to me, very helpful potentially to the patient so he can see what's changed. The final note looks like a regular note, so you can't see it. But it's that kind of tool that I think at least was behind my interest in certification criteria that would help providers do things right, would help decrease the risk of things that are known to be completely unchanged from the past and the provider would sit there and tell you, I didn't realize I had copied something forward without change. So I think that's part of the goal I'd like to see, if we're going to keep this in.

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

So I think that was the goal, it seems like it is – it has been challenging and potentially impossible to write words that would allow any way that people could achieve the goal that Mike just enumerated. So, if we're not adding this certification criteria, then this could be subject to remove, because it was core in Stage 2, if I'm correct, then really we haven't changed anything and so there's really no need to continue it. Does that make sense as the alternative? We –

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

Well Paul –

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

Go ahead.

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

Paul, wasn't it 30% in Stage 2, so I would think more and more we certainly should be having people do more, if not all of their notes in the EMR.

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

Okay, that's a fair thing, we used to up the threshold, right.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, although – this is the other Paul, I sometimes wonder if there's any value in upping the threshold. If somebody achieves 30%, my guess is they're going to go all the way and do more, if it's useful to them. I don't know if you go from 30% to 40 or 50% you necessarily accomplish anything.

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

So this is Mike, I'll make the counter-argument for that, it relates to how much people strive to make improved templates so that it's easier to document, or at least as easy to document in the EMR as it is for the form. So in order to get all the way there, all those rehab forms, all those physical therapy forms, all those other kinds of things that are being done on paper today. Because you don't have to and you haven't gone to the time and effort and energy to build EHR forms related to it are going to go away if we make a higher threshold.

Paul Egerman – Businessman/Software Entrepreneur

My comment was not related to the forms, it was a general comment about increasing the thresholds. I just generally don't think that that is a necessary and useful thing to do. If people like it, if they start to accommodate it in their workflow, they will increase it on their own.

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

So why don't we – so let me just ask the question of – well, let me put three options on the table and see if there – we're dallying around one of them. So one option is to accept this concept and work on the wording. Another option is, it's actually too hard to describe the intent without having an unintended consequence of prescribing certain functions, or particularly the method of doing it. And the third is to keep it with an increased threshold. So, it goes from dropping it completely, because it was in Stage 2, and we're not changing anything, except potentially the threshold, keep the same and increase the threshold or push for the new certification criteria. Let me go ahead and try – go in that order then. Dropping it completely?

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

This is Charlene and I'll vote for that.

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

So this is Marty, me too.

Paul Egerman – Businessman/Software Entrepreneur

Yes, so yes Paul.

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

Okay. Keeping it the – keeping the functionality but raise the threshold?

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

This is Patty, can I just clarify. When you say increasing the threshold, that's just for the – for electronic progress notes?

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

Correct.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Okay, I'll vote for that.

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

So far just –

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

Dave Bates, I –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I, too. Leslie.

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

Okay, so there's –

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

Neil, too.

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

Okay. And then the final one, and maybe we can just elim – is to work on the wor – have new certification criteria with better wording.

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

So this is Mike, I would endorse that, I'm working on some wording now. The key question will still be whether development is high. My fallback position would be raise the threshold, but I'm working on some wording here, I'll try to forward in a minute when I'm done.

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

Okay, so this is going to be a little tough. So let's try actually counting votes. Okay, the first one was to drop the objective completely from Stage 3, and of course everybody knows that it still stays in Stage 2, etcetera, and we don't really have the complications that we had with public health. Okay, all in favor of that option?

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

This is Charlene, yes.

Paul Egerman – Businessman/Software Entrepreneur

Yeah – other Paul, yes.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Marty, yes.

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

I guess George, yes.

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

Okay. Option two is keep the requirement but raise the threshold from low, 30% to high.

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

David Bates, yes.

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

Mike Z., yes.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Patty, yes.

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

And Christine, yes.

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

Neil, yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Leslie, yes.

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

Okay.

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

Neil, yes.

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

Amy, yes.

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

I think we – I think everybody agrees now that we do have a majority for number two, they're not super different, but – okay, so we'll keep it and we'll change the threshold from low to high. Okay, next slide please. Okay, this is only a clarification; people didn't understand what did we mean by the abnormal test. It is that the EHR has no say in the abnormality if the transmitting source includes as the HL7 message allows, a flag that says it's abnormal, the EHR displays it. That's the criteria about abnormal, is that better?

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

So should we real – should we actually be using out of reference range rather than abnormal?

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

No, actually I want the lab to decide whether it's out of the range or abnormal for a different reason. In other words, I don't want to make a judgment that it was out of range or versus some other reason it could – I can't think of what it would be, but – you know what I'm saying?

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

Is abnormal the HL7 approved name?

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

So I'll just represent my pathology colleagues too, who say we never use abnormal in our results.

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

Yeah.

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

We state that a patient is outside the reference range and you will decide whether for that patient, since 5% of normal patients are outside the reference range, whether that represents an abnormal result.

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

Well I agree with you that maybe we shouldn't use the word abnormal, but what I don't want to do is say specifically out of the reference range. Because some results don't have a reference range, they have a different kind of range, like the dichotomous or something, so that's – so I – we should get the right phrasing for what we want. The lab indicates –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, can't we just say, support lab or pathology generated flags and not say –

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

Flags, maybe generic flag, yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– right, because they don't flag them unless it's an untoward result.

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

Is there an HL7 code name, like there's a field and it says, normal/abnormal, check or not?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, there's a whole range and there's a – yes.

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

What's the word for that flag that is checked or not checked?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I don't know off the top of my head, but it's not – it's a flag, but it doesn't – the flag has from anywhere from normal to abnormal or a range, it's a result with a flag that the lab has indicated is out of their norm. And I can find out for you.

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

Okay. If you can find out, we'll try to use the word to match it.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Will do.

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

Okay, thank you.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah – this is Paul. I wonder if there's another way to approach this. Would this be easier to implement and helpful if we just narrowed it to referrals, and say we want to simply close the loop on referrals?

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

No, we're trying to make sure, in this case, part of the intent is to make sure that "abnormal tests" get followed up, because that is one of our problems, it's been documented in the literature, etcetera. So, we want to give the system the ability to act on that and then pass that on to the appropriate provider.

Paul Eggerman – Businessman/Software Entrepreneur

And acting on it is simply telling them that it's abnormal?

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

Yeah. Or –

Paul Eggerman – Businessman/Software Entrepreneur

That's just displayed on – that's just displayed when they see it, I don't understand what –

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

Well no, but you can track it down, you can write rules that say, okay, if it's abnormal and then there's also critical, then it goes to this party and after a certain amount of time, if it's not been acknowledged – I mean, you can write rules around that, but you can't write it if it's not flagged. Okay, so we'll get the right words for this to match HL7 language. Next slide please.

Here, that parenthetical in red is to say, for patient-generated health data, because there are a lot of both policy and practices and workflow around this, we're right now keeping the scope at things that are requested by the provider.

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

So this is Mike, I would agree with that, but I'd like to make it easy for what that means in terms of, for example –

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

You've got –

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

Yeah, for example, if I put a questionnaire on the portal for my patients to fill out before every visit, I would hope I wouldn't have to send an individual request.

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

I think that you get to decide that.

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

Yeah.

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

That's the discretion of the provider.

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

Yeah, it's always in the measure though, how are we going to measure it, what's the denominator, what's the numerator and –

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

Right.

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

– what's going to count. Yeah, fair enough.

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

We'll let the reg writers –

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

Paul, just –

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

Exact –

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

I just want to flag for folks, this is referenced in the matrix, which is the part about you get credit for device data, but it's not on the slide.

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

Yes, that's correct. That is correct.

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

Okay and also, I just had a real question about the standards immaturity here. I think the immature was right if you're talking about device data, but secure messaging is highly mature, and Leslie, I don't know if you can speak to structured or semi-structured questionnaires, but I thought those were actually pretty mature, when we limit it just to those.

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

Yeah. Yeah, and the piece between the lines is yes, it's immature for the device and that's actually our explanation for why, despite our original desire, we can't get to devices because of this. So, if it comes up, I'll explain it that way.

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

Right, but I think it's –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, but –

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

– totally misleading to say that on the slide where device is never mentioned.

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

Okay, that sounds fair.

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

So I think we just need some nua – and you could say, devices immature and then other – the rest of them are mature.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, because we are naming standards that have already been in Meaningful Use named, and modified existing matured standards to accommodate patient-generated health data. So, when we reported on this to the group and asked for direction from Dixie Baker and others, if something is mature for provider, but newly used in the patient, is it immature; and the answer was no, it's not. It's right in the middle, because it's an existing standard, and in this case we're recommending the Consolidated CDA, questionnaire and the Direct standard that's already been named for transport or secure messaging when it's a proprietary system. So, it was the device area and there was still discussion about that, but we came away with, it was directionally appropriate to go forward with the standards we named.

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

Okay, so we can put open parent device or something like that to indicate what it applied to, or just –

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

Yeah, and then just add the mature for the others, yeah.

Paul Egerman – Businessman/Software Entrepreneur

Well, that's – this is Paul. I think it would be helpful to reemphasize the secure messaging, it's an important concept that we're going to somehow capitalize on secure messaging.

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

Yes, I mean, it's there. Okay. Thanks for that clarification. Next slide please. Education – we just found that we – somehow the language got dropped that's been carried all the way through, is it's publically available.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
(Indiscernible) This is the one – this is George. This is one of the ones referenced in the letter we talked about.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, in the Congressional letter.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
In the sense that they want the educational level target of the educational materials to be at the level of the patient.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
This is Leslie –

Paul Egerman – Businessman/Software Entrepreneur
That's not the same as what this says, though.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Right, they're asking for an addition.

Paul Egerman – Businessman/Software Entrepreneur
Yeah.

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

Paul Egerman – Businessman/Software Entrepreneur
Because I –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
They – and this is Leslie

Paul Egerman – Businessman/Software Entrepreneur
I'm sorry, go ahead.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
This is Leslie and we've been doing this for about 38 years as a non-profit, providing health education materials, and we just want to make sure that we use existing evidence and science about literacy, which is not a grade level. It is about plain language and understandability. The Center for Plain Language brings us specifications on this, as does the – there's pending legislation right now about a Plain Language Bill in Government Policy. So that might be a place where we would be able to lift language and apply here.

Paul Egerman – Businessman/Software Entrepreneur
And this is Paul, because what I hear being discussed is not what I think I see on the screen. What seems to be on the screen is something, if I look at it right, it's like incredibly easy to do, it just says, you have to be able to take publically available information, I guess like off the Internet, in another language and the Meaningful Use criteria is you just have to do this for one patient. So one patient comes in and you say, ah, you speak French and you've got a bloody nose, terrific; here's something on the Internet showing how to handle your bloody nose, and then I check the box and I'm done.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, so it's Christine. We –

Paul Egerman – Businessman/Software Entrepreneur
That's how I'm interpreting what's on the screen, so –

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

Yeah, you're correct Paul. And you had raised the issue previously of whether or not just doing this for one patient is meaningful or not. And we had a long discussion about this a couple of calls ago and what we agreed to do was to make this slide read like all the other slides. Which is to say, low or low, a small number, whatever, but rather than to say one, really allow CMS to sort of figure out what the best approach might be. We had agreed to that like a couple of calls ago, but it's not reflected here.

Paul Egerman – Businessman/Software Entrepreneur

But it's still – it just doesn't really accomplish anything, because – what everybody's trying say, because there's a difference between giving people educational material versus giving them material that they understand. And giving the patient the two, people understand is a hard thing to do, just to give them something is an easy thing to do, but it doesn't accomplish anything. And this slide it says just give them something in a different language –

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

Well, in their preferred language.

Paul Egerman – Businessman/Software Entrepreneur

– and you can get it off the Internet, and that's not – it's – in some sense it's incredibly easy to do, but it's not – I just – I still don't see that it accomplishes –

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

Well – so this is Mike. I think we've got to look a little at professionalism here, we also have to look at the tools that we have to use. I mean, we work very hard to give our patients educational material that's effective. So the fact that that's not in here, I don't think keeps us from our professional duty.

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

Right.

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

We purchased technology that has sixth and eighth grade reading levels, different languages, etcetera; if we want to make that a requirement, we could talk about that. My bigger concern is actually that if a physician doesn't find the actual one that was prompted by his EHR or her EHR, and then goes to the extra trouble to find one that's actually more useful, that doesn't count for Meaningful Use, because the computer itself didn't take information it knew about the patient to propose that specific information. And I think that turns patients off to the issue of trying to engage and do what they're trying to do. So I would like to see it change to be educational material provided by the provider, whether or not the EHR technology, from something it knows in the systems, prompts it. So I'd like to see that change.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and actually, I like that. I think that's a better solution.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. The patient specific language there talks about making sure that the education material is relevant to the patient's age, gender, chief complaint, principal diagnosis, problem list and others. So it gets to very specific information, which providers say all the time, I don't want all this general stuff, I want to get something that's unique. It never prohibits the ability to go outside and look for that additional information, in fact, everything that the NLM has done, and I think they're up to several – 18 million or more requests online, is coming in that format that allows for the specificity. So, I don't think that we are – there's nothing in the standard that mandates the specificity that you've talked about that it has to stay inside the EHR, it just mandates that when we request education materials, it's relevant to the patient and specific to their need.

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

No, no, but let's be very clear here. As I read it and as I've gotten feedback from CMS, if the EHR does not suggest the educational material based on something it knows about the patient, it does not count in our numerator.

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

That's correct.

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

That's correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

If the pa – if you use the National Library of Medicine, which is not inside the EHR or any content service outside –

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

Yeah, it's not about inside or outside the EHR, it's about the EHR knowing something that takes you somewhere that gives you that piece –

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

Correct.

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

– of information –

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

Right and that was the whole point was to be really specific, really patient-specific –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Um hmm.

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

– not just I have diabetes and so thanks for that diabetes brochure, but I'm this age or this functional status or I'm at this state of the disease, is it Type 1, Type 2, I mean I don't know, I'm not a doctor, right. But it's really supposed to be making it easier for doctors, frankly –

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

And it doesn't, that's all I'm telling you. It does not.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well, it's the most adopted – was in Meaningful Use 1, the most adopted menu item and when used, it was up in the 80-90% range.

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

Yeah, but that doesn't mean we're being effective here.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So I would respectfully argue about – argue against that.

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

All right, so let's keep it up then because I'll go on this one. What you see is it's easy to comply, but I think to – I can't remember who else said it, but to get the exact right material to the person is not easy. So when I had a 91-year-old with quadriceps weakness yesterday, and my ICD-10 could not tell me quadriceps weakness as a specific diagnosis, and we looked at what was available using the technology and then we went to a website for elderly to do quadriceps strengthening exercises and found the right material, that extra five minutes of work I did negotiating with the patient for this, did not count for Meaningful Use –

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

However –

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

Okay, but listen, that's fine. It's not supposed to cover everything, right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

I mean we're trying to move people in a particular direction, we're not trying to cover like every last patient that we possibly see and say that that's the best way to give that patient information. We're trying to – create a functionality and a use where people use the electronic health record to facilitate more people getting any kind of health education. Because remember, that wasn't a common thing in practices, other than the kind that maybe you and I and other people on the call run; it wasn't common that people got any information, they were shoved a prescription and sent out the door. So we're trying to move the culture a little bit using electronic technology, not cover every –

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

And all I'm saying is, you're doing it in such a constraining way you're discouraging certain best practices.

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

So, can I weigh in for a second here; its Christine. I think Mike what you're describing is an implementation issue, it's not a policy issue and so if there's an implementation issue that we need to fix around details, I think we could put something in the narrative to CMS that says, here's how it's really happening in the field, but here's how we intended it; I think that's fine. But from a policy viewpoint, I think Neil's right in that this is a good – this is the right – this is the policy direction we've been pursuing and have agreed to continue to pursue, but there may be implementation issues with how CMS has required it, that need to be addressed. And we can look more closely at those, I'm just not sure I completely –

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

I hear what you're saying, all I'm saying is that the policy difference we could recommend and implement if we desired, is a physician who uses their certified EHR technology, whether the technology itself was able to prompt for the right one. If they use their technology to find educational handouts, educational materials, even if the EHR didn't prompt them for it specifically, they should get credit for that in the numerator. That's a policy decision.

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

But I disagree with that because as a policy matter, because this is an EHR Incentive Program. So, if we were talking about an ACO Incentive Program, I would completely agree with you and say that that's right, but they also don't have to do this for such a hi – they don't have to do this for 100% of their patients. The threshold is low because – for exactly that reason. So, you've got to find the ways where the EHR can be helpful and find the right information, but if it's a really specific case where your EHR wasn't all that helpful, that's okay, because you've got plenty of room in your numerator.

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

So right now, one of the two EMRs I use on a regular basis has one strategy for patient education that meets this goal and that is to print the handout that goes with the prescription. Everything else you have to do manually, but they meet Meaningful Use criteria.

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

Okay, I think –

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

So that's the issue of the difference between meeting the rule and meeting the spirit.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And I agree and I think that that's also the difference between a menu item and a core item as we move to core item in Meaningful Use 2, we'll see that implementation improve.

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

I think this is something that's already been in from Stage 1, so I'm not sure it's useful to –

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

Right.

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

– debate the – because I believe there is value to what's here and it is consistent with the EHR Incentive Program. There can be other things, like Mike suggested. So right here, I don't – I mean, does the concept to – I don't know actually that we have time right now, and we have discussed it in the past, about literacy level, and I think we found it was hard. One is, it's hard to assess, two, there is no standard for describing the exact kind of educational material that would fit this indivi – so, it's a laudable goal and we need to move further on the ability to assess exactly what is appropriate for an individual and then try to match that to available educational materials. It's a good goal, but I don't think we're there yet.

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

Right, Paul, and I agree with you, I just was really raising the issue around one – the non-English language –

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

Oh, just the –

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

– and the one because, yeah, because well we had already agreed a couple of calls ago, since people were very mixed on whether it should be a percent or a higher number or whatever. So we had said that it was really the only one where we actually call out a number now, since everything else is low, medium, and high, that we would –

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

(Indiscernible)

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

Yeah.

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

Okay.

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

Christine, this is Michelle, I think we fixed it in the matrix, just not on the PowerPoint. So the matrix says low, this should be a number not a percentage.

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

Perfect.

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

So – okay. Thank you.

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

Okay. Can we move on? Next slide please. Notification, this is merely a – it's almost a correction. In the RFC we posted – we said 2 hours. We got feedback that's tough, and it is, but we recognized that for any intervention to occur, you have to know almost "while it's happening." So, and then we had used the word timely in the latest draft, and that – boy, that doesn't help anybody, so we're now putting in 4 hours versus the 2 hours versus timely. People comfortable with 4 hours; it still can be a challenge, of course, but the goal of this is notification so you can do something about it. So, that's why there is a time. Does it sound reasonable? Remember, this is just a recommendation.

Paul Egerman – Businessman/Software Entrepreneur

Is there a consent issue here?

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

What?

Paul Egerman – Businessman/Software Entrepreneur

For the notification. Is there a consent issue here, does the patient have to give consent for this to occur?

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

The way we have it here is, if required. In truth, HIPAA does not require it, as long as you are participating in that person's care. Each organization – organizations often elect more to ask for consent, so, it's whatever the organization's policy is. Okay.

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

This is Amy, Paul. Do we have experience that the ones that are doing alerts and notifications now are doing it within a 4-hour time frame?

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

This is a new – this is a new function so I don't know that we know.

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

I know a lot of HIEs are doing notification, I know in our case it is pretty instantaneous, so it sounds reasonable, but I can't answer whether it is or it isn't, because I don't know what the expert – I know a lot of our hospitals also notify, but I don't know in what timeframe.

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

In general if it's an ADT, it's happening immediately.

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

Yeah.

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

Okay, I just wanted to make sure. I mean I can't speak to whether it is or it isn't, I just want to make sure we think it is.

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

Right.

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

If we had any experience knowing that that was accurate or reasonable, rather.

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

Right. Well, we're going right now based on the comments we got back from the RFC saying that 2 hours seemed tough.

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

Too little. Yeah, okay.

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

Okay, next slide please. Immunization – so this is where we dropped – instead of the generic, being able to consume external knowledge, we stuck that requirement in here, partly at Art's suggestion that we be able to use external source of knowledge guideline and then be able to receive the result of that. So an example is immunizations; and the goal is, as immunization rules or guidelines change, then somebody, like the CDC, maintains that and when you describe this kid of this age and how many shots they've had in this series, you should – one way is to get back what's the recommendation here. Did I get that right Art?

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

So Paul, this is Art.

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

Yeah, please correct me.

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

Yeah. So, this is a good start, I just want to take us back to where we were in some earlier versions, maybe about a year ago. It said that we had the capability to receive, generate or access these recommendations. So that the way that its written right now is that the only source for a recommendation is the – let's say, the immunization registry. But some EHR vendors may actually take rules and implement them locally, so you don't have to receive the external results, you could implement it internally. So that's why the wording, just slightly different is, to receive, as it is stated now, to generate or to access at some other method, there are a variety of methods that this could happen and it is happening by all different methods around the country. I wouldn't want us to state it has to be one way and the other ways are not acceptable.

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

Well Art, so far – this is George. Remember that receive, generate or access means receive and generate and access for vendors, because this is a certification criterion, and I think we'd have to be a lot more specific about, we're saying, what do we want to add to the certification criteria, not what we're measuring. So we're not forcing anyone to do even this one, never mind the other ones at this point. So I'd have to look, so you're saying receive is not enough, you have to be able to generate. Well I think that's what our CDS rule is giving them the opportunity to do, so that would be the generate, or access. That one is the toughest because I don't know what it is they'd be – they'd need a link to go to some other system but we don't know what that other system is today.

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

I agree with you George, we just don't – I think there are a variety of methods here, it's not that I think one is right, but the way that it's written know about consuming results suggests that the information would only come from a registry, when indeed the local site could build its own rules.

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

The local site can still build its own rules, because we have a CDS objective, and they just wouldn't use this to consume the external rule – the not the rules, but the decisions of the other system. See what I'm saying, CDS is already allowing you to generate it, that's why we have that objective –

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

Okay.

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

– we have that one covered. Access I'm not sure exactly what we mean, I'd have to know what system I'm accessing.

Paul Eggerman – Businessman/Software Entrepreneur

So this is Paul. The way the rules part was explained to me, because I asked some questions about it, was that it might be something that is very simple, from just simple Boolean rules that is the kind of stuff that CDC has right now on immunizations. So that might enable providers to utilize those simple rules. The functionality that's being described, however, to basically receive and consume the actual immunizations, that's going to be pretty tough.

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

Right, so, hold on. What we're suggesting is simpler than your first one. I think the word consume is confusing people, ability to receive results of external CDS is what's intended by this bullet. So maybe if we change consume – we're not talking about taking any rules and doing anything with them, it's just the outside system –

Paul Eggerman – Businessman/Software Entrepreneur

Well, when you say receive an external CDS, I don't understand that. Are you going to somehow send information to the CDS about the patient and the immunization history and the age and –

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

They already have that –

Paul Eggerman – Businessman/Software Entrepreneur

– allergies and then it's going to recommend something?

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

Yeah. I mean what happens now, say in New York City is, they have the age and all the immunizations and they can generate recommendations about what immunization is next. And we want the EHR to be able to receive that from the city health department into my EHR so I can see the recommendations. I might have to be the one who does the – my E – I might have to do the allergy part. But right now what we want – because we don't want to have everyone have to re-implement – force everyone to have to implement in every system all the complex immunization rules. So this is just – it's like another lab result in effect, that's why it's simple.

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

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

But, so George, if you do get your flu shot at Walgreens or other immunizations at Walgreens, you're saying in New York it all gets reported? You literally are depending on this external registry to have all results and you're counting on that and how would you assess –

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

Well, no. I think the perfect's the enemy of the good here. What – normally what happens is a kid comes in, you look at the paper chart, you see when you last gave the immunizations and then you give them the next one, regardless of whether he's gone to Walgreens or any other hospital.

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

Right.

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

So what we have now is when we all try to submit to the central thing, I have more immunizations than I used to. Does every Walgreens send the childhood immunizations there, maybe they do. I actually don't know the answer to that, but it's certainly better than what I've got now, which is looking at my paper chart and making the decision with no other information.

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

So –

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

So I'll get the rec – so what you're saying is, is you rely on the information that is contained solely in this external source, to make its recommendations and you basically only receive the recommendations. And it seems like you should also receive the justification for that, right, so you can at least try to –

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

Yeah, but that's the first part. So the first part is receive the patient's immunization history supplied by the registry. The certification criteria is, you should also be able to get the recommendation along with it.

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

Got it. Okay.

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

So this is Art, let me just explain a little bit more about the three options here. I think the one that we just described is the immunization registry that may not be, as George pointed out, may not be perfect. It may not have all immunizations. A second option is one that we're exploring in Denver, is where you actually send the immunization history to a Web service that gives you the results and says, here's what you should recommend. So it could be the Web service, it could be the immunization registry. And the last one, which is the one that we're trying to get away from in Denver, is implementing the same rules inside of our own EMR. So, I think that there is an opportunity here to allow people to – or organizations to select the one that works best for them.

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

Yeah but Art, in your second one, what are we going to tell the vendors to do? We don't, it's like an experiment at this point that was –

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

No it's – well, there are vendors out there – in New York City, they're using this system, George.

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

No, but they're not – we send our immunization data to New York City, as per the previous –

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

Right.

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

– objective. And then they send us back both the data they have and their recommendations. So that's covered in this current objective.

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

That's correct, but that doesn't mean that everybody has a city that's using this Web service and –

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

Yeah, but what Web service are we going to tell the vendors to connect to? I mean –

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

– that's – they just have to connect to a service that gives them the right results.

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

I don't know, if I'm a programmer working for the vendor, I'm not sure what I'm – I don't know.

Paul Egerman – Businessman/Software Entrepreneur

Well, this is Paul. There's another issue, too, which I don't think you can look at the immunizations in isolation. I mean basically there's a whole process of preventive care and reminder system where you tell a patient, hey, you're due for your six-month or your annual physical and you've got to take – have the following tests and get the following immunizations. And there's lots of times the immunizations may trigger a reminder system and if you take all that stuff out of the EMR, I don't understand how that'll – you'd have a ripple effect on other aspects of how these systems operate.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. I think that someone just mentioned that if this is just another result that's coming from a registry or public health that indicates an immunization has taken place, the system that actually generates the rules reminders or that's relevant to care has to be where the provision of care is. And so this is –

Paul Egerman – Businessman/Software Entrepreneur

But I thought –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– indeed a result.

Paul Egerman – Businessman/Software Entrepreneur

– I thought Art was suggesting that the EMR systems would no longer do that decision support.

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

No, I'm not suggesting that.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I would disagree with that, yeah. I think the confusion is consume an external CDS. We're not asking that the external clinical decision support be consumed in the EHR, only that the immunization result be communicated back to an EHR where the care is given and any necessary rules that need to be fired would take place. So I would advocate that we remove the words consume an external CDS and simply the ability to receive results from external patient immunization registries or public health systems that would get to the issue. From a consumer point of view, this is one of the things that mothers just go nuts about, not knowing where their immunization, who's got it on track? Where is it? How do I record it? Do I need to do this over again? And I think this would be really good for public health and for consumer satisfaction, just simply getting that immunization in. And I think that drops the development down from high and helps to move this along.

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

This is Amy and aren't we talking about just the capability here and not requiring that it – I mean, we're talking about certification criteria for a capability. How the provider uses it in the outcome is not what we're tall – I mean that's in the actual objective. So I think in my mind –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, but it –

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

– we have to separate those two out, because –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Correct.

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

– from a vendor point of view, different – I mean again, there's – I'm talking from my state and I haven't been intimately involved of late, but there are sometimes the schedule is the schedule, but there are different products and depending on how vaccine is purchased and supplied, things may vary a little bit. So, vendors don't want to have to do this variation practice-by-practice, state by state. I think that's where Art is coming from, but I don't want to speak to him. So I think we need a little flexibility in this one, in terms of the certification criteria, not what we do with it.

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

So – and that's correct. So I wonder if I could ask George if you wouldn't mind summarizing where you think we are to propose for this group.

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

Well, I was actually proposing just changing the word consume to receive and leaving it – the objective that's on the slide.

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

Yeah.

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

Okay.

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

I think that covers the intent and what we agreed on last time, which is that we weren't going to go so far as consuming rules, we really just want to get the result to the external thing, that's the next step. I think most of what Art wants to do, I'm just worried about – well, I don't even know what it means to say that we're going to go to an external Web site, it's too vague to encode in a rule and I think this was our intent. We really want them to receive the history and have the ability to receive the recommendation that comes with that history. Period.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, I agree –

Paul Egerman – Businessman/Software Entrepreneur

Receive just means like look up, is that what you mean?

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

I mean that –

Paul Egerman – Businessman/Software Entrepreneur

You have a little bit of a patient matching problem, but you look up the patient's stuff and it tells you something.

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

Remember the first half says, receive a patient's immunization history. So I'm already receiving something, I'm just going to add on this extra field, which is the recommendation.

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

So if I'm understanding this correctly, if you're sending your data to a state immunization registry and they have an algorithm in the state registry and they send back a set of recommendations. That is what you're saying, then you would know that your – that this child is next due for X, Y and Z based out of whatever larger registry or set of rules it's being connected to.

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

Right. I mean I'm saying that's the next step, that's not the end-all, but that's –

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

Right.

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

– the step for Stage 3.

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

Right.

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

Art, does that work for – from your perspective?

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

Yeah, that works. George, just to let you know, in New York City they actually use a Web service.

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

Okay, well that may be –

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

It's an open CDS.

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

All right, well that may be where we receive – well that's what I was trying today, that in effect that's what we're doing, that's what I meant. Because the previous objective said, send your stuff, and that might be via Web service. And then we're going to get the history and recommendation back, which might be via Web service. So if that's what we're talking about, it's already covering it, in effect.

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

Okay. So I'd like to call the question here and it's what you see in front of you with the word "receive" instead of "consume."

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

Right.

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

And are people in favor of this?

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

Yes.

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

Yes.

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

Yes.

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

This is Art, yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

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

Okay.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Yes, this is Patty. Can I just ask a logistical question. So what we're asking here is for organizations to, along with their vendor partners, to determine a registry, it may be a state one or an immunization information system of some kind, so there might be multiple. And knowing that people move state – from state to state and across the country, we're asking them to figure out how to receive information from one or many or somebody help me out with the logistics of the potential for multiple systems that people would need to receive information from.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. That might depend by state.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Right, so would we be expecting – would the expectation be that we just – that they just connect to one – the one state registry or multiple systems or multiple states or –

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

This is Art and I don't know that there are expectations. I mean a practitioner practices in some jurisdiction and reports to a registry; Patty you're bringing up a good question, the patient may live in the next state over. I think some states, I think New York and New Jersey, have tried to do some sharing between the registries. I don't know that this is intended to ask providers to submit to multiple registries based on the residence of the patients.

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

Yeah, I think this is like George was saying before. I mean it's a great question and I don't think registries are at the point where state-to-state they're talking to each other routinely across the country. But I think to some extent we have to not let the perfect get in the way of the possible on this one.

W

Yeah, that's what I was just going to say. This is one of those, don't let the perfect be the enemy of the good.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Gotcha. Thank you.

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

But good question and something that we need to work on as we go forward.

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

Right.

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

Okay, next slide please. And the final slide, this is registries. This really is clarifying the word we used, “reuse” and what that meant is because this is an EHR Incentive Program the data has to come out of an EHR, so that’s what these new words are intended to state. Is it better?

Paul Egerman – Businessman/Software Entrepreneur

Well it’s better, I mean it’s still –

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

It’s still hard.

Paul Egerman – Businessman/Software Entrepreneur

I mean you’ve still got this – you look at the bottom of the screen, high provider use effort, emerging standards, high development effort. It seems like that’s –

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

It’s like the old story, the old joke – the food tastes lousy and the portions are small, it’s like –

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

Yeah, the – well, it is one of our focal areas and it also includes trying to address the needs of specialists. So it does get in the trap of where this is – does require high development, high effort in order to do that, but it’s part of population health.

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

And this is Art –

Paul Egerman – Businessman/Software Entrepreneur

I agree it’s population health, but I don’t feel like we should just check the box and say we’ve –

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

By the way, it’s menu – it’s menu also Paul.

Paul Egerman – Businessman/Software Entrepreneur

Yes.

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

And this is Art –

Paul Egerman – Businessman/Software Entrepreneur

Even so, we have – if we want do something with population health, we ought to do something that’s reasonable. This is one of these things that almost nobody’s going to do.

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

Well this is Art and I don't know that it's unreasonable, Paul. I think that there are plenty of sites that are actually doing this already and in Stage 2 we have the cancer registry, which does not meet those two high boxes in the lower portion of this slide. It has a standard, it's been implemented and it happens all over the country. So I think that – we are making it available to other opportunities, but there are some that are low provider use effort, will happen in Stage 2 and there's not that much development that really needs to happen, because it will be from Stage 2.

Paul Egerman – Businessman/Software Entrepreneur

Well if it was just the Stage 2 stuff, I wouldn't have any trouble, but this is more than Stage 2.

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

It's more than Stage 2.

Paul Egerman – Businessman/Software Entrepreneur

This is much more than Stage 2 and it's good that it says reuse the data, in one sense that's good, but the question is are there even registries that will take the data? Lots of these registries have their own like forms and things that you have to fill out and it just strikes me, you've got the emerging standards, high provider use effort, very high development effort and we're calling it a menu item and we're including it because we feel we need to do more with population health. And to me that's not a good enough argument, if we want to do something more with population health, we should do something that's reasonable. This strikes me as something that's not going to have a big impact.

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

It's Christine, maybe I'm thinking of registries in a different way, but if you're talking – I've always thought this was a clinical registries, which hundreds exist. And many, many specialties have their own registries because their area of practice is fairly specific, but there are big, national registries and Art mentioned cancer. So, I mean I just don't agree with your assessment that there aren't very many out there, people won't use this, they don't exist. This is an area that I think is actually pretty mature.

W

Yes.

Paul Egerman – Businessman/Software Entrepreneur

So you think there are mature standards for doing this, people are doing this all the time and this is just wrong what it says here about the emerging?

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

Charlene on this one. I think, what I don't know and I can't validate, but would support Paul in his comment that again, what we found is the requirements to submit data to registries vary, because there are different types of data that are required, different frequencies of data that's required. So I know the intent is to try and come up with a common standard to meet the requirements of all the registries, but that's a pretty high order, just because they have – they're programmed to do things in a certain way. So, I don't disagree that this would be of high value, if it would work, but I have to support the fact that I don't know the extent to which there's going to be development work on a common format that gets us to this end. And it strikes me that's going to be really hard.

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

So Charlene –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. I think that there was work trying to get to a minimum data set and they found that that had some value, but the disease-specific registries had more specificity –

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

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– required.

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

And provenance and time –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

However, using the standards that exist, if we named a high value area like cancer, where there was critical mass and the suggestion of a standard way to do it could inform hundreds of thousands of transactions that would be highly valuable. So, it's not the – a one registry that's difficult, it's stating that all registries choose from one. Is there a possibility that we could name a high-value health area that serves a large population that we would be able to address moving the public health, be able to minimize the high development efforts, use the existing standards and move this agenda?

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

This is Amy, I have a question, do certain specialties tend to use certain EHRs because they're more targeted towards that specialty?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Uh, no.

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

So – and where I was going with that was, would it be an option. I mean, I understand the fact that if you're trying to say do this generic for any registry and there's no minimum data set now, that's a potential challenge, and that's what I think I'm hearing. I was just wondering if we named a few where we knew there were some EH – like pick one or the other or the other. And gave a – so it's not just so limited to cancer, but there are choices, whether it's birth defects as a number of states have or chronic diseases, if there are some other more common ones, to give a little bit of flexibility in choice. Because my sense of our discussion on this has been a lot around less – I mean around population health, but also around trying to accommodate for some of the specialties.

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

Yeah, I agree with that, I think there's also a number of large registries for cardiac disease, Heart Association, American College of Cardiology. I mean, if you picked off the main ones, I'm by no means an expert, but if you picked off the main ones that would be helpful.

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

So then at least you're narrowing down what the vendors have to do from a development point of view while we sort of try to figure out if there – while someone tries to figure out, is there a standard minimum data set or some way to do this in a more generic way.

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

So are we moving away from this objective? We did narrow it from two different ones to one and it is menu. I think a big thought behind this is to try move more in this direction, despite its lack of being able to apply this universally for all people and all –

Paul Egerman – Businessman/Software Entrepreneur

And there's a – this is Paul again. There's a – I don't know how to describe this, like a fundamental challenge here which is that ONC has the limitation of only being able to deal with certification from what comes out of an EHR. It doesn't really have any way to impact what the registries –

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

You're right, Paul. We can't –

Paul Eggerman – Businessman/Software Entrepreneur

– receive or require. And so you have this – the concern I'm sort of trying to explain is the concern that we're going to require that these systems send out square pegs and the registries all want various sized round holes, and it just doesn't work.

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

Yeah.

Paul Eggerman – Businessman/Software Entrepreneur

I mean, it gets frustrating.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. Perhaps our suggestion would be not only one registry, but for ONC or CMS to recommend one condition or particular registry – one condition type that we could address. Because we do want to move this agenda, it's important for population and public health and to advance quality in research and many other things. But – so we don't want to throw it all out, but having every vendor comply with every single registry would be very difficult.

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

So we're running of time. I think this is a valuable discussion. I think sort of this – the effort row here at the bottom sort of speaks for itself and we may want to call this out. The value to managing populations, the value to specialists, but the challenge we face in having – in trying to have one system do all, not one-size-fit all –

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

Right.

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

– but one system do all and that's a real problem. And it's for that reason why we sort of have this special – special attention to this area. We certainly don't recommend it for more than menu and we do have an asterisk on this one. And the Policy Committee can decide either to leave it on the table as far as moving it on in the letter or actually taking it off, but sort of discuss the challenge we have with this. Is that a fair way of presenting this?

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

Meaning to discuss the challenges in the transmittal letter, but talk about how the – it's important –

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

Well, no, to talk about it – it's importance and the challenge that we face in front of the Policy Committee and the Policy Committee can decide that it wants to either accept it, reject it or put it as an asterisk and explain this. But obviously, I mean, Karen is right there, she'll –

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

Yup.

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

Everybody's listening, so – but, we do want to point this out that this has been challenging for us. Okay –

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

So Paul, I know we have to – I know we need to end, I just – someone mentioned before about letters, there was one other letter that we got around advanced directives. I don't know what we want to do about it.

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

At this point we don't have any further time and as I say, we're still in a process of hearing and people deciding, like ONC, CMS, then putting out their thoughts, then getting reactions, so there's still time left. But unfortunately we're out of time for our discussions. I think we've had a really good discussion on many, still hard topics. And those letters of course are public as well.

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

Paul, it's Christine, I think – the letter that Amy's referring to, it's not – I think it's not as hard to think about it as we might think. Because we did actually a lot of it, I think it's just worth – what it's saying is, move away from record presence and absence of advanced directives to providing a link to the document, and we've done that. So it might just be – we've done sort of that, like it might just be worth looking at that letter, folks can look at it offline and thinking about whether there's a way to strengthen it, because we heard the same feedback in the care planning meeting.

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

Yup, I agree. This is Charlene.

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

Okay.

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

Provide that link.

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

The other thing, we are arranging, as we talked about before, is because of the timing, and we're trying – we're in between two things, everybody wants more time, more lead time and that's what we're working very diligently to provide, but that does mean that we don't have as much feedback on, for example, Stage 2, as input. But, as you know, HHS is listening and looking at the feedback as they write their own proposal, and then certainly as they write the Final Rule. So our plan is to also have a listening session to get more information about early experiences and experiences as people are going through and then we're going to use our next call to help plan that listening session. And the listening session still, although it won't affect our recommendations at this point, it's still obviously going in the ears of HHS as they write their NPRM, etcetera. Anything else Michelle?

Public Comment

Rebecca Armendariz – Project Coordinator – Altarum Institute

Paul, Michelle had to drop off, but we're ready to go public comment when you are. If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you're listening via your telephone, you may press *1 at this time to be entered into the queue. We do have a public comment from Janet Hamilton.

Janet Hamilton – Florida Department of Health - CSTE

Hi, this is Janet Hamilton and I will be brief. I am from the State of Florida and I also am on the CSTE Executive Board. And I just wanted to thank the group for reviewing the letters submitted on behalf of public health and for having a very productive discussion around the request made by public health. So thank you very much.

Rebecca Armendariz – Project Coordinator – Altarum Institute

And we have another public comment from Allison Chi.

Allison Chi - Program Manager - American Immunization Registry Association

Hi. Yes, this is Allison Chi from the American Immunization Registry Association and I also want to thank the workgroup members for the decision made today to keep clinical decision support as a part of the IH objective. And that the wording change from “consume” to “receive” will still support the goal of IH to provide clinical decision support and forecasting to healthcare providers. So thank you very much.

Rebecca Armendariz – Project Coordinator – Altarum Institute

We have no further comment at this time.

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

Well thanks to the public for listening in and for acknowledging our responsiveness. Thank you workgroup members for a vigorous discussion and I think we’re ready to present to the Policy Committee and continue the discussion for our final letter, which is only part of the process. Thanks everyone, talk to you next time.

Public Comment Received

1. With respect to the conversation around EP syndromic surveillance. I wonder about an unintended consequence of that decision. If it is not part of Stage 3, I suspect that States will stop any development on Stage 2. We are then, in effect, reducing the number of EP menu items for Stage 2 from 6 to 5. Since the 2 registry items are least likely to be implemented, you are, in effect, requiring eligible providers to enable the other 3 menu items (notes, family history, radiology images). I believe this will increase the failure rate for providers who are not connected to a hospital or health system. It certainly will for rural providers in our State (Maryland).
2. I have a concern that "abnormal tests" may result in too many alerts. There are extraneous results that are technically abnormal but don't have clinical meaning. I would venture to say that most "abnormal" test results are actually irrelevant.
3. Specialists already feel that much of MU does not apply to them so if a specific condition or registry is named, there should be exemption for those for whom it does not apply.
4. This is Alison Chi from the American Immunization Registry Association (AIRA). We support the decision made today to keep CDS as part of the IIS objective, and the wording change from "consume" to "receive" will still support the goal of IIS to provide clinical decision support and forecasting to health care providers.