

HIT Policy Committee
Final Transcript
December 13, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to the 19th meeting of the HIT Policy Committee. Just a reminder, this is a Federal Advisory Committee, which means there will be opportunity at the end of the meeting for the public to make comment. Also, there will be a summary of the meeting on the ONC Web site. Just a reminder to committee members to please identify yourselves when speaking.

Let's go around the table and introduce the members, beginning on my left.

Deven McGraw – Center for Democracy & Technology – Director

Deven McGraw, Center for Democracy & Technology.

Marc Probst – Intermountain Healthcare – CIO

Marc Probst with Intermountain Healthcare.

Paul Egerman – Software Entrepreneur

Paul Egerman, Software Entrepreneur.

Judy Faulkner – Epic Systems – Founder

Judy Faulkner, Epic.

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

Paul Tang, Palo Alto Medical Foundation.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Art Davidson, Denver Public Health, Denver Health.

Linda Fischetti – VHA – Chief Health Informatics Officer

Linda Fischetti, Department of Veterans Affairs, representing Dr. Madhu Agarwal.

Charles Kennedy – WellPoint – VP for Health IT

Charles Kennedy, WellPoint.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Larry Wolf, Kindred Healthcare, for Rick Chapman.

Scott White – 1199 SEIU – Assistant Director & Technology Project Director

Scott White, 1199 SEIU.

Judy Sparrow – Office of the National Coordinator – Executive Director

On the phone, I believe we have Connie Delaney? David Lansky? Do we have any other members of the committee on the telephone? Okay, with that I'll turn it over to Dr. Tang.

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

Dr. Blumenthal is on his way from the airport, so we're going to postpone his opening remarks until a little bit later on in the day. He may or may not have a time when he has to be out of the meeting, so we might do some agenda scheduling if that becomes true.

Let me open up first with approval of the minutes, so we don't forget that. Has everyone had a chance to review that? If so, is there any motion to approve the minutes?

W

I so approve.

M

I second it.

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

Okay, any further discussions, omissions, edits? All in favor? Any opposed? Any abstained? Good. Well, we have a very full agenda, with important updates from many of the workgroups, and most of them actually are asking for some actions, so we will get right in.

We'll start out with NHIN Governance Workgroup recommendations presented by both John Lumpkin and Mary Jo Deering. The Meaningful Use Workgroup will update us on the detailed draft recommendations later on this morning. We'll have a lunch break, and then hear from the Information Exchange Workgroup on provider directories, followed by the Privacy and Security team update on their recent hearing regarding patient matching. Aneesh Chopra will not be presenting on the Enrollment Workgroup at this meeting.

We'll begin with the Governance Workgroup recommendations. John Lumpkin, I understand, is on the phone and Mary Jo Deering is here.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Why don't we start off with our first slide? I just want to thank everyone for their forbearance. We had not planned for this presentation on the 13th and I needed to be up here in Princeton. What we're doing is that obviously we got a lot of very good input from the Policy Committee at our last presentation. Our workgroup went back and met once or twice a week for the last month to come back with a set of recommendations. What we're going to do with these recommendations is to keep them at a fairly high level, having presented at the October and November meeting, fairly detailed background material. So we want to take it to what exactly we believe the decisions that should be made by the Policy Committee. Of course, at the Policy Committee you can decide which decisions you actually do want to make and give further direction to the committee.

The members of the committee, next slide, are on this one and I wanted to thank them for their yeoman work in pulling this together since we came together first in August. Again, thanks to Mary Jo Deering and Mariann Yeager for their stellar work, along with other staff from ONC in helping us get to this point.

What I'm going to do today is talk about where we are, how we got to this point, and what our recommendations are. I'm going to tell you that our report is included in two different slide decks. The first deck, which has just a small number of slides, are those recommendations that I had talked about that we're looking for approval by the HIT PC, and the second deck are the background materials, many of which you've seen before, which has been revised based upon the conversations that we had at the Policy Committee in November.

The workgroup started with initial meetings. We had a public hearing in September. We did work in October looking at our first phase recommendations. They were presented to the October Policy Committee. We presented again in November, so this is pretty much how we've gotten. Our final recommendations will fall into the following six categories: principles, the Health Information Network as a

preferred approach, federal leadership, conditions of trust and interoperability, validation, and oversight. So let me move to the recommendations.

The first recommendation is that the nine principles for the Nationwide Health Information Network governance be approved. These recommendations for principles that I've presented before are transparency and openness, inclusive participation and adequate representation. This one always has the asterisk, including consumers, which we think is critical. Effectiveness and efficiency, accountability, federated governance and devolution, moving decisions to the point at which they can best be made, clarity of mission and consistency of actions, that relates directly to the next one, fairness and due process, promote and support innovation, which we felt was critical and should be reflected throughout all the activities that we'll talk about later. And then finally, evaluation, learning and continuous improvement. We recognize that the governance process is essentially putting tires on a moving car, and as such the process of exchange is going to be going through transformations and we believe that this governance process needs to identify those changes, understand where new or unrecognized barriers exist, and then change to remove those barriers.

Paul, do you want me to step through all the six recommendations and then take questions, or do you want me to take comments on each one?

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

Yes, I think that would be appropriate, thanks.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Which one?

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

Go through all.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Recommendation two is that the Nationwide Health Information Network should be an environment of trust and interoperability for exchange based upon conditions of trust and interoperability, and it should be the preferred approach for exchange of health information nationwide. As such, we believe that it should be supported by the federal government, with strong incentives to vigorously promote adoption.

Our third recommendation is that there should be federal leadership and shared responsibilities. Federal leadership, the federal government should establish fundamental conditions for trust and interoperability and utilize its full range of authorities to assure compliance, that we need to recognize that there are existing state authorities across all relevant domains and facilitate coordination of harmonization with state and other entities as needed. This may be entities in the private sector; it may be currently existing governance mechanisms.

Now, federal agencies should participate fully and directly in the Nationwide Health Information Network and its governance. By that, we want to clearly indicate that we see roles, while we will say later our vision is that there's a leadership role for the Office of the National Coordinator, that there are other federal agencies such as the Veterans' Administration, which we believe need to participate fully in the network and its governance process. And that the federal information exchange should be conditioned upon compliance with the requirements so that the federal government should not get a pass on having to meet the conditions of trust and interoperability. Then finally, shared responsibilities reflecting the fact that we have this concept of governance of governance and other entities should have specific appropriate roles within the framework as established and monitored by the federal government.

Recommendation four relates to the conditions of trust and interoperability, and that the Office of the National Coordinator should establish conditions to assure trust and interoperability, optimizing broad stakeholder input including consumers and doing so in a way that will encourage and support innovation.

The conditions of trust and interoperability should provide a baseline and address the need for variability. Some are required and apply across all health information network scenarios. Others may be required in certain particular circumstances.

We're going to hear later about some issues related to provider networks and exchange and we recognize that there may be some conditions of trust and interoperability that may not apply across all groups. Then that the governance rules should establish an initial set of conditions of trust and interoperability. By initial set we mean that we don't believe that this process can wait for the full scope of potential conditions of trust and interoperability to be fully determined and spelled out. That to encourage exchange to occur and to occur within a reasonable time frame, that we would expect that the federal government would make an initial cut, issue initial set of conditions of trust and interoperability. Then establish in that rule a process for adding and modifying conditions of trust and interoperability, and should provide maximum flexibility for innovation and adaptation. This would include for instance, a waiver process so that if there's some experimentation going in the field the federal government should create an opportunity for that innovation to occur in an environment that may be established by a waiver process.

The potential conditions for trust and interoperability would be, for example, this is not an inclusive list but is for illustrative purposes, privacy, security, interoperability, other policies, and includes technical requirements. That if we're going to have conditions of trust and interoperability and we're going to have entities that are participating in the environment of trust and interoperability that we call Nationwide Health Information Network, then there must be a mechanism to verify that the conditions of trust and interoperability are satisfied and that we recommend that when this is set up that there is a balance, a balance between the cost and a balance between the burden of validation and the assurance that they're being made, leveraging existing validation methods, processes, and entities where appropriate. For instance, certification would be an example. It may be validation that occurs through an entity such as a health information exchange or other means, and those should be leveraged.

Then validation should be required when exchanging in the Nationwide Health Information Network environment and asserting, and when someone asserts that they're in compliance. That there should be various methods for Health Information Network validation, which is appropriate to specific conditions of trust and interoperability and level of assurances that are needed and so that that mechanism would not be all—for each condition of trust and interoperability there would have to be some determination of what that process of validation would be that would most appropriately meet these principles.

Finally, oversight, that the Office of the National Coordinator should oversee governance and assure accountability. This means coordinating between federal agencies, between state agencies, validation entities and other governance mechanisms, that the Office of the National Coordinator monitor and highlight innovation as part of the process of promoting innovation. That the Office of the National Coordinator should address any governance barriers that are determined based upon the monitoring process and begin to identify ways to remove those barriers. To provide ongoing evaluation and continuous improvement of the governance process, so those are our recommendations.

I'd be happy to answer any questions, or listen to any comments.

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

Thank you, John. Mary Jo, do you have anything to add to those before we get started with questions?

Mary Jo Deering – ONC – Senior Policy Advisor

No, thank you.

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

Okay, so we'll open it up for questions. Paul Egerman's up first.

Paul Egerman – Software Entrepreneur

Thank you for a great presentation. I especially liked the way you put all the detail in the context. It was extremely helpful because we had more time for discussion. I was thinking about the whole issue of NHIN governance and validation and trying to understand how that relates to the certification process. It seems to me that if a physician purchases a system that's supposed to be certified and is certified, then it's a reasonable expectation that it will operate on the NW-HIN. So you're putting forward some various requirements and technical requirements as to what's involved in meeting all of these conditions of trust. Is it the case or isn't it the case that whatever those technical requirements are have to also be included in the certification process? Otherwise, people will buy certified systems and discover they won't necessarily operate according to what you need for NW-HIN.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

I think the answer is mostly yes. There will be technical requirements that don't apply to individual provider or systems providers' electronic health records. So technical requirements that may talk about how an HIE communicates with another, how we set up a directory of providers, those will be technical requirements that will not be part of that certification process.

Paul Egerman – Software Entrepreneur

Isn't there then another recommendation or an expansion on these recommendations that the certification process include all of the technical requirements that are necessary to operate on NW-HIN?

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Actually, no. It's really included in the validation recommendation so that certification would be the validation of meeting those conditions of trust and interoperability.

Paul Egerman – Software Entrepreneur

But then that means, John, if I buy a certified system it might not pass validation.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

I think that represents one of those coordination functions that we would see the Office of the National Coordinator engage in, so that because they oversee the certification process, once they establish the conditions of trust and interoperability one would assume that the next logical step would be then to have them incorporate it into the certification process.

Paul Egerman – Software Entrepreneur

I guess I personally would like to go one step further and make that part of our recommendation. Otherwise, this is very confusing to the purchaser, because they have two things: they have to get a certified system and then they have to go through a validation process. So I think whatever the requirements are, the technical requirements or any of the other requirements, but the technical requirements are that pass validation have to be in certification, that would be the least.

Now there's a flip side to it too, which is whatever your test process is in certification should be the identical testing process in validation. So you run into a problem if you have one methodology to test, say, on a certain interface or technical thing for certification, but you test it slightly differently than you do validation that it's possible you could pass one and not pass the other. So there needs to be some very close coordination there, I think. I guess that's just my view, is that any technical requirements for NW-HIN have to also be in certification and any certification testing process has to be identical in the validation process. Otherwise, we're unnecessarily creating two mechanisms that are, at best, confusing to a market that's already confused.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

I agree.

Mary Jo Deering – ONC – Senior Policy Advisor

What I was thinking of is we have here sort of a Venn diagram, and the way I would interpret what you said, Paul, which I think is absolutely true, is that any of the technical requirements that pertain to EHRs that a physician provider would need to be assured of should indeed be included in the EHR certification. I think what John's point was is that as you think of all the types of exchange going on there will be some that are simply not relevant to the individual provider per se. So I think what we would take, what ONC would take away from what you said is to take a look at our certification program and to make sure that it matched completely to any of those technical requirements that pertain to that setting and make it complete so that there is indeed no need to go through multiple groups.

Paul Egerman – Software Entrepreneur

Yes, I agree. There may be other things that don't pertain directly to group practices or to hospitals. But another way to phrase what I'm trying to say is if there's a purchaser, in a group practice I purchase a certified system or a hospital purchases a certified system the reasonable expectation on my part as a purchaser is that I'm all set now and I can operate on NW-HIN, that it has the technical capabilities. Now, there may be other things I have to do in terms of behavior or policies, but at least I have the technical skills, technical capability to do that.

Mary Jo Deering – ONC – Senior Policy Advisor

I think we agree to the extent that we are speaking about exactly those technical requirements that apply to a provider to exchange information through the system that he's purchased.

Paul Egerman – Software Entrepreneur

Right.

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

Deven?

Deven McGraw – Center for Democracy & Technology – Director

I read the validation process as also being about the spectrum of COTIs for which there's probably policy in there. So it wouldn't be the case that if your system is certified that you're done. Yes, I just want to make sure that that's crystal clear.

Paul Egerman – Software Entrepreneur

But it shouldn't be the case if you buy a certified system.

Deven McGraw – Center for Democracy & Technology – Director

Right.

Paul Egerman – Software Entrepreneur

... do it.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Paul Egerman – Software Entrepreneur

... this is some bell and whistle or some tool or something.

Deven McGraw – Center for Democracy & Technology – Director

Absolutely. This is an excellent set of recommendations, by the way. I can't speak for anybody else, but the one thing that I want to make sure we understand at the Policy Committee is that notwithstanding some, what I perceive to be strong statements in here about the federal government writ large, so maybe not even just ONC, needing to use its full range of authority in order to assure compliance.

I want to make sure we understand that there's a big difference with respect to making sure that people comply with these COTIs between having them be law and having them be, for example, enforced through meaningful use levers that require participation in the NW-HIN. Only because I think, especially when you get to the privacy and security issues that we've teed up some recommendations on, it's quite possible that for some we might actually suggest as a Policy Committee that they be enforced on everyone. Not just people who are voluntarily participating in NW-HIN, versus other criteria where we want to establish a higher bar and create the NW-HIN out of the trusted mechanism of exchange. So we are encouraging, it's almost like thinking about best practices, above and beyond where the law would go. But just answering these questions about COTIs and having a process for establishing them in rule making doesn't really answer the question of which ones do we want to be law and which ones do we think are appropriate to enforcing this process.

So I'm not actually suggesting that these recommendations be modified in any way, but just that we understand as a Policy Committee exactly what we're doing, which is setting up a process. But we haven't quite yet taken the steps of saying all right for the COTIs that we would want to see out there and established which ones do we think really ought to be for everyone and which ones do we think ought to be part of this voluntary structure that we're trying to establish and very much encourage.

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

Any other questions? Yes, Marc?

Marc Probst – Intermountain Healthcare – CIO

On recommendation six and the NW-HIN oversight, we talked about ONC should oversee the governance and assurance and coordinate between federal agencies. How much specificity do we have on that, on who's going to be involved in the governance? When I think about governance, it's a fairly logical structure of decision making that's going to drive to a conclusion. I guess the recent example is the ... report that came out that seems to have some overlap with this particular NW-HIN issue. Does this have any meat? Saying ONC can coordinate this process; does it have any meat? Or is it still just going to happen all over the place and we're putting in a body that makes us feel good that we're talking about overall governance of the NW-HIN?

Mary Jo Deering – ONC – Senior Policy Advisor

John, do you want to take that?

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

No.

Mary Jo Deering – ONC – Senior Policy Advisor

Fools jump in where wise men fear to tread. I think the answer to that is you will have many opportunities to see us flesh this out and come back and you are quite right. What this says is both sort of a foundational floor and guidepost as to where the Policy Committee may want to send the ONC team as it begins to draft all of those details and then I'd like to make an additional comment that I shared with some of our staff on Friday. I've already laid out about three pages of policy issues that are going to need to have to be decided for us to set this up, not just the COTIs themselves, each and every one of which has to be considered and decided, which one is it, how are you going to get there, and who makes the decisions about it. What I suggested is that we begin to, with all due respect, take a look at the agendas of the Policy Committee and the Standards Committee over the next six months. Make sure that we have plugged in at the appropriate spots all the input we're going to need from you, because they're across the board, as you've already sensed, and we need that kind of input or we won't get to that detail.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

And I'll just add, because I did answer too quickly, this is going to be a process. The first step in the process is saying that ONC should play that role. That's not going to filter throughout the whole federal administration, but with support from senior levels in the administration we can begin to make sure that

across, whether it's the Federal Trade Commission or others, that they begin to realize that there's an importance in coordination and that the ONC should have that role.

Connie Delaney – University of Minnesota School of Nursing – Dean

Given the comments just made and in relationship to Marc's question and then the previous discussion related to the certification, I want to very much support that the recommendations from this group overtly and transparently represent the need for the coordination between the certification standards and the work being put forth here. I think given at least the large number of players at the table and the fact that there's an evolution unfolding here, it makes it more imperative that we ensure in writing this coordination.

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

Thanks, Connie. Any other comments or questions? I think the sense of the group is that they're very appreciative of these recommendations. I think the biggest question is the one that Paul Egerman posed, and is the workgroup in a position to accept that and would you like to propose an additional recommendation or attach it on to one of your recommendations, or how would you like to do it there?

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

I would suggest, and see if this language works, in recommendation five, if we can get that slide up, slide number 11, that when we say there should be various methods of validation, we should say one more hash mark, which is that certification should include applicable conditions of trust and interoperability.

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

Say that one more time, please, John.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Certification should include applicable conditions of trust and interoperability.

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

So EHR certification?

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Yes.

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

Yes. Go ahead, Paul.

Paul Egerman – Software Entrepreneur

EHR certification will include applicable—it's not should. It has to be the same, is what I'm saying. I actually had a second comment too, which is how any validation testing methodology that is used should be identical to any certification testing methodology that is used for the same technical test. I'm not necessarily wording it right, but I just want to make sure that we don't create two different test approaches too.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

So if I could suggest what would incorporate that, I will leave it to the will of the committee. After my years in government I always thought that "should" means it's a recommendation and "will" is what happens when it's adopted as a rule, but EHR certification should include applicable conditions of trust and interoperability and EHR certification is a pathway to validation for those conditions of trust and interoperability.

Paul Egerman – Software Entrepreneur

I agree with that, but we have to keep in mind that there will be other players in the NW-HIN who are not certified. So you think about, say, commercial laboratories, if a commercial laboratory has a validation process and you're validating a laboratory interface and use a different test methodology than you use for

the EHR laboratory interface, you're going to have a problem. So that's my point is that we need to make sure that there's coordination between the validation testing and the certification testing. In other words, if we have two different testing approaches and people are going to get very frustrated.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

I guess what we intended under the second hash mark under the first thought point, that ONC should leverage existing validation methods, processes, entities where appropriate and maybe we can say "including currently existing testing."

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

David Bates?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I'm reluctant to say that the two should be identical. I definitely think they should be coordinated. But the way things have been done so far is that the validation has been an extension of certification and there have been things that were certified that did not necessarily include full validation. So that is the way that it's been done so far.

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

I wonder if the word is "incorporate" because that doesn't stop the further validation but it takes advantage of the EHR certification.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I certainly want to see them both be on the same page.

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

So David Bates was saying it's almost a limitation if you make it identical. Other comments? Should we have a final read on that recommendation, the additional recommendation?

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

I'm sorry, I wasn't tracking. Maybe if someone there was taking notes. Mary Jo?

Mary Jo Deering – ONC – Senior Policy Advisor

I'm taking notes, but I'm not sure. I don't know where to insert the "incorporate." I've heard two things. So up on the top at the second hash mark "leverage existing validation methods, processes, and entities where appropriate, including currently existing testing." Then add to the bottom of the slide, under various methods of validation, or actually, I guess would it come at the bottom of the slide, John? Or would there be another hash mark up on top, but wherever it is John's language when EHR certification should include applicable COTIs and EHR certification is a pathway to validation for those COTIs. My question, John, is your initial suggested additional hash mark—?

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

It probably should go up under the first one.

Mary Jo Deering – ONC – Senior Policy Advisor

Under leverage, right. Okay, so would you like me to read that one more time, or did everybody get that? So all of these additions come at the top of the slide under the first main bullet. The second current hash mark would now read, "Leverage existing validation methods, processes, and entities where appropriate, incorporating currently existing testing." There would be an additional hash mark underneath which would read, "EHR certification should include applicable COTIs and EHR certification is a pathway to validation for those COTIs."

W

That's a testing piece which I had as, "Any validation testing methodology should incorporate the testing used in the EHR certification where applicable."

Mary Jo Deering – ONC – Senior Policy Advisor

Oh, that's where ... came. Would you repeat that, because I didn't understand that as a separate one? Would you say that once more?

W

"Any validation testing methodology used should incorporate the testing used in EHR certification where applicable."

Mary Jo Deering – ONC – Senior Policy Advisor

Okay.

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

Does the group need a re-read of that, or have we gotten the three points? So is there any motion to approve the recommendations from the workgroup?

M

So move.

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

Second. Any further discussion? All in favor? Any opposed? Any abstained? Well, Mr. Chair, I deliver you a recommendation

M

I should have ... even later.

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

Thank you very much to the workgroup for presenting very cogent and concise recommendations that I think will advance

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Thank you.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Thank you, John. I missed the best part, but all the work was done, which was just perfect.

John Lumpkin – Robert Wood Johnson Foundation – SVP & Director

Thank you.

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

We'll go back to the opening remarks by the National Coordinator.

David Blumenthal – Department of HHS – National Coordinator for Health IT

I feel like the weatherman, actually. It was 55 and misty this morning in Boston, in Baltimore there were snow flurries, and here it was brisk and semi-clear. So here I am just bringing you the Eastern Seaboard weather report. I want to thank John again and I want to thank the Governance Workgroup. This has been, I think, among the most challenging, unexpectedly, for me, interesting and exciting set of recommendations. If you had to step back and ask, "How is this going to come together? Where is the glue going to come that's going to make interoperability work from a political, social, economic standpoint?" the governance recommendations are really critical. So it's great to hear that they have been greeted with such— Well, I didn't hear the discussion so I'm assuming they were greeted positively. Anyway, they were approved.

We are actually today, if it hasn't been mentioned already, watching all our grantees from around the country crowding the local airports and train stations, bringing their own weather reports undoubtedly, and tonight and tomorrow and the day after we will be interacting with them, learning from them, watching them teach each other. I'm not sure which of you around the table might be among them, but if you are we look forward to your participation as well. So this is in some ways a unique week, a milestone week for the HITECH Act and all its programs. As I've been traveling around the country greeting and meeting the individuals who are part of this new grantee community it's been truly enlightening and inspiring. To see that there now is a community of people who in all the 56 states and territories, in local communities around the country have signed on to the HITECH agenda and are trying to make the programs that you all on this committee are helping us envision and elaborate, making them work at the local level. So this is an important week for the program and now that you've endorsed governance recommendations I think an important week for the policy development.

I also note that the Meaningful Use Workgroup has made a lot of progress and look forward to hearing about that, as well as the Information Exchange and the Privacy and Security Tiger Teams. So there are a lot of parallel streams moving, we hope, in a way that will bring them all together very soon.

I look forward to the rest of this meeting. I'm going to have to leave for about an hour to go meet with our Beacon community grantees who are having their own pre-meeting today, and I'll spend about an hour there and then come back for the remainder of the meeting.

Paul, I don't want to hold up progress any further, so let's move on to the next agenda item.

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

The next one is the Meaningful Use Workgroup, so I'll just move chairs. This is an update by the Meaningful Use Workgroup which George and I co-chair and have the benefit of the counsel of all of these people listed on the slide as part of the Meaningful Use Workgroup. In this presentation, I'm going to briefly recap the process we've been using to develop the stage two draft recommendations, go through them with you, and then conclude with the time line.

First, just to recap from last time, we had a series of hearings over the past year which focused on some of the needs of the specialists, the small practices, the smaller hospitals, state issues, health care disparity issues, patient and family engagement, and population public health and care coordination. This is all in a broad sweep to get additional input and formal input from various perspectives. We had the CMS and ONC rules come out and we've used all that as a starting place for the deliberations in stage two and three. Last time you heard us talk about some directional approaches or philosophies in dealing with the next two stages and we've positioned stage two as a stepping stone to stage three, trying to set a destination, a trajectory at least and a road map to give both the industry and the provider community more time to move in that direction.

The other thing we tried to do is move more towards outcomes where possible, knowing that that's still an early science and also not wanting to discard any processes that are important to continuously improving outcomes across the board. We know the importance of parsimony, and Tony Trenkle's way is we don't want to hang a whole bunch of Christmas tree ornaments and just keep adding to it. We want to get the really important few. We had a notion that this is not to describe the world as it might be in 2050, but really an escalator, as Dr. Blumenthal describes it, erasing the tide and floating all the boats. So the functionality we propose, the objectives we propose are intended to be a floor and not so that we can pass the threshold on giving everybody the capabilities of continuously measuring and improving their outcomes. By having a floor, that also opens up room for innovation, by pushing it too high and prescribing too much you would tend to dampen or even stifle innovation, so that's part of our rationale for using floors.

Important for this discussion today, this morning, is that what we're going to present you are draft recommendations for discussion. There are still two more opportunities we'll be bringing back to this full committee for discussion, so this is prior to going out with a request for public comment, as we did with stage one. Where we can't a full agreement here, and we didn't have full agreement on each and every one of these proposals, we're putting it out for public comment.

So we're going to go through, and I think perhaps the best way is to discuss each screen and then open it up for comment and work through that way rather than go through all of them at the same time. The first category, which as you'll recall improve quality, safety and efficiency in health care and reducing health care disparities, we're looking at these four objectives. So on the left you have the final rule, on the right you have the proposed stage three and some comments where appropriate, and we're going to focus today's discussion in what is in yellow, which is the proposed objectives for discussion and public comment in stage two.

So in CPOE, as you recall, this committee originally recommended CPOE for all orders and that got back down to CPOE for medication orders in the final rule for good reason. But we would like to advance the ball from 30% CPOE for medication orders in stage one final rule, to CPOE for not only medication but also lab and radiology orders, and that the threshold be raised 60%. So we're basically trying to go after more of the orders that have a great deal of impact on patient care. By the time people have had two years' experience in stage one, for example, we think that they should be able to move on to other orders. Importantly, just like in stage one we don't require it to be transmitted to those departments, for example, laboratory and radiology, so that requires other interfaces to be in place. The important thing is for the system to provide feedback to the ordering provider at the time they're making those decisions, so that's why transmission is not crucial at this point.

The second row is drug-drug interaction. In the final rule for stage one it's just that it's enabled. This is an interesting topic. It seems like a no-brainer in terms of trying to avoid drug-drug interactions and drug allergy interactions, but yet what's available in practice has a high false positive rate. In other words, there are far too many alerts than are clinically reasonable. So we've actually tried to tackle this problem by saying employ drug interaction checking on appropriate evidence based interactions. What we're calling for is additional work to create much more credible drug-drug interactions, much more relevant drug-drug interactions to occur in practice. We understand that ONC has a contract with Rand to work on this problem, and others are also working on this problem. So right now we're trying to put this issue before us and generate some discussion, but also generate some additional work to narrowing the kinds of interactions that are currently being alerted to ones that are much more evidence based and more actionable.

The third row deals with ePrescribing. Right now the final rule says 40% ePrescribing. We've raised that to 60% and we've also added hospital discharge. The reason that hospital discharge, which as everyone knows is a very important transition time, was not included in stage one because that wasn't available in current software. So again, we're hoping that with two years' experience and its advance lead time that vendors can put this functionality in their systems in the inpatient sector, so we've raised it to 60% and we've included hospital discharge.

The final one on the screen is record demographics. This was a new kind of functionality so that's why it's at 50% in stage one, we've raised it to 80% in stage two, and we're headed towards using the full IOM categories that came out after the publication of our recommendations for stage one. In stage two we've basically raised the threshold from 50% to 80%.

Let me pause there for questions and comments on these initial four objectives.

Marc Probst – Intermountain Healthcare – CIO

I was wondering if schedule two and schedule three narcotics are included in ePrescribing or what the committee's recommendation is in that area.

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

Currently they're not included because I don't think we have a final rule on that, so it's a little bit up in the air. I think it's always said where appropriate or where permitted, so in this case if controlled drugs at this point in time were not permitted, then they don't count in the denominator.

Marc Probst – Intermountain Healthcare – CIO

Just a couple of questions. The first question is on not specified transmission that is on CPOE. I don't think I understood what you were clarifying there.

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

Well, what we're clarifying is it's not an end-to-end, so the license provider needs to make an order in the system. However, the system may transmit it via printed copy, for example. So this avoids saying that there must be an electronic interface between the ordering system in the EHR and all the ancillaries, at this point in time.

Marc Probst – Intermountain Healthcare – CIO

This would suggest just getting the order in with the interaction with the clinician.

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

Correct.

Marc Probst – Intermountain Healthcare – CIO

I have two other quick questions. My first question goes to all the percentages, are they arbitrary and just trying to grow it? Because we don't have any history and it's probably going to be ... for me today and we really haven't gathered a lot of detail. I know MC has, but I'm not sure we have a workgroup that's digested what has been brought in and the success rates people have had. So I don't know if going from 30 to 60 is a huge mountain for people to climb or an average mountain for people to climb.

Then I think the last question before you answer that is on the hospital discharge ePrescribing, if that vendor capability doesn't exist today there are a lot of challenges with ePrescribing. Just certifying an ePrescribing application takes months and months because the way it's happening today, I don't know where the vendors are, maybe Judy would know better than I, but it seems to me that if it doesn't exist today that's a pretty high bar to put out there for people. Then to have faith that they will all get there in time for the hospitals to actually implement that functionality. Those were my questions. Thanks.

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

The first one has to do with the experience and whether the bar is too high, so a couple of things. One is this is going out for public comment. The second opportunity we'll have in this full committee discussion is after we get back and digest the public comments. And the third opportunity will be once we get some initial experience from the field, from a combination of the early adopters who are submitting in the early time frame in 2011, as well as all the information coming back from the RACs and all the surveys that are being done. So there are other opportunities to get that kind of experience.

You asked whether these percentages were random. They weren't random. We looked at stage three, and so by 2015 we thought it would be important that, for example, 80% or 90% of x would be available, and that still is our goal. The reason it's not 100% is because there's still some kinds of outliers and still special situations. Then we pick something in between. For example, in CPOE once you have it up and running, it's not as if you want to only apply it to half of your population, whether it's in a practice setting or in a hospital setting. So we thought that 60% really means you might have in a hospital some department, some ward that might not be fully computerized, so that's the reason why it's something around half.

You asked about ePrescribing, and clearly we have to take into account how is the country doing and we're putting up a milestone for 2013 and estimating that 60% should be possible, but that's something subject to revision based on other experience and other data we get from the field.

Yes, Judy?

Judy Faulkner – Epic Systems – Founder

I think the 60% and the 80% is going to depend a little bit on the—

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

Which objective?

Judy Faulkner – Epic Systems – Founder

The first one, CPOE.

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

....

Judy Faulkner – Epic Systems – Founder

Yes. If it's an oncology facility, for example, that takes specialized CPOE and it may be a lot harder for oncology than it would be for general. There are some other areas too that I think you'll look into and find it's going to be very hard. Your ePrescribing does mean that there's going to have to be an ePrescribing implementation for every hospital and the question I have on demographics is, are they the same demographics as in stage one?

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

I'll work backwards, the demographics, yes, they are the same as in stage one. We thought about moving to the IOM categories by stage two, and it's just a question of how it would be new functionalities, new categories, etc., and a new work process for the providers. So that's where we fell on continue stage one, but up the threshold and then move into ... IOM categories by stage three. The circumstances, and oncology being an example, I think it would be no different from stage one in the sense that we've already put on the table CPOE for medications, 30%. As I say, it's sort of hard to say you only automate 30% of your practice. So you have a puzzled look, and maybe I'm not addressing your question.

Judy Faulkner – Epic Systems – Founder

Yes. Like I said, I'm not sure I get that. In the oncology department where the CPOE is tremendously more complex than oncology, so they have to buy a separate product sometimes. So it's not the general purpose EHR necessarily that does that.

Paul Egerman – Software Entrepreneur

Correct. You think that 40% wouldn't allow for the ... oncology?

Judy Faulkner – Epic Systems – Founder

Well, I'm more worried about the 80% coming up. But it will depend, so if you're going to go to Memorial Sloan-Kettering or if you're going to be at MD Anderson does that rule them out of these?

M

Paul?

Paul Egerman – Software Entrepreneur

Like Judy, I had some questions about the demographic data. It says 80% of patients have demographics reported and can use them to produce stratified quality reports. How do you know for sure that that metric is met, and ... I have a question, from stage two to stage three you go from 80% to 90%. It doesn't seem like a big jump relative to the other jumps. So that's just a question. On the

demographics, Charles had an observation, and Deven and I present perhaps after lunch on the patient matching hearing, one of the things that we learned a lot about patient matching as it relates to the information exchange is the quality of the demographic data has a huge impact. It could be that we might make a suggestion to you as to how to alter this a little bit. But those are my comments about demographics.

The overall comment is if you think about stage one, it would be great if we could write these so that fundamentally it was objective as to whether or not you met them. And ... objective is that the EHR system could produce a little report as opposed to having the situation you have right now, where you have ... which is uncomfortable. I'm on the board of a hospital and we're just nervous about having to ... to something that is this complicated and are we getting it right. You really would like to get it right, but if the metric's 60% you don't want to attach to it in terms of you only use 58%. So ... do you think of those comments?

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

We certainly are trying to, and I think CMS and ONC did a good job with stage one trying to move for some of the objectives that came out of this committee and try to get them into things that could be measured objectively and automatically by the EHRs. So that's point one we're trying to follow that. We do have those as goals and if you point out something where we have a better way of measuring something, we certainly would be open to that. With respect to the demographics, are you suggesting that we make it more stringent or less stringent in stage two based on your patient ...?

Paul Egerman – Software Entrepreneur

More stringent in stage one, do you mean? I'm having trouble with raising the bar for stage two. I'm just not sure about this part where it says "... and can use them to produce stratified quality reports," as to whether or not that's measurable. I'm just wondering if there's something else we could choose that's easily measurable.

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

I think that can almost be certifiable. In other words, can you use demographics to produce reports out of the EHR that would stratify whatever you're measuring, whatever quality measures you're reporting on, by these demographic categories. That's where some EHRs cannot do that easily now and they have to export them, for example. What this is doing is asking that the certification be, the criteria be ... of being able to get the stratified out of the EHR and making it easier at reducing the burden for the providers.

M

I just wanted to comment about the oncology situation, that it is harder but there's even more benefits if you do computerize it. ... was a similar issue, it's clinically very complex but it appears that there's a lot of benefit. In terms of Paul's comment in going from 80 to 90, once you get up to the high end it does get to be a lot harder. So even though that may seem like a small increment, that's the kind of thing that actually makes me more nervous.

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

Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director

I just wanted to check, since it seems like at this point in response to one of the questions we thought there would be the same demographics as in stage one. We will come to the public health piece where we make reference to contact information for patients of value to public health, which improves efficiency and our ability to control disease, so is it the same demographics as in stage one or are we expanding to include the address, the phone number, and the municipality?

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

I'm trying to remember what's in stage one.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I did look back in the final rube just now and I don't see that there. So that might be something we need to revisit.

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

It certainly can be. We didn't intend for it to be more than stage one.

Judy Faulkner – Epic Systems – Founder

I think that the need to be specific and everywhere we say "in general" or in the second one "appropriate evidence based interactions," anything that is vague at the end of it won't be vague. If the vendors are to do this on time, because there's a very little time frame, all that vagueness needs to be cleared up very quickly and not left vague, so those demographics need to be defined. "Appropriate" needs to be defined throughout everything, if we're going to make the dates.

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

That's exactly right. Now we did get some input from this brand contract, and I believe the results are coming in very early in 2011, I don't whether anyone can offer input on that, and we're hoping that they literally come up with some categories where you can produce much more actionable evidence based drug-drug interaction alerts. So that's where we're headed and then that's why the wording is that way in today's discussion.

Judy Faulkner – Epic Systems – Founder

But the need is really for the vendors to be able to do the development needed for the users to install it. If we have to back that up, because there's such a short time frame in there and I think we should put some date on, that by this date we will know what it is, rather than let it slide.

David Blumenthal – Department of HHS – National Coordinator for Health IT

This gets to the time frame for producing stage two of meaningful use regulations and a question of when things are specific enough for the vendors to move forward. The current plan is, as I recall, around summer to have this group make recommendations to the Office of the National Coordinator. Obviously, the process that has been laid out by Paul, which involves a round of public comment revisiting will give us fairly ample time to try to get specific.

Having said that then I feel that I have to remind everyone that this will then go through the sausage maker in the Department of Health and Human Services and ... and the White House and round and round. So there may be some modifications but I think that we are acutely aware of the need to make this as early as possible and yet not so early that we don't take into account the experience of stage one. That's the balancing act that we're constantly engaged in. How late can we make it so that we can learn from stage one? How early can we make it so we can provide warning to the industry about where we're going? I don't think there's a right answer to that except as late as possible and as early as possible.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

One comment on demographics, you want to be careful not to be defining the national EHR. So we don't want to get into a situation where we're saying, okay, demographics, what are all the demographic fields one could want and then what are all the next fields and the next fields and in fact come up with requirements for an entire EHR. So our first cut at demographics was to say what things aren't being collected, what things do we really need to achieve a clinical goal.

Now, if you're finding that in fact people aren't collecting address and that we need that for public health we can add that as necessary to the definition, if you think there are things that are missing. But we don't want to be in a situation where we're telling everyone every last field they need to collect for demographics. Some of it is driven by finances and so forth. I think we just need to figure out what it is that is not being done or won't be done unless we say it.

M

I agree with that, George.

Art Davidson – Public Health Informatics at Denver Public Health – Director

It's just that in terms of disparities you have to look at it in terms of strata by race and ethnicity. You could also look at it geographically by what neighborhoods are more likely to have certain problems, less assets, things like that. I know that there's an intent to focus on some of the social determinants of health over time from these systems so we need to be thinking about that down the road. I agree. We can't do every little data item here.

M

So this may be one that we do need. I just want to clarify. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I want to support the sense that we want to put in enough time in this project so that we get feedback of what people are actually able to do. That as we go into stage two that we not only signal people but we actually have concrete requirements so that vendors can build the things that are needed and so that providers can then implement those. At an earlier meeting months ago, there was a lot of discussion about a ballpark of 18 months being needed from the time the regulations were finalized until the providers would start their calendar year of demonstrating use. I'd like to point out that the proposed time line at the end of this in fact puts us in the same bind we were in with stage one. That NPRM goes out at the end of '11, presumably we'll get then a final rule in the summer like we did this past time, which gives three or four months before the start of the clock for providers to qualify.

So one of the things that is not in here that maybe I can put out is helpful or controversial is that we think about moving out the start of stage two. So that part of what we signal here is that stage one continues longer, these people are baseline to achieve to the current bar. Then that we give people the time to actually implement things we're proposing in stage two with feedback from stage one and not start stage two until 2014.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Charles?

Charles Kennedy – WellPoint – VP for Health IT

When I look at this, I have a hard time knowing whether 60% is the right number or 80% is the right number. But one thing that comes to mind is, is there any value in creating a meaningful use objective around cross-cutting measure. For instance, linking several to, say, anticoagulation management, which has a component of prescribing, has a component of structured lab, and might have a component of clinical decision support. I'm just wondering, is that being too prescriptive? Or is there some value in looking at a disease state and kind of using that as an organizing principle in some of our objectives?

M

This might be, and I don't think there are ..., a good time to switch over to address exactly that question on the next screen. Is that fair?

Linda Fischetti – VHA – Chief Health Informatics Officer

I have a question on this one. The 30%, someone was just sending me a message saying that right now it's 30% of patients have had a CPOE order metric, moving it to 60% of orders versus the patient. Is that accurate? That's what my message says. So the percent of patients is a much lower bar than the percent of orders and are we doing two switches at once?

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

I don't think it was our intent to do a switch, so whatever—

Linda Fischetti – VHA – Chief Health Informatics Officer

I want to check the wording on—

David Blumenthal – Department of HHS – National Coordinator for Health IT

It is 30% of patients right now.

Linda Fischetti – VHA – Chief Health Informatics Officer

So if it goes from patient to orders it's not just moving from 30% to 60%, you're really moving a lot.

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

We didn't intend to change the denominator, we intended to add, so for CPOE for Rx orders we were going CPOE for Rx lab and radiology orders, so not to change the—

Linda Fischetti – VHA – Chief Health Informatics Officer

Okay, as done before?

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

Yes.

W

Okay, you might want to ... that

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

Absolutely.

David Blumenthal – Department of HHS – National Coordinator for Health IT

There is no bar in stage one for lab orders, so the question I guess for the group is are you talking about 60% of patients have at least one medication order in stage two? Is that the—?

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

I see what you're saying.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Or do 60% of patients have at least one of several types of orders, which would be changing both the type of order and the percentage.

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

That's a good question.

M

Sixty percent have one of the three. You would say 60% have each of the three because they have ... in order, 60% of patients. Actually, what it says here is 60% of orders, so backing off of that would be of patients, but not backing all the way to any one of three.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Okay. Neil?

Neil Calman – Institute for Family Health – President & Cofounder

It doesn't change me just because we had patients in the first round that we need to go with that. It's not really the appropriate denominator. We're really looking at orders, and I think if we want to lower the percentage I think we should stick with what our recommendation is, which is orders. It doesn't seem to make sense to count the patients when you're really counting orders. The problem that we're solving is

how do you count the paper orders, and so we need to come up with an objective that doesn't make them count paper orders. So that's what we just have to think about when we phrase this.

David Blumenthal – Department of HHS – National Coordinator for Health IT

The reason that we changed that from 30% of medication orders to 30% of patients was precisely because we wanted to hold very firmly to the principle that we not increase the amount of paperwork in the process of implementing information technology. That would have been the net effect of saying that of the 30% of orders because people who don't enter all their orders electronically would have had to count all the orders in the paper world. So I think that the patient denominator makes a lot of sense in this process even though it's, in some sense, imperfect. But it may be the lesser of evils.

Neil Calman – Institute for Family Health – President & Cofounder

Another option is for the common denominator to be the charges, the claims for all orders, because that's one way to capture it. But we can come back and

David Blumenthal – Department of HHS – National Coordinator for Health IT

I want to just see as we think about the right number at each stage. One of the clarifying and simplifying aspects of setting your goal and then determining planning backward what you have to do to get to the goal is that in stage two the level set is in some sense the right level to get to stage three. It's not a level that has absolute value in itself. Its value is a step toward an ultimate goal. So though we're talking about stage two everything we say about stage two has to be viewed in light of what stage three is. It's true that 60% of CPOE, whatever the denominator is, and 80% of the CPOE, whatever, 60% is a stepping stone to 80%. One might say it's too high a step, it's too low a step, but I think we may not have to justify scientifically the value associated with each of those steps as long as we're comfortable that we're going in the right direction.

M

Okay, if there's no—

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

... on that comment but I think there has to be a reality applying to it based on what people can actually achieve for stage two. Even if it's a stepping stone, if it's an unrealistic stepping stone everybody's in the river.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Absolutely. Up to their knees or their waist?

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

I wish it was just the knees, yes.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Okay, we were going to take on Charles' question.

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

On the next slide, I'll address Charles' question. Originally in our framework and the way we viewed criteria for meaningful use is to try to come up with one objective that was HIT sensitive, that is where HIT is known to cause an improvement to be made. The other is to use the exemplar approach, which is very much what you described. The way we were hoping to implement that is through the quality measures. So if you could measure and improve upon, let's say, your mammography rates, for example, there's a lot of things that have to be in place, including CPOE, for example. So that's where we in the past have been focusing our attention for the exemplar strategy that you enumerated.

So we're still using that and in the first one since going out with stage one we've created sort of a Tiger Team on clinical quality measures, that David Blumenthal and David Lansky co-chair, and we'll hear an

update, I think we're hearing an update from them. Hopefully they're working on the same problem, which is we can't measure everything. Let's measure things that are one, HIT sensitive; and two, are a good exemplar for testing the entire system end-to-end in the way that you described. So what we're doing with the other functional objectives are to say what are the functions of an EHR that we would imagine are known to produce improvement in practice and care. So it's a bit of doing both, measure them out at the outcomes knowing that you need some of this functionality to get to where you want to go.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Paul, if I could elaborate on Charles' question, it would have been possible and it's still possible to mix these ... particular objectives with a disease related or a problem related objective. One could even imagine a total reconfiguration of the framework that would give people a chance, or institutions a chance, to take an alternative path altogether, which set objectives around disease management using IT and you could choose, you could be on track one or track two. Did your group give some thought to that? If so, could you discuss it?

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

Sure. We did talk about some of that in one extreme to say oh, gosh, you're doing really well. You can just test out of the whole process. Neil Calman is one of the folks who countered with what that opens you up to is teaching to the test or gaming and what we're trying to do is to make sure that the systems that we're asking people to install and effectively use have the capabilities for everyone to tackle whatever problems are germane to their local situation. So we still thought it was good to make sure that there's functionality built in to certification criteria into these systems that give people the capabilities to measure and improve their practice on a continuous basis. So that was the counterweight to saying you could, in a sense, test out of the system.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Let me ask Gayle for

Gayle Harrell – Florida – Former State Legislator

Yes. When we're talking about quality measures, are we moving down the line of being specialty specific? Because we had backed off of that and it's hard to test quality measures for another specialty. Really, we've not looked at how we want to broaden this to include many of the specialties who really are going to have a difficult time qualifying under stage one. Are we finally going to get down to the point where we go with specialty measures and allow specialists to get into this? We need to make sure this is as broad based as possible.

David Blumenthal – Department of HHS – National Coordinator for Health IT

So the answer to that is that the quality working group is paying attention to that. They are trying to come up with measures that are as robust and practical as possible. We are always going to be limited by the ability of measures in some specialties. Some specialties have been slower to come up with testable, valid, reliable measures and that's just a handicap we face. There will be many more measures available in stage two and stage three, whether they will pertain to every conceivable specialty, of which, as you well know, there are a large and growing number, I think we'll have to be practical about.

Gayle Harrell – Florida – Former State Legislator

I think it's important that we make sure we have the ability for every specialty to qualify. I think that it's incumbent upon us using public dollars to make sure that we do this as broadly as possible and that there's an opportunity there for every specialty to qualify. We certainly don't want to go inventing criteria for quality measures, I don't think that's our role, but we want to make sure that there's some mechanism within the framework we established that gives the opportunity for all specialists to qualify.

David Lansky – Pacific Business Group on Health – President & CEO

Can I make a comment? Sorry to not be present. Gayle, I think the sentiment you're expressing is shared by the Quality Measures Workgroup. As Dr. Blumenthal suggests, we are a little bit early in the

process and we're beginning by identifying measures, which hopefully can be applied to all specialists and the measures solicitation that we have out right now. The request for comment will be an opportunity for us to hear from the measurement community as to what they have that is likely to be ready for deployment during the time frame of stages two and three. So I think when we get the responses back from the field in the next year or so we'll have a sense of what the inventory is. Then we'll have to make a decision whether the cross-cutting approach will apply to virtually all specialties or whether there is enough robust measurement available, specialty by specialty, that we can put something together that would allow individual specialties to qualify. I think we'll end up frankly with a mixed bag that will lend to some policy discussion by the full committee at some point.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Judy?

Judy Faulkner – Epic Systems – Founder

I'll just add to this. As I was looking at record vital signs and record smoking status, in general practice a lot of the organizations may have significant psych departments. Will they be doing that and how does that affect the denominator? Will that harm them in their 80%?

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

I think the current stage one specialists are allowed to test that particular measures don't apply to them.

Judy Faulkner – Epic Systems – Founder

So we're okay then.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, and I think that the group has to have a discussion about what its approach is to certain basic public health questions. In the case of psychiatry if you're giving out medications that have hemodynamic consequences it's very important to know what the blood pressure of your patient is and also, for example, Effexor has major blood pressure effects, and the other thing is that the biggest, biggest problem in smoking, and persistent problem, is among patients with severe mental illness. So it is really vital for psychiatrists actually to know what the smoking status is. I think that it's easy to conclude that certain public health issues are not relevant to particular specialists, but if you probe what you sometimes find is that they're not traditionally done even though there is a strong rationale physiologically, medically, for this information to be known. Charles?

Charles Kennedy – WellPoint – VP for Health IT

Just to finish up on that quality measurement point, the thing that worries me a little bit is that that quality measure, the data there might be rather noisy, because you aren't starting from zero. Obviously people are getting mammograms, let's say, at a certain rate and there are so many confounding variables going on. We've had situations where we thought a mammogram rate went up because of one of our programs, and in '2 fact, somebody else had a bus that came around. I worry that relying on a quality measure may not give us enough of an appropriate link between the intervention and the measured outcome to be able to point to, hey, we created values through the deployment of health IT. I think there might be some value in more tightly linking that in a condition or two.

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

I think that's fair. I don't think we're preventing people from sending around the bus, though, and that's a good thing. So I think with a variety of measures we're hoping to catch the good that's being done with the deployment of these systems.

W

Dr. Blumenthal asked me to ... so I can help you run the queue look out, so I have Marc and David.

Marc Probst – Intermountain Healthcare – CIO

I feel like I came right out jabbing, and you did an awesome job on this again, I mean, the work and the thought and the sensitivity, so thank you. I really appreciate that. Now, I'll go back to jabbing. On recording the smoking status are any of these percentages, particularly that one because it's at 90%, do we know what's a reasonable percentage? You get people coming in to ... and it's busy and crazy and you don't always do everything you want to do or mean to do in a lot of these settings, is 90% a reasonable number? It may well be. I just don't know if we have any statistics to back that up. Because these are cut-and-dried, 90% you're going to get a 3% penalty or you're not going to get your incentives.

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

So before you start jabbing, can I at least do the presentation? So, should I continue on the presentation then?

W

Well, let's pick up David first.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I feel, having done a bunch of studies on looking at quality and trying to improve it, I feel like we're just not going to be able to get the tight links that we want. If we set up the goal posts and people know where they are and get there, then I think we will have been successful. It may or may not have been related to the HIT. It might have been due to other things. On smoking status, we're approaching that level already and it is an achievable thing. In the U.K. they've done far better than that.

W

This is to remind folks if you haven't looked ahead in your packet we have 11 more of these slides. Okay, Paul, take it away.

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

The CQM we just talked about in response to Charles' question. The next three, maintain problem lists, med lists, and med allergy lists we intended for this to be up to date and yes, in stage one the final rule that CMS issued was just that it sort of exists with one or none as indicated. At this point we're still interested in this notion of up to date, we're trying to figure out ways, as people mentioned, to be objective and automatic, where you can try to capture that something is up to date, but don't have at our disposal right now, other than doing some kind of random audit for a sample chart. So that is one possibility. Another is our approach to sort of rely on some of the other measures to motivate people to maintain the up to date status of these lists.

So for example, with medication reconciliation hopefully that would mean that your medication lists would become more accurate and more up to date. Similarly, for clinical summaries as they're being transmitted from the provider to the patient or provider to provider that would seem to be good motivation for these lists to become more up to date. So in some sense our approach right now is to use these other measures to help drive the completeness and accuracy of these lists and from a functional objective and criteria point of view continue stage one measurements, at least in stage two, and move towards the up to date measures in stage three.

Record vital signs, now the vital signs and smoking status are actually that it has been recorded. So neither of these require each and every visit to have a vital sign and there is some wiggle room in terms of some specialists being able to attest. I don't know who decides whether the attestation is correct, that such-and-such a measure doesn't apply to them. So with the provisos that occurred in stage one, what we did in these two instances is to up the measure threshold from 50% to 80%.

So now I'll be open for questions and

W

Turn while you can, Paul.

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

Okay, good advice. Now we're getting into another interesting area where I think we've come up with an approach that does what we're asking, which is have a floor but not stifle innovation. So that's clinical decision support. We came out with the one rule and then the ... had five, and then the rule back down to one, and I'm not even sure there's even, and I think the rule was quite permissive in what you called clinical decision support, so I'm not sure that anyone has a definition of clinical decision support. Yet, we might know one if we saw one. So we're trying to at least come up with the spec of attributes of one that you might see because of this problem with the definition. So we came up with eight attributes and these are things that we believe need to be present in order to inform and influence decisions that are made in the care of a patient for their positive

The attributes are, one, whatever pops up ought to have a source, so it has to be authenticated. Two, it should be credible and evidence based. Now, you start getting into a discussion, well, what's evidence based? Another alternative might be evidence rated, but the notion is when you find out what the source is, the person writing the order, the provider, needs to be able to say never mind, that's credible or not. That's the attribute.

The third piece is that it should be patient content sensitive. What's that? Why is that there? For example, people have called it textbook or other kinds of non-sources like that that are very general decision support. Well, yes, those are decision support, but it's not getting to the point of using the information in the EHR to make the information relevant to a specific patient available to the ordering provider. So that's what that's all about.

The fourth is invoke relevant knowledge. It's not helpful to say, well, I've got something here, go find it. That just doesn't help people get to what's important. How do you make it so that the trivial thing to do is the right thing to do? The way you do it is to make it patient content sensitive and relevant knowledge for that patient's decision. This is timely. That's to say you get much better response when you present it at CPOE time, computerized provider order entry time, rather than having the pharmacist trying to chase after people after the fact, for example.

Patient workflow, no matter what you put in this is sort of rule 101 in EHRs is if the workflow is too cumbersome it just doesn't get used, so that's why that is there. It's integrated with the EHR, that's what makes it a meaningful use concept because this HITECH is to promote the adoption and effective use of EHRs and PHRs, and so having a system standalone somewhere else is not fulfilling that prime objective.

Finally, that the information, the clinical decision support is presented to someone who is licensed and is able to act on it. So with those eight criteria we're imagining that you can apply that to whatever a vendor or provider says is clinical decision support, and if it meets those tests it probably is along the lines that we intended. So rather than say you must have one of these and three of these and so on and so forth, we really wanted to set a floor of attributes that we believe that would make good use of this technology, EHRs and PHRs, and yet not stifle innovation.

The second one is implement drug formulary checks. Right now that is a menu option and our recommendation is to move that into core. The challenge over in the comment section is that it's pretty hard to keep up with formularies per plan per specific, I don't know what the term is, maybe Charles can ..., there's a plan, like a health plan like WellPoint, but then there's all these plans for any one employer or individual markets. But anyway, to keep up with the formularies that may change with all those is pretty challenging.

The final one is advanced directives. What I want to acknowledge is that Tony Trenkle did advise us that we may want to get an additional public comment. That's our intent, but right now the final rule says that the existence of such an advanced directive is present in the electronic record, but it doesn't say that the actual advanced directive document itself needs to be there. What we've done is to say that, yes, the

existence should be there and if it does exist that document should be there as well so people can get quick access to it. It does bring it over to the provider's side, since in stage one it only applies to hospitals. So we think it's just as important in the provider side as well. So it adds providers and it also adds the actual advanced directive, which can be scanned of course when it's available. So that screen is open for discussion.

W

Marc?

Marc Probst – Intermountain Healthcare – CIO

On the first one, on CDS, is there a ninth? I know you're going to say he's adding something, he's on drugs, but is there a ninth? Related to outcomes shouldn't the system track the results of using that decision support protocol so that you can learn and you can grow and modify it or whatever you should do?

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

That's already in stage one, so it's to implement the CDS rule and track its use. So the same would apply to

Marc Probst – Intermountain Healthcare – CIO

Okay and Then the second one on the percent of patients, and this may also have the same answer, but the percent of patients like on advanced directives, is that from a period of time? This whole historical database and patients that we may not have recorded smoking status or an advanced directive, is there a way to ... that?

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

I believe the denominators for all these things are people seen during the reporting period.

W

Judy?

Judy Faulkner – Epic Systems – Founder

I've been really interested in evidence based medicine and from what I've been speaking to with a lot of different groups, the general rule of thumb I hear is that there's less than 10% of it available for decisions. So if there's really less than 10% there's a bunch of questions that come up here. One, when we say high priority health conditions, do we know what's available? If we don't know what's available we're setting a bar that isn't realistic and one of the things I think is pretty exciting now is that there's a bit of talk, I think the IOM is using this terminology now which is practice based evidence rather than necessarily evidence based medicine. I think that a lot of the evidence based medicine rules go back to paper based methods back in the 1970s. So I do worry about that authenticated source cited which applies, it was published in a journal, and so I'm nervous about what do we mean by that, number one, and the lack of it that might not be there for

Secondly, is this something that the EHRs should be certified on, or is the EHR primarily the mechanism to push it but the certification must come from a different area which publishes evidence based medicine or decision support rules and the EHR can drive it. So that's my second question, how does the EHR get certified on this?

My third is, I've seen quite a lot of user organizations cut down on their alerts because of alert fatigue, and some really interesting studies have been done on it showing that if you really pare it down you get much better response than if you have a lot then they lose that importance. So I guess those three things: separating it from the EHR, the dearth of real evidence based medicine, and alert fatigue.

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

Okay, starting from the top, at least on this slide. So high priority conditions, recognizing that the HIT Policy Committee doesn't determine what's high priority but the secretary will as part of the ACA, so she gets to set the high priority conditions will follow. Presumably, she will set high priority conditions for which there is evidence that we can do something about it. Typically, people do set them because there's a gap but there's an addressable gap, so presumably there's evidence around that. The authenticated, which I also mentioned, that's just listing the source. In order to get him and his professionals to engage in something they've got to say where's it coming from, do I believe it? That's points one and two. So authenticated means that you just list what the source is.

Judy Faulkner – Epic Systems – Founder

What are the sources? If the source is I've talked to four people and here's what they do, what is the—?

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

You ought to put that down and it will be up to the ordering professional to say do I believe those four people? But obviously the—

Judy Faulkner – Epic Systems – Founder

But where's it coming from, yes, is it coming from the EHR or is it coming from something else?

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

It's really just the ability to display that. That's the functionality. That's correct.

Judy Faulkner – Epic Systems – Founder

... doesn't have the necessities ...

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

So the EHR, which I think addresses one of your three questions, the EHR has to provide functionality that allows the provider group to be able to display things that meet those criteria. How you do it, you could connect it to a reference source that was able to produce patient content sensitive relevant knowledge at the point. However, you happen to be a vendor but vendors choose to do that is up to you. So you're not judging the credibility, the evidence of this information, you're just providing functionality to the provider group ... to implement that. Does that catch all three of your questions?

Judy Faulkner – Epic Systems – Founder

... credible and evidence based, how will the users be judged on that?

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

As a vendor you would need to be able to invoke information that—

Judy Faulkner – Epic Systems – Founder

Right, I get that. But as a health care organization credible and evidence based—

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

The health care organization does not—

Judy Faulkner – Epic Systems – Founder

I understand what you said about authenticated, so they cite the source. I'm a little nervous about the definition of—

M

... measure. The measure is using at least one CDS rule or whatever we come up with there. This is the alternative to naming six CDS types, alerts, order sets, so if you name those six then we've just stopped innovation in CDS, if we name the six ..., so we don't want to name them. So what Paul's saying is why don't we save properties of what do we mean by CDS, what would be good CDS. Some of these will

become ... criteria that you can say, the source can be who the committee or the medical board that set the policy for that source then. But this is not the measure we're going to use for these.

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

... define CDS'. Yes, these are intended for the HIT Standards Committee ... certification criteria, that's what it boils down to. I do understand your point for number two. It is not the functionality of the EHR that determines whether it's credible or evidence based. The other things are part of functionality that can be specified in an EHR.

Judy Faulkner – Epic Systems – Founder

Yes.

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

I understand that.

Judy Faulkner – Epic Systems – Founder

... make the bar too unattainable for the health care organizations out there when the data may not be as attainable as it's needed.

W

David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

The EMR can serve it up.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... like we were talking about, but to achieve meaningful use there's going to have to be that CDSF capability somewhere, and likely if it's not part of a particular vended system then you're at site certification, right, you're going to have to certify another product that actually does that logic thinking that gets served up in EMR.

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

So in a sense we're trying to address Charles' question. Everyone has a natural and market driven need to measure improved outcomes. We're trying to create the objective for certification criteria so that these providers have at their disposal CDS tools that meet those attributes and allowing for innovation.

W

David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I just wanted to flag the way that advanced directives are represented as being especially important. It's going to be used for a host of quality measures. That's something that, and if it's represented in a standard way that's one area that everyone will be better off. There aren't really good standards for this today, so that's just something for the Standards Committee.

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

You can imagine that in stage three that we'll have the things that we've been carrying along, but also have, as standards get developed, structured ways of recording the various attributes of an advanced directive, so that can be used in decision support.

W

Okay. Judy?

Judy Faulkner – Epic Systems – Founder

I just want to make a comment on your formulary checks, that not all ePrescribing vendors may do that. It does come from the prescribing vendors to make it available, and so therefore it won't necessarily be in EHR, the EHR then has to present it, but once again similar to the first one the EHR doesn't necessarily include it.

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

Okay, let's move on to the next screen. So for lab results, right now it is a menu item and we're suggesting to move it to core. Now, presumably part of the reason it's a menu item, even though it's one of the top useful kind of data that appears in EHR that is lab results presumably one of the issues with that, particularly in the rural areas. In the private practices, it's hard to get all of the lab sources, the sources of lab results to comply with the standards and to interface with the EHR system, so that's why it's a menu. By moving it to core hopefully we're giving time between now and 2013 for the lab systems and operators to be able to interface and to deliver this information in structured format back to the EHR.

The same thing applies to the next one, which is generate patient lists, move that into core, and also not limit it to knowing one thing about each patient, like knowing whether they have diabetes. So most of the patients, particularly in the Medicare area, in the Medicare insured base, they have multiple diseases diagnosed and the functionality within EHRs need to be able to present patients with comorbidity.

The third one is send patient reminders. We're basically moving the menu item again into core. We're headed towards not just touching the people that you've seen, but also your entire "active" patient base. Since we don't have a definition for what active is, we've postponed the stage three. Then we've come up with three new ones. They're not new in the sense we haven't proposed them before, but we're trying to introduce them into meaningful use. As you know from before, we had, as the HIT Policy Committee, recommended that documentation be in the EHR as part of meaningful use. It's because we believe that the documentation, like progress notes, is very important to care and should be electronically accessible just like much of the rest of the chart. So we've introduced that in our recommendation, our proposed draft discussion recommendations, to move that into stage two, moving towards having a mostly complete set by stage three.

Now, recognize that we're not saying how documentation gets into the chart. So, for example, progress notes might be dictated, they still can be dictated. They can even be scanned, but we're suggesting it's very important that they be accessible in an electronic format. The final one at the bottom is medication orders, trying to complete that medication tracking and complete that medication ordering and administration process to reduce medication errors in the hospital. So they have people starting, and one of the things is this objective actually is being pushed both by the hospitals and by the vendors just saying this is something people are already doing, so going towards that closed loop. You have a medication order in the system now, make sure that it gets to the right person and in the right dose and so on and so forth. So that's moving that medication order process into an electronic and automated form.

Questions? Comments?

W

Paul?

Paul Egerman – Software Entrepreneur

I have some questions about the progress notes. Thirty percent of visits have at least one note. Don't we have to deal with the issue of what's the definition of a visit and what's the definition of a note? If I come in for my annual flu shot is that a visit, they just record that they administered a flu shot? Is that a note or do they have to say the patient had his flu shot and tolerated the procedure well? I'm just curious as to I also noticed that you had patient days for ineligible hospital. Is that intended to only represent inpatient activity in terms of notes at hospitals?

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

Versus outpatient, do you mean?

Paul Egerman – Software Entrepreneur

What about emergency departments and day surgery and people coming in for imaging, for example? Those are all activities of a hospital and how do they count as it relates to the hospital side of this thing?

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

Good question. I might start out, and I don't know that we addressed this specific question so other members please chime in, by calling a visit or visits or an encounter available ... so if they came in and there was a professional service vendor then probably there isn't a professional note required. Your example of a flu shot actually is an interesting one because the fact that they did tolerate that is one, useful, and two, something that should be documented. So that's an example, and the fact that the nurse did make that documentation, that would count against the 30%.

We do want those notes available. The reason it's even 30%, and I sort of question why would it be and only one, is to get around some of the definitional questions that you just raised, although one possibility is that what's a visit? It's a billable event. What's a note? It's any time when a licensed professional makes an entry that can qualify.

Linda Fischetti – VHA – Chief Health Informatics Officer

I have a question and then I have Gayle and then Judy. Paul, my question is on patient reminders. I'm sorry to say that I should have brought Robin ... great meaningful use cheat sheet with me, but I think the denominator in stage one for reminders is all patients seen within the reporting period and obviously it's a pretty low percentage, 20%. So moving that to core I get, but the way that I'm looking at stage three, and I know we're not diving into stage three, but I want to make sure I'm getting this because I think it's going in the wrong direction. I think we're putting two criteria on the denominator that would make the denominator a much smaller, smaller number and therefore the 20% makes no sense to me. So the two criteria are, number one, an ... and you'd have to define that, and then number two, the two ... reminders. Do you remember for stage one what the denominator is?

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

For stage one, if you've seen this person then they become the denominator in the reporting period and then 20% of those should have received a reminder. What they're saying is, well, even though you have healthy folks in your denominator, ... people should have received reminders. In stage three, to answer your question and to clarify the words there, there are two things that are going on. Well, actually the major thing is active patients. So you said make your denominator smaller, no, that's the expanding your denominator because they don't have to be seen, this is to incorporate outreach. So now your patient panel, your "active" patients and so if we were in the accountable care organization well, we'd sort of know what those are, those people would be in your denominator and you knew to reach out and get those folks to come in where they have things that are appropriate. So that's moving towards public health, moving towards population health, etc.

Now the words which are hard to parse, so the patient preference is not whether they prefer to have a reminder, it's whether they prefer to have it electronic or other ways. So we're trying to mimic that same language even though maybe some of us think that it should be whether they opt in to reminders. I think we want to be able to give people a way to opt out of reminders. It's not that we'd encourage that, but anyway so that's what it means. It's to mimic the stage one.

Linda Fischetti – VHA – Chief Health Informatics Officer

So we might work on the language Neil?

Neil Calman – Institute for Family Health – President & Cofounder

Just a further clarification, I think this also calls out the need to have the electronic health records be able to record patient preference for reminders, and that's really important.

Linda Fischetti – VHA – Chief Health Informatics Officer

That's really good. Gayle?

Gayle Harrell – Florida – Former State Legislator

Going back to the lab situation, in small communities we know that many of the labs do not have the ability to do this in a structured format and many of our hospitals do not have the ability to send those labs in a structured format. When you're moving to requiring that to be a core issue are you going to lower the percentage at 40%, or are you going to keep it at 40%, or where are you going with the percentages?

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

The hedge there was the "only where results are available." So if the provider would like them, can receive them in their EHR, but their rural lab vendor can't deliver them, then the provider doesn't get docs for that.

Gayle Harrell – Florida – Former State Legislator

Is that going to be through attestation, or how do you go about doing that?

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

That's an exercise for the reader, but presumably.

Judy Faulkner – Epic Systems – Founder

... answer a question there, and maybe that's the same hedge, but should it be 90% of the lab results ordered by the EHR rather than just stored? Because then it will help with historic information that might be there, it will help with if you have a trusted partner who doesn't use meaningful use and you want to store that data, but still everything you're doing as an organization might be reasonable, and I am a little worried too about being able to calculate the denominator carefully. Given all the things that Gayle said and these other things it might be tough to calculate the denominator.

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

... electronically ordered?

Judy Faulkner – Epic Systems – Founder

Yes, from the—

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

If it's electronically ordered then it's measurable.

Judy Faulkner – Epic Systems – Founder

Yes, for that it is. But it's not that it just said "stored." It doesn't say electronically ordered. With electronically ordered you have a much better chance of doing it, with the exception of what Gayle was saying, which is you may be electronically ordered but the lab isn't able to get it back so you might struggle with the denominator. Then my second comment is, I hope we can figure out, on the patient list, the parameters very quickly so that those who have to program to it can do that.

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

I think electronically ordered was a good mod. I think some of this-- We're not trying to accomplish everything through meaningful use, so some of this, because meaningful use incentives do not apply to lab vendors. We're hoping that the market will drive, over time, let's say, as accountable care organizations or those kinds of things become available the providers are going to depend on this stuff and that the market forces we're hoping by 2015 will be around and help push this along. We just want to be able to receive it and act on it, and that's our job in terms of specifying things for the EHR.

Ready? All right, we're going to transition from category one, which is the quality, safety, efficiency disparity section, into engaging patients and their families, and George is going to take over.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Thank you, Paul. So a sub-group of the workgroup, Christine, Deven, Charlene, Neil, and me met and talked about accessing copy and we decided that the framework of accessing copy was too limiting and so we did some discussion and came up with a new framework, which is a separate document. But for the purpose of this discussion I'll describe it this way. On the one end of the spectrum patients want to get a copy of their legal chart. They just want to say I want my chart, take it as is. CMS clarified in stage one that that means only the stuff that's already electronic you don't have to go back and scan, but what's electronic you should be able to get a full copy of that.

On the opposite end of the spectrum is, I've just been there for a visit, I want to get something that's very readable by me and very concise and relevant to me, and they're already existing documents generally that represent that, like discharge instructions. I want to be able to get them electronically.

Then there's something in the middle, which is I want my longitudinal record, which is not the whole dump of my chart, they'll never get through that, nor is it just limited to one visit. But it's the record and it's in a form that I can either read, that I can hand to my next provider if I like, or that I can give to a third party service and get some service out of it. They could analyze my record and tell me something that I'd be interested in. So what you'll see here, which looks like a lot of rows, is actually just applying that framework to eligible professionals and to hospitals, so let's go through that.

The first row is private electronic copy of health information, so this one is that one where I get a full copy of my chart and we continue stage one and we emphasize that this applies to information already stored electronically in the EHR, no new scanning.

The second one is on that opposite end of the spectrum for hospitals, which is to provide the electronic discharge instructions for hospitals. And these things are given to the patient as they're leaving the hospital and they're offered to at least 80% of patients, and the patient can elect to have that electronic or in printed form. This one is 80% offered because there's a workflow already in hospitals for patients as they're being discharged. It's not a new workflow that we're adding to hospitals.

We've come up with a tentative definition of discharge instructions which says items like a statement of the patient's condition, discharge medications, activities and diet, follow up appointments, pending tests that require follow up referrals and scheduled tests. However, we've gotten a lot of pushback, especially in the last week, on defining something that's already existing. So what we've done for right now is we've put this definition in the comments column so that we can say what we're thinking of when we say the word "discharge instructions," but we're not at this point formally defining what it is because there's already a definition out in the field.

Then the third row is EHR-enabled patient specific educational resources. We're continuing stage one with an increase later on in stage three to address the common languages in that area. So let me stop there for a second before I go to the next one. There's going to be a lot more about accessing copy in the next slide. It's kind of split out over many slides unfortunately.

Linda Fischetti – VHA – Chief Health Informatics Officer

Gayle, did you have a question or is it left over?

Gayle Harrell – Florida – Former State Legislator

Yes.

Linda Fischetti – VHA – Chief Health Informatics Officer

Okay. So Paul has a question, and Judy, is yours left over, or do you have a question?

Judy Faulkner – Epic Systems – Founder

....

Paul Egerman – Software Entrepreneur

Am I next?

Linda Fischetti – VHA – Chief Health Informatics Officer

Yes.

Paul Egerman – Software Entrepreneur

On the discharge instructions offered to patients to at least 80% of the patients as they're leaving the hospital, I mean, my questions or comments about it are when the patient is leaving the hospital they don't necessarily go home. They can go to another facility, go to an extended care facility. And it doesn't make sense to offer electronic discharge instructions to a patient when you're going to put them in an ambulance and take them to an extended care facility and just a lot of transitions of care that go back and forth a lot, so that's one observation. The other one is still an issue of measure. How do you know you really offered it to the patient? I don't understand how that process works.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

First of all, so being transferred to another facility is a good point, although in some cases you still want to give them their discharge instructions just because they're going to another facility. Now, in some cases the patient is comatose and they're being moved to another medical facility and you cannot talk to that patient and you're transferring, the transition of care becomes a provider to provider link, so I agree with that.

Linda Fischetti – VHA – Chief Health Informatics Officer

Although, George, can I just say caregivers we absolutely cannot forget so many patients have caregivers. So if you're moving even to a facility, having the caregivers of proxy get those discharge instructions is huge and I don't—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I agree with that. That's the quote I read here. But if that's what that was intended as, that makes a lot of sense. It's very frustrating for the caregiver to try to figure out what's going on.

Linda Fischetti – VHA – Chief Health Informatics Officer

Right, and then they can potentially be able to download and move those instructions around with a primary care—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That issue would be a huge step forward.

Linda Fischetti – VHA – Chief Health Informatics Officer

Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Now, if they're given their discharge instructions electronically, that's actually easily logged by the system because you're pushing a button already. So the question is, how do you log the ones where you've offered the instructions electronically and they said, no, I want it by paper instead or I don't want it at all? Right now that would have to be a button that you would push as part of the thing. So we don't want to create more manual processes. I have to go back—

M

We can lower the—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This was a question that came up, and maybe Christine, who advocated for this, but the thought was that it was important that it be part of the educational process. So in other words, and Christine, jump in, but I think the fact that people aren't even aware is why she wanted to have the offer be part of education.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, so I'll re-frame me and say that a number of consumer organizations, and I'll give you a list if you'd like, particularly want to begin to shift culture in this area in particular where it is so important that not only the patient but potentially their caregiver have access to discharge instructions. And what we talked about in the full Meaningful Use Workgroup was the fact that hospitals already have processes at intake where frankly they can say even at intake now when you're discharged we can give you instructions electronically and what is your preference or then around their processes at discharge as well. So I think there are multiple opportunities. To answer your question, right now in stage one hospitals are attesting to the fact that they are able to provide those instructions upon request, so all this is doing is really shifting from upon request to an offer and then it would still be, I think, an attestation measurement. Neil, did you want to add anything?

Neil Calman – Institute for Family Health – President & Cofounder

Just there's a number of ways in which you document refusal. So basically we have that in a lot of things, in flu shots and other things, where you want to get to 100%. So you basically not only document that you're, when it's printed and you give it to somebody that's documented, but if you refuse it that's another way of documenting it. You can document the refusal.

Christine Bechtel – National Partnership for Women & Families – VP

So where's my list of people, Judy, and Jodi is the other one on my list.

Judy Faulkner – Epic Systems – Founder

A question, please. When you say there's a patient that's discharged and they get something electronically what are you thinking though when you say electronically?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

They can have a physical item, a USB drive, CD, whatever we set up there, or they can be defined in the system so they can access the information, so it can be an ID and a password.

Judy Faulkner – Epic Systems – Founder

That's stage one, right? We did not change the definition of what is electronic over stage one. Because I can certainly see electronic meaning it connects us electronically from home. With the CD of course, like in a typical hospital how many places would you have where they discharge different places? Because then you'd need a CD driver, encryption tools, and training at every location, so I want to make sure that –

Christine Bechtel – National Partnership for Women & Families – VP

They already have to have the capability to deliver discharge instructions electronically upon request from any place the patient is discharged, so I don't see the difference between stage one and stage two.

Judy Faulkner – Epic Systems – Founder

Aren't they doing that? Are people having CD drivers and—?

Christine Bechtel – National Partnership for Women & Families – VP

Is it a required or

Judy Faulkner – Epic Systems – Founder

How are they doing that one?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Generally it's the HIM department that's responsible for getting that information to patients, or it's being served up through a portal.

Christine Bechtel – National Partnership for Women & Families – VP

So the HIM department comes over to the patient at discharge time?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

It's not always at discharge. Generally it's a request that happens after discharge.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, and this is—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

But that's something different, that whole record. Actually, I think I understand this.

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

Judy, I think the intent and the likely way that most people would do this is through the methods you described, which is it would be electronically accessible.

Judy Faulkner – Epic Systems – Founder

So it doesn't have to be a ...,it's whatever way they—

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

However they do that. But I think in their final rules ... want to do is give people the option to do whatever ways you want to fulfill this, including physical devices.

Judy Faulkner – Epic Systems – Founder

Just to back up, when we have electronic notes isn't scanning setting the bar too low, scanned notes?

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

Oh, you're backing up to screens?

Judy Faulkner – Epic Systems – Founder

Thirty percent of ... at least one.

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

Yes.

Judy Faulkner – Epic Systems – Founder

Isn't scanning setting the bar kind of low?

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

We're just saying that the goal is to have immediate access to this information. However, people want to get it in it's clearly much better in semi-structured form than others. Scanning may be one of the least desirable, for a whole host of reasons, but we wanted to make sure that people understood that this wasn't doing structured notes. That was one of the comments was just being ...

Jodi Daniel – ONC – Director Office of Policy & Research

I've got a couple of questions. One quick one, just following up on the conversation about caregivers, does that need to be clarified in there, "offered to at least 80% of patients" should it be "patients or caregivers"? I think that's fine to do as a clarification. I would have to go back to stage one and see whether it's already in there or not. But I think there was an overarching reference to patients and/or caregivers and that's why this category of patients and families—

Judy Faulkner – Epic Systems – Founder

... pulling from that?

Jodi Daniel – ONC – Director Office of Policy & Research

I think so, but if not we should make that clarification.

Judy Faulkner – Epic Systems – Founder

Then two other questions: I'm just wondering what the thinking is on continuing stage one for both copy and educational resources as opposed to moving that bar, because I know it's a pretty big jump by stage three. On access whether that's supposed to be based on request of the patient or is what the number—provide electronic copy obviously not everybody wants an electronic copy of their entire record. Is that based on request for copy?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Hold on. First of all, let me say that we've got three slides worth of access following this, so let's not raise the bar too high on this one. You may be right, going from 50 straight to 90, I mean, we could have gone to 60. At a certain point we felt that if we could continue that and move on these other areas and that's the full chart version and then access we're about to see in a second. This is one version of access which is electronic, having discharge instructions, so that's just one piece

Judy Faulkner – Epic Systems – Founder

And is it based on request?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Which one?

Judy Faulkner – Epic Systems – Founder

The copy. The first one.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

The first one's based on request. You just don't get offered a copy of your chart every time.

Judy Faulkner – Epic Systems – Founder

... and it's based on those requested?

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

I think that's the way stage one goes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, I think that's how CMS defines stage one.

Judy Faulkner – Epic Systems – Founder

Delivered within three or four business days.

W

Right.

Judy Faulkner – Epic Systems – Founder

So that's the big difference. Great, thank you. ... on this past slide, or do you ...?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair

It's sort of in the boundary. I'm not sure where this gets addressed so if I could just jump in. I want to pick up on Paul's comments about providing continuity of care, because a lot of these within 36 hours

undercuts the kind of care where the first few hours, the first few minutes is really the most critical. So I really want to support the notion of what information can be available, not just to the patient but to downstream providers at the time of transfer would be really, really valuable, and to sort of reinforce where that ties in to the current meaningful use and as they get extended.

M

The summary of care record, there will be another place for us to talk about that under care coordination where we have the summary of care which is provider to provider as opposed to provider to patient.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I guess the piece I want to make is really to emphasize its timeliness because traditional discharge summaries can lag days or weeks and it really needs to be with the patient. Ideally, some of this needs to be in advance of the patient so the receiving facility can be ready for the patient when they show up.

To answer quickly on timing, we have, number one, discharge instructions which we want you to get immediately. Number two, we have a summary of your hospitalization which is this one we're about to come to, which is 36 hours. Discharge summaries are something that may come later because we understand the workflow of hospitals, so that one could follow it off and it takes two weeks to get discharged or whatever. So that's a later one. A third number is four days you'll see frequently, and that's to accommodate the fact that if it's not in the middle of a visit and you just get a lab test coming you need time for the provider to review it before sending out. So those are our four time frames: immediate, 36 hours, four days, and whatever it takes to get a discharge summary.

M

So maybe the thing I'm struggling with is I'm asking for something that's really not covered here, because this is not so much discharge instructions to the patient or their informal support system, but to the formal support system of the health care system. And that that needs to be immediate as part of the discharge process and probably needs the additional detail of a traditional discharge summary, recognizing some of the elements may not come in for several days.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I think that's the summary of care record which we'll get to, although the caveat will be you have to be able to talk to someone and if they are under meaningful use, and if not are you getting penalized for them not being able to take it yet. But let's cover that when we get there.

M

Or rewarded if they can even if they're not being penalized. Or rewarded if they can take it even if they're not required in meaningful use incentives.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Again, this gets back to the offered problem, which is still a little bit tough for me how we count them. I agree with the idea of them always being offered, but how do you count them? Eighty percent of patients offered the ability to view and download within 36 hours of discharge relevant information contained in the record about eligible hospital inpatient encounters. The data available in a uniformly human readable form and the Standards Committee can define it as something like PDF or text, that stage two and stage three becomes a uniformly structured form and the Standards Committee can help us define whether it's CCD, CCR, etc.

So let me go through a couple of things. First of all, when I say the word "uniformly" what I mean is simply that the Standards Committee should come up with one format or some small number of formats, maybe just one, that cuts across all hospitals. So if you're getting whether they decide PDF or text, that's the one for everybody. That's what the word "uniformly" means. What do we mean by relevant? In the comment section on the far right slide this was derived by looking at the CCD, the CCR and stage one what's being mandated to be entered already. Mapping what is common between CCD and CCR saying

those are good categories and saying if we're already collecting it in stage one it's reasonable to ask that to be in the summary.

So the inpatient summaries include hospitalization, admit and discharge date and location, reason for hospitalization, providers' problem lists, medication list, medication allergies, procedures, immunizations, vital signs at discharge, diagnostic test results, if they're available, discharge instructions, which we were already saying have to be available. Care transition summary and plans, discharge summary when it's available, which may not be available within 36 hours, and then gender, race, ethnicity, date of birth, preferred language, advanced directive, and smoking status, which are linked to the other things. So this is our suggestion of what comprises an inpatient summary.

Christine Bechtel – National Partnership for Women & Families – VP

Do we have questions? Paul?

Paul Egerman – Software Entrepreneur

I just had an observation about this 80% offer the ability to view and download, which is have you considered the operational aspects of this? In other words, for a patient to be able to view and download they're going to have to be given a user ID and a password and some instructions as to how to do that. Having recently ... Marc Probst I wouldn't want to have his job. That's an interesting—

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

Well, in hospitals the way that we offer it is to give a piece of paper that says if you want to access your information here's what you do. That's our offer. That doesn't mean 80% of patients participate in that. It means 80% got the form on their way out of the hospital that says that here's how you access your information if you want it. Now, how do I guarantee that 80% of patients got that piece of paper is a question I haven't answered for you yet. But it doesn't mean 80% of patients get an ID and a password.

Paul Egerman – Software Entrepreneur

Well, then how do they access it without those—

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

There's a process in place for those patients to request their ID and password, of which we would expect a smaller number would actually participate at this point in time. When it's a larger number that's a good thing.

Paul Egerman – Software Entrepreneur

The thing, Paul, 100% of people would have their information available if they choose to access it. Some thresholds, 80%, are offered that chance to take advantage of it and probably a lot smaller percent of patients will actually go log in, etc. But the providers are being asked to make it known that you can access your information electronically

M

I'm a little concerned about the operational aspects of that, but I understand what you're saying.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I have a question, and this may fall under the category of don't ask a question you don't want to know the answer to, but I'm going to do it. That is, for EPs we've asked basically for them to do this in stage one and so it will require some way to probably have a log in or a password portal or PHR with a link, whatever. Is there something unique about hospitals that they should not have to do the same thing when there's such a rich source of information about the patient?

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

I would be concerned about all the things that happen when you try to discharge the patient. It's sort of an exciting time. There's a lot of procedures that go on, there's actually a fair amount of anxiety

sometimes among the patient and the caregivers and the family, and I'm trying to understand how this is all really going to work practically in terms of given that at that point in time ... electronically. To me it's a lot easier to do for a physician, and that's using a lot of benefits, especially as it relates to caregivers. To me I'd rather see this happen almost more on a pre-admissions basis or something so that if you can you set this all up, if the patient wants it, in advance as opposed to adding something else to a checklist of what you have to do when you discharge a patient.

Christine Bechtel – National Partnership for Women & Families – VP

I think that's a—

M

It could be pre-admission, but remember if you're trying to do, other than the exceptions, trying to do discharge instructions with 100% of patients, other than these exceptions of being transferred in a coma or whatever, that could be where you offer this as part of the discharge instructions, as one more paragraph on that form. I just want to point out that there are ways to do it that are low wait, relatively speaking. I didn't mean to—

Paul Egerman – Software Entrepreneur

You could actually give the instructions for how to do it on admission.

M

Yes, that's true.

M

... good idea. Here's how you can access your information.

Christine Bechtel – National Partnership for Women & Families – VP

Right, so how the workflow happens shouldn't be, in my opinion, our domain whatsoever. But I completely agree with you, you want to do something that is the least confusing for the patients but still leave them with the kind of empowering information that they need as they move through the rest of the health care system. But I think workflow-wise you could do it at any time. Marc?

Marc Probst – Intermountain Healthcare – CIO

And just playing off of Paul, there are operational aspects of it, there's no doubt, and the 80% does worry me because patients show up at multiple places even within our own network or even within our own hospitals, and how we track that they've had this opportunity is a little bit of a challenge. There's also the operational challenge of they will get passwords, they will get user names, and they will lose those and there's a fairly large infrastructure required as you grow this number to support that. That doesn't mean it shouldn't happen. I think the intent of where this is going is very good. I just do think there's a reality that a lot of organizations are going to have to put in place that they may not have had in place currently to support achieving the benefits of this. So I actually at some point hope that we go back to Larry's comment on 2014, because we just heard that and I know now it's not the time to discuss it, but it does have an impact on the reality of people being able to put all these pieces in place.

Linda Fischetti – VHA – Chief Health Informatics Officer

Other questions?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Now we're going to look at eligible professionals. And the next three rows, which are on three slides, are the EP side of this. Here we were worried that it would be hard for an eligible professional to track how many times something was offered, so we basically maintained the approach that was offered in stage one. This particular one is about the longitudinal record, so when I started this section I talked about the three sides, the full chart, the very focused thing and the thing in the middle. This is the one in the middle for eligible professionals. So patients have the ability to view and download on demand. That means

once they have their ID and password they can just log in, in general relevant information contained in the longitudinal record which has been updated within four days of the information being available to the practice. They should be able to filter or organize the information by date and encounter.

The data are available, again, in a human readable form in stage two and in structured form by stage three. On the right hand side it clarifies the elements are analogous to the elements we had for hospital but tailored to the eligible professional, so encounter date and location, reasons for encounters provided, providers, problem list, medication list, medication allergies, procedures, immunizations, vital signs, diagnostic test results, clinical instructions, orders, longitudinal care plans, gender, race, ethnicity, date of birth, preferred language, advanced directives, and smoking status. The intent of the list were the things that we're already collecting for other reasons that made sense to put in a summary that's a little bit bigger than that short thing that I mentioned earlier.

Then let's go to the next – it won't all make sense unless you see three in a row. This one is for eligible professionals, the focus document for the visits. This is basically the same thing, only it's triggered by a particular outpatient visit. This one's within 24 hours of the encounters because the doctor or the eligible professional just had a chance to review the record during that visit so we didn't put in the four days for that unless there's a lab result that didn't come back yet and then they still get their four day lag time, and that's in the rule. Then on the right hand side is the definition which is analogous to the previous one only there's only one date instead of several dates, and so on.

Then finally, if you flip to the next slide, just looking at the first row here I want to talk about this separately, now you'll notice in those previous two I didn't have a percentage there. It's just the ability to do it. It's like an attestation that they're capable. The counting of it occurs in this top row here, and this top row, although it's listed as a new objective it's really a splitting out of the old objective, not a new introduction. So for EPs 20% of patients use a personal health record, which includes their portal, to access their information either for a specific encounter, that is a visit summary, or for the longitudinal record. In other words, either of those previous two slides can count towards this and they use it at least once, excluding patients who do not have the ability to access the Internet. So we have to figure out how to count that, but I'm just saying that's the intent here, and then stage three goes up to 30%. So in this case we're counting how many times we're successful instead of the offering. And we can talk about what the percentages are, right, but let's just open up for comments.

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

Maybe another framing way to approach this is the previous objectives essentially become certification criteria for an EHR to be able to have this stuff. This last one is essentially the enrollment requirement. So we're saying make sure that EHRs can capture and make this available to patients through PHRs, for example, and the meaningful user should be offering this stuff so that 20% of the patients sign up.

Linda Fischetti – VHA – Chief Health Informatics Officer

Gayle?

Gayle Harrell – Florida – Former State Legislator

Thank you. I really have some issues with this and how practical and functional that is going to be in an everyday setting. You're holding the eligible provider accountable for the actions of the patient over which you have minimal control. I really think that you could lose your entire incentive payment over something you have no control over. I think the functionality needs to be there, but to hold the eligible provider accountable becomes very problematic. And you are, once again, setting ourselves up for failure and you're going to see physicians and providers will see this and they're going to say that's ridiculous, I can just hear the conversation in the doctors' lounge right now and they're going to say forget it. We want to do something that is going to make sure that we are successful, not set ourselves up for failure. I think this is one of the things that's going to do that.

M

Christine, can you clarify what is “Stage one: provide timely electronic access by EPs 10%,” what is the denominator and the numerator there?

Christine Bechtel – National Partnership for Women & Families – VP

The denominator is, Joshua, correct me if I’m wrong, but the denominator is already the entire patient population would actually use it once. This is actually only a 10% increase in what stage one is already doing. While I have the microphone—Josh, that’s right, okay—and so, Paul, you also, we had a long discussion of the scale and the workgroup. It will be no surprise that I think it’s extremely important to actually look at the use because it is so easy to just say, yes, yes, we’re doing this and not make sure it’s really meaningful and understood by patients and used. So in the workgroup we had a nice discussion, and Paul and actually David Bates spoke about some of the evidence and studies that they’re seeing from the field and maybe if you guys could share some of that, that would be terrific.

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

One is that the provider support of this is crucial. So lack of provider support, which means when you order tests saying, hey, did you know you could get this online if you’d like, that’s the crucial thing that will engage patients. Without support, you have virtually zero. With support, we’re already up to 60%. Even in rural areas in smaller practices, and we have some of those in California too, it’s fairly easy to get to at least the 20% That’s how we picked that number. It’s possible that that number is off a bit, but we do know that it is impactful, whether the meaningful user or provider supports this or not and encourages it. And we do know how transformative and engaging it is for patients to have access to this

M

We picked the 20% figure because we believe that that’s achievable even in a place that does not have a lot of people who are relatively sophisticated with computers, that’s what the evidence would

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

And one more piece, that exclusion, patients without ability to access the Internet we thought we could rely on the FTC, because they have geographic categorization of the accessibility of broadband, so that’s another objective way to characterize geographic areas.

Gayle Harrell – Florida – Former State Legislator

Depending on the socioeconomic level of your patients you can have situations where there may be broadband available, however the patients have no access to the Internet. You might not want to go to your local library to download your current STD results, you know.

Christine Bechtel – National Partnership for Women & Families – VP

Certainly, and we talked about, and again, I’ll remind folks that this is for public comment, so we talked about ways that we might construct some reasonable exclusions that would permit for circumstances that might vary across the country, including broadband and other kinds of Internet access, but that we would continue the stage one direction here. So in the queue I had Judy and then Deven.

Judy Faulkner – Epic Systems – Founder

On slide six, you have EP being defined as ePrescribing and here you have EP being defined as eligible provider, and that’s confusing.

Christine Bechtel – National Partnership for Women & Families – VP

But if you look on slide six it says “ePrescribing (EP)” on the third one down.

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

ePrescribing was only a—

Judy Faulkner – Epic Systems – Founder

Oh, that’s where eligible provider

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

Yes.

Judy Faulkner – Epic Systems – Founder

All right, thank you. Second, longitudinal care plan, a lot of what you have in there is very well defined, problem lists, allergies, date of birth, but longitudinal care plan is not well defined and unless we define it, because it is something very complex, I would question whether it should be in there.

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

First of all, this is for public comment. I'll say that this was referring forward to, there's another row about longitudinal care plan but it's also not well defined there. So we recognize that and we did some homework but did not come up with something yet that we feel is adequate to define what a longitudinal care plan is. But we didn't want to leave it out just because we were unable to do that yet, to leave it out of the public comment period, because we're not defining the rule at this point. So we think that that's a reasonable thing to have in there if it can be defined.

Christine Bechtel – National Partnership for Women & Families – VP

Deven?

Deven McGraw – Center for Democracy & Technology – Director

Another point I wanted to add on the Internet accessibility, I agree with the exclusion but I think we have to be mindful of some of the research that's coming out of Pew, for example, about how many people even at lower socioeconomic levels have Internet access through smart phones, not just telephone access but Internet access through their phone.

Christine Bechtel – National Partnership for Women & Families – VP

Great point. Marc?

Marc Probst – Intermountain Healthcare – CIO

And that's in the same vein as what Gayle was talking about. I think it's incredibly important that people have access to this data and the percentages are what percentages are. I just question whether or not that's part of EHR certification and meaningful use. I can see this being part of the RECs challenge and we're funding RECs, or the government is funding RECs. I don't know, to me it just seems like kind of a non-scientific or where they control all the variables, the eligible providers to get this done they can help with it certainly. But they don't control the variables. To me that one seems a little soft. But I think the outcome is the correct outcome.

Christine Bechtel – National Partnership for Women & Families – VP

The view and download?

Marc Probst – Intermountain Healthcare – CIO

I think trying to get these percentages up with people using PHRs and having access. The systems absolutely have to be able to do that. My question is, is that really part of the EHRs' meaningful use goals? Should it be there or should it be somewhere else that's doing more education and more encouragement of that to happen on the public? I just answered a set of questions and asked another question.

Christine Bechtel – National Partnership for Women & Families – VP

I don't have comments. Do you have a comment before—

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

I think part of the transformative changes in HITECH and in meaningful use really half of it's with the patients, and that's why we're feeling so strongly about it. Just another one on percentages, our health system wants 50% within two years, so I think it's achievable throughout the entire system.

M

I do too. And I think that's great and at some point some of these things have to become market driven, that that's what the patients want to do, there's value and let's go use it and I'm going to go to Dr. Calman because Dr. Calman provides that to me. But again, to put that incentive of just one more thing these physicians have to track relative to EHRs, it just seems that it's not as defined as the other requirements that you bring.

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

It's one more thing that the health system is requiring of its physicians, so that's the same thing we're trying to do.

Christine Bechtel – National Partnership for Women & Families – VP

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I think this is one of the areas where all three of us who are on this sub-sub-sub-workgroup have exactly the same experience, which is that the uptake on this is totally provider based. It's the extent to which the providers engage their patients, inform them, and actually use it as a means of communication that actually creates the patient involvement. So that's why we felt so strongly that there needed to be some sort of minimum threshold here, and we all have great variability in our practices between the providers who do this and take it seriously. In our practice one of our providers is at 70% and another one in the same practice is at 10%, so it's very, very variable, and it is based on the provider so that's why we felt it was important to call this out as something that the providers needed to engage their patients in. But I hear exactly what you're saying. We are putting more and more things on them, but that's part of the transformation we're trying to engage people in.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Can I comment? I'm afraid of all this stuff. I'm actually the person arguing to do less and less. But the counter argument is that this is a little bit of an outcome measure. Why should meaningful use be saying that your hypertensives ... but yet the Quality Measures Workgroup might be looking at hypertension, so I see this as a form of outcome measure. We only have so much effort to spend in this whole initiative of doctors' effort and we have to decide which things we should spend it on. I guess the feeling of the sub-group but will be the decision of the Policy Committee, is that the patient engagement is such an important part of this that it's worth spending something here even if it means spending less somewhere else, because we only have so much doctor effort that they can put into this initiative. But it was felt that this one is a key one and that in fact years from now when you look back maybe getting patients their data was the key new thing that we did that really changed things and not so much that they just happened to install an EHR, which they were going to do anyway. So that was the feeling of the group.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, George. Judy?

Judy Faulkner – Epic Systems – Founder

I'm fine with it in general, but I think ... the discussion here with the people here who have been involved in the discussion are with getting the patient access to information that is kept private, confidential, secure, etc. My concern is not the statistics or the value of doing that, because I think that's very high. My concern is are we going to be pushing organizations to send their patients to systems that are not business associates, that are not following some of the rules because it was carved out in the stimulus package of standalone EHRs can sell the patient data, advertise the patient, etc. Are we going to be

pushing our patients to that because that's the only route that folks have and is that in the best interest of the patient once their data may no longer be private and may be sold and they may be advertised?

Christine Bechtel – National Partnership for Women & Families – VP

I'll maybe address that, since you're still sitting far away from the table. That is to say, I guess, first of all, I'm not convinced that a personal health record or that kind of service is the only thing that this criteria would push folks to, because clinicians could use support for something that is more directly tied to their system. But I also think that it points to the importance of the broader communications work that ONC is doing around, and also actually to the future privacy NPRM, which I think we expect around PHRs, right, Deven?

Deven McGraw – Center for Democracy & Technology – Director

I don't know ... NPRM is a report, because HHS doesn't have authority to regulate non-HIPAA ..., but we do have a report also from the Federal Trade Commission that's relevant in this space and in an ongoing effort to create baseline rules that apply to Internet based companies with respect to consumer privacy. So it isn't the ideal situation in terms of where the regulatory framework applies currently, but I think there's a growing acknowledgment of need and I think certainly if an entity creates its own portal or has a PHR that it creates or asks another company to create on its behalf, then it clearly would be covered. And then I think to the extent that patients would prefer to use an independent company it's important that they understand that they need to read that entity's privacy policies and be comfortable with the terms.

Christine Bechtel – National Partnership for Women & Families – VP

Right. So ONC is doing a larger communications effort for the public for exactly those reasons but I think it's a valid point and it's definitely worth paying attention to.

Judy Faulkner – Epic Systems – Founder

And could we put that into these rules that if you're going to hit those high percentages that you say not just that the patient has access ... but has private secure access but the information is kept private. Can you add that to this?

Christine Bechtel – National Partnership for Women & Families – VP

They're all covered entities, so don't they—?

Judy Faulkner – Epic Systems – Founder

Not necessarily.

Christine Bechtel – National Partnership for Women & Families – VP

I'm sorry, the clinicians who are governed by the meaningful use incentives, though are.

Judy Faulkner – Epic Systems – Founder

Right, it's the clinicians who are getting this information to the patient and the patient is signing up for the ability to review all this information. The patient may be signing up for something that doesn't keep that information private, so can we add to this that it needs to be kept private?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Let me answer the question differently and pick up on what Judy's saying. So you buy an EHR that's certified but it's not a certification requirement is it that it has a secure portal?

Judy Faulkner – Epic Systems – Founder

No.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That's not a certification requirement, so you buy a particular EHR and they say the way you get your information is through ABC PHR and ABC PHR resells that information and so that's the only way if you buy this particular EHR that you can get your information to a PHR because it doesn't—

Judy Faulkner – Epic Systems – Founder

To go with an outside group, yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Right, and so that PHR might not be acceptable to that particular patient. The question is, should a patient have a way to get this where it is free of commercial interest? Is that what you're trying to say?

Judy Faulkner – Epic Systems – Founder

That is what I'm trying to say—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

And should we guarantee that that happen?

Judy Faulkner – Epic Systems – Founder

It may not be that the EHR only goes one PHR, it may be that the organization selects a commercial PHR. The patient may have a choice, but my reading of some of those choices is it's very difficult for the patient to tell what exactly is his or her choice. However, what if ONC through its current communications work and working with OCR, who is actually doing a lot of work in this area, that is directed at patients, were to create a frequently asked questions? A standard piece that is plain language that simply says we're offering you the opportunity to view and download your information through a secure mechanism. However, if you download it and you choose to upload it then into another personal health record, these are what you need to pay attention to, read their privacy policies, ask them if they resell data, blah, blah, blah, so that the provider is actually delivering a standardized. So it's no extra burden but piece of information that the patient could use to make their own decisions.

Christine Bechtel – National Partnership for Women & Families – VP

I don't know if you've read any of those things. They go on for page after page after page and it makes it more

Judy Faulkner – Epic Systems – Founder

Yes, and it's really hard to tell. I'm used to reading legalese and it's still hard to tell.

Christine Bechtel – National Partnership for Women & Families – VP

It is, but I'm suggesting that at least as a first step and given that providers are trusted messengers for patients that having a plain language simple educational piece that says look, this is a landscape out there that you need to pay attention to, we can't control Microsoft Health... or Google Health or ... 30 page privacy policy. We don't have an influence on that. But where we could influence the process is potentially using a clinician as the communication mechanism for some basic what you need to know in plain language that OCR and ONC can develop

W

Even though we don't have the regulatory authority, as Deven mentioned, we could obviously do education materials. We also are still working on our model PHR notice, which is long in coming but which again wouldn't be something that is mandatory, but it would be a way of folks being able to communicate some of their uses of data in a way that's easy to understand for consumers. So that's something that we could figure out how we might be able to encourage the use of that, at least as a transparency tool, even though we wouldn't be telling folks what they could or couldn't do with the data specifically. There are some educational pieces, some models and that kind of thing that we could do to help address some of this, although it still leaves open Judy's point of pushing folks to use PHRs that are not necessarily regulated as to how their information is being used.

Christine Bechtel – National Partnership for Women & Families – VP

This is just that I want to alert you as a patient to be careful of this. I think many patients will not be able to judge accurately, especially when every three months you get an updated version that to continue to see your stuff you have to say yes to that updated version, number one. Number two, those systems may, even if they keep the information private, may allow other vendors, hundreds of them, to come in and share that data. Those other hundreds of vendors through the apps may not keep it private. My concern is once the data is out, it's out. It doesn't come back. You can't cut it off easily. Paul?

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

Yes. I think your comments are excellent, Judy, and I'm wondering if one way to address this is as part of this whole process is to say that these certified systems have to have a secure portal. So they have that at least as one alternative for the patient. Then the patients then have this secure portal from their provider or from their hospital, or if they want to use one of these other services or their PHR services perhaps to aggregate or whatever other purposes they still can, but this gives a secure way to make this all happen.

Judy Faulkner – Epic Systems – Founder

It's not just that the portal is secure, it's that the data is treated with confidentiality.

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

That's right. I agree. The user covered entities have this certified system so they're under the whole OCR HIPAA umbrella anyway.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Am I hearing Judy's suggestion and Paul's to say that we write objectives so that EHRs are certified to be able to comply with these access objectives? If an organization chooses to become a meaningful user by using another third party, that it's on the meaningful user to say that they have ... turns it into a business associate so that the meaningful user can assure us that the third party is abiding by the privacy protections that the meaningful user has. Is that what you're saying?

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

I agree with the business associate part, that a provider or hospital should be able to in effect outsource it. An HIE organization or an HIO might provide this service for providers, but then it's a business associate agreement and that then responds to Judy's concerns.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So two pieces, one is make sure you have a patient portal in a sense through your EHR that can meet these objectives. And two, if you choose to do it through another organization then they become business associates and then they inherit all of the restrictions ... comment about that. Okay.

W

Our illustrious chair is back. I did not get to use the word "hemodynamic consequences" but I'm going to look for an opportunity at my next meeting.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

You have to put on your white coat every once in a while. Well, obviously you've made a lot of progress and I should probably leave again soon. This issue of the privacy of data in the personal health record world is one that we might want to request a comment on specifically so as to inform our deliberations rather than rush to a conclusion. It seems like it's a crease in the regulatory and policy making space, and maybe people understand this space better than I do, and you understand all the links between these. But there may be multiple solutions and multiple ways of getting to solving the problem that Judy's raised and I don't think it's one that we can think up on the fly here. Yes, Christine?

Christine Bechtel – National Partnership for Women & Families – VP

I wonder, I was thinking as we were having a discussion if our Tiger team might want to take a closer look at this to make sure that we're coming up with all the creative options we can.

W

Not that I eschew more work, but I do think it's worth getting some public comment on this versus just through the Tiger team. Secondly, there was just an open comment period that ONC sponsored as part of its PHR roundtable, and for those of us who are on the side of actually writing comments it might be nice if we went through some of those to help inform us on this particular question as well.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Gayle?

Gayle Harrell – Florida – Former State Legislator

I just want to address the issue on PHRs. I think you have to look at the statutory authority that we have as a committee and that ONC has to really deal with PHRs. I think it's very, very limited. So we can certainly ask for comment, but in taking action or putting meaningful use requirements or whatever in place we are all very limited in what can be done. It still remains pretty much the Wild West out there. Patients do not understand the implications frequently of what is going on. I think the RECs perhaps could play a role in education. Providers do not have the time in the limited time they have in the exam room to become the total education facility for their patients on the pros and cons of which PHR to choose. I don't think that's their role. I think since we are using public dollars the RECs could be a good area for general education out there on this issue, and it's a significant issue. It's a real privacy and security issue.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

It does fall between authorities and there are multiple agencies involved, even outside of HHS, and there are multiple actors moving in this area right now. There's the Commerce Department, the Federal Trade Commission, all doing things that could have a material impact on the problems we're concerned about. So that we may not have to address this issue because the FTC or Commerce might Judy?

M

Let me just point out that we have five slides left, so go ahead, Judy.

Judy Faulkner – Epic Systems – Founder

I think one of the problems they're addressing is if at the same time we're incentivizing behaviors, it may be in the provider's best interest not to be as careful because they have to hit those percentages.

M

All right, I guess we have to move.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Thank you. This slide, remember we've done the first row already and although it seems like a new objective it's not actually a new objective. The second two are EP, so this is the new thing, EP is 30% offered secure patient messaging online, so that's the proposal for a new function in the EHR. Then the last one, patient preferences for communication medium recorded for 20% of patients, that's not so much a new objective as the infrastructure necessary for the other stuff we talked about. I'll just point out that there are a number of other objectives, the four shown there on page three that I won't go into detail, the last one being patients uploading data to the EHR from their homes. ... in the future we chose those that won the secure patient messaging as something that we might be ready for now, whereas, the other ones that we need a little bit more time to achieve. Questions about those two? Marc thanks Paul for bringing it up for us.

Marc Probst – Intermountain Healthcare – CIO

Excellent presentation. On the issue of 30% offered secure patient messaging online, this obviously ... a concern I have about how you offer something. But if what we decide is that there's going to be a patient portal you can wrap the secure messaging into the patient portal and so now you've got systems that have that capability and that might be just as effective as doing this. And that's just a suggestion.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

We've got to turn it on and make it, maybe available is the word rather than offered, because people clearly have this capability now that do not offer it. So maybe the word is making it available to patients and it's really not a threshold thing, at least right now.

M

You mean switch from a threshold to an attestation that it's on?

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

Maybe there's another way you could do it. I'd really like to get away from the attestation, because if all you did is have evidence that there is some messages being sent, then you would—

M

So in use and then basically you can automatically capture that it's being used.

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

You can capture that it's being used. To me that would be better than the attestation stuff, and so that would be my suggestion is to wrap it into the portal capability and provide evidence that it's in use.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, are you just suggesting they would report the usage rates, but there wouldn't be a threshold associated with these?

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

That's a possibility. I don't know, because I don't know quite how you define an initial threshold. But especially if you're doing this to get started is just simply say you're going to make this available to your patients and you show that you actually are using it. I wouldn't necessarily put in a threshold of 10% or 20% or 30% for secure messaging, only because I worry that for some provider groups it just may not be possible. So now you're going to say, well, you'll allow it except when you test it it's not possible. I'm not sure we've accomplished anything then.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Marc?

Marc Probst – Intermountain Healthcare – CIO

I guess the second one kind of goes with the first one in that they're a little smushy, whether that's a technical term I don't know. I really like the third one, and I don't know whether the third one, if you attain that, if you can get the preferred communication medium aren't you going to solve the first two? Because they may decide that they want it on paper or they don't want anything at all. But if it's offered and you're building this database of how they want to communicate with the physician, it seems to me that that's a lot, again, easier to manage and you'll get the right outcome in the end if you're recording those things and you can actually then do it. I guess if you're recording and you can't do it then that's a problem.

M

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

You actually answered your own question because we need to have objectives to have certification criteria to have it in the system.

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

Yes, and I think if you're going to give them preferences you have to be able to meet those preferences. But you've defined out there what kind of preferences we'd be tracking and they need to be there, they need to be certified to be there, and then that's going to drive your percentages of actually use of it

M

I don't know if this is covered in the language for stage two, but we have communication medium preferences, which I'm assuming is paper versus portal versus secure messaging, whatever, and I'm wondering if we can extend that a bit to enable the patient to state their preference for data sharing, period. In other words, it seems like there's a small but vocal minority who wants very strong, virtually no data sharing. Most of us want, I think, all of our physicians to know everything they can possibly know. I'm just wondering if we had a vehicle to enable patients to state those preferences as enabled by the technology whether that might help the privacy and security crowd feel a little bit more comfortable about their privacy being protected.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair

I think the Tiger team is going to give us some guidance on that.

Deven McGraw – Center for Democracy & Technology – Director

... put some recommendations already on the table with respect to consent. I think we need to be very careful about what type of role we give to patient preferences in a framework of protecting privacy. We certainly have better technology capabilities, if you read the ... report it's definitely heading in a direction of using metadata in order to make sure that patient preferences, when they have them and when they're required, are persistently honored down the food chain. I think the thing I worry about with putting something like that on there is it's almost like putting the technology ahead of the policy. I think rather than thinking of what the technology allows us to do from a functional standpoint in terms of recording patients' preferences, is to think about what role we think those preferences ought to play in the comprehensive framework and then think about how the technology can honor that. Don't look to the fact that we have a technological ability to tag something as being therefore we have technological ability therefore we should do x.

I think we have to think very carefully about, number one, whether we can honor those kinds of commitments within the health care system, sort of absolute don't shares, or don't share except in certain circumstances. I think that conversation has to happen before we think about what we want the technology to be able to honor. We certainly have put some recommendations already on the table over the summer about the role we think consent should play. State laws already require consent in numerous ... and those are going to have to be honored by systems. So I think rather than again let the technology lead the policy, to think through what the policy ought to be and then have the technology available to honor it.

M

... marry it with the technology.

W

Just to give an example, we've got state law that exists in most states that are subject specific or categorical privacy laws that say your mental health data will not be shared unless you authorize it to be shared. It's not true everywhere but it is true in a number of circumstances. Federal substance abuse treatment facilities absolutely have to get patient authorization before they can share data. So one way of looking at that is if there's a way to either tag that preference to the data if you're familiar with that technology and agree with the ... report that it's the direction we ought to be heading in, or some other technological mechanism to make sure. Because that policy is already in place that we need to make sure that it's persistently honored similarly with respect to the Tiger team's existing recommendations on

consent and the type of information exchange infrastructures where we stated as a committee that there ought to be consent before a patient's data is accessible through those.

It's another way that you can use the technology to indicate that. Rather than saying, oh, we have a technological tool that can honor preferences therefore we should now happen, because the issue of consent isn't just about whether the technology is available to honor it, although it certainly plays an important role. It's fundamentally about what is the privacy infrastructure you want to create while also making sure you have the data flows for treatment, care coordination, and public health that you need to have happen. In some instances because an electronic record of a provider also serves as a business record of that entity, it's not always possible to give people absolute choices about how their data is shared.

David Blumenthal – Department of HHS – National Coordinator for Health IT

If I can usurp the chair's prerogative, I don't think we want to surface the entire privacy framework here. We will get to it. We have gone to it. We'll get to it again. Mindful of the time, I think with the committee's permission I'm going to extend the time for the lunch break a little bit so we can get to the rest of what's on the table. I do want to clarify something here in terms of what's being presented and after this discussion I'm a little unsure of what exactly is being discussed as a stage two recommendation with respect to patients' electronic access to their own information. Whether we are saying in effect you have to have electronic health record to be certified we'll have to have three or four options for access by patients, portal, secure messaging, a personal health record that is private and secure. Or whether we're also saying there is not only that but you have to show that a certain percentage of your patients are using it or whether you're making it available to a certain percentage of your patients. So I guess that, I, for one, have lost a little bit of focus on what we're actually suggesting here. We could just, again, put this out as a request for comment with options and come back to it if we don't want to deal with it today. Yes, George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

The framework was for hospitals. Maybe this may work or not, but for hospitals it was number offered, and that was the 80% and we had an extended discussion about that. And for eligible professionals it was seeing the outcome, how many patients actually use the system. So that was our suggestion at this point in time and maybe both should be outcomes and both should be offered, I don't know. But that's what we put forward in these slides.

To answer your questions, David, I think incorporating the comments that were raised here, we are saying that the EHRs should have the capabilities themselves to address all of these objectives, and that's a little bit of a difference that we're seeing. So that means everybody should be able to address that completely as covered entities through their certified EHR, which typically will have a patient portal feature attached. In addition, if they choose to do it in some other way that would in a sense mean that's under the covered entity that would turn those other operators into business associates. So I think that's the implications of today's discussion. And yes, for the EPs we are asking that they actually have 20% use.

M

It's just that there's 10% requested in stage one.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So that's an increase in level from 10% to 20%.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Okay, any further comments on this?

W

You were not present, but I did want to say that I did have a problem with that, requiring physicians to be responsible for things that are totally out of their control and requiring that they are accountable for the patient ... record.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

There is an unknown about this, which is how many people actually want this and will use it. There's a lot of variability. Kaiser has one set of experiences and other organizations have others and ... patient population specific.

W

We ... while you were gone, about the fact that it's also incredibly clinician driven and so Neil gave an example of in his practice. He has one clinician who has 10% of patients using this kind of service, whereas another has 70% or 90% or something much higher. So because stage one already lays the groundwork for an outcomes based measure and because what the evidence and people's experience in the field is telling us is that when clinicians put a high priority on it, then in fact patients are using it at much higher levels than just what is happening organically without clinician leadership. That this is one of the most meaningful ways that meaningful use can actually be meaningful to patients and families, was through this kind of access and actually ability to download.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay. Our next slide, this is our care coordination slide. Remember in stage one we did a test of health information exchange and we proposed in stage two basically to connect to at least one external provider in their primary referral network, in other words, the doctors that they interact with regularly. This focus is that using, say, an indirect you'd connect to at least one external provider or establish an ongoing bidirectional connection with at least one health information exchange in your area. Then when we're working on the HIE network we're going to hear a presentation after lunch about the entity level provider directories, and the question is how to tie that into meaningful use so it gets pushed forward to certification.

The way we've decided to do it so far, and Paul, you can comment in a minute, is to put in a comment that successful HIE will require development and use of infrastructure like ELPD. The point being that there's going to be a lot of infrastructures that are required for HIE to succeed related to provider directories, security procedures, certificates and so on. We can't make a separate objective for each one, so we want a mechanism whereby HIE is the objective and then we can pull in the things that the other workgroups need for this to succeed in there and that's the route into certification. So that's that one.

Next, medication reconciliation: Medication reconciliation will be conducted at 80% of transitions by the receiving provider, and this represents an increase from the 50% from state one. Provide a summary of care record, so this was alluded to before. Remember, this is not from provider-to-patient, but from provider-to-provider, although it could be from provider-to-patient-to-provider depending on the local workflow. And then we just move this from menu to core. Then two new objectives are really related.

It's about starting off on this longitudinal care plan, which, as I said earlier, is not that well defined. So the first part is list of care teams, so if you don't have a care plan, you need to know who are the players, so a list of care team members available for 10% of patients in the EHR. At this point, within stage three, actually be able to share that list of providers. Then, similarly, analogously, record a longitudinal care plan for 20% of patients who have high priority health conditions. So it's not 20% of all patients, but 20% of patients who are defined on this list of high priority health conditions to create a care plan and then sharing would be in stage three with a comment on the right. What is the longitudinal care plan? So we've looked at some things, but they're not a formal definition, so care team members, diagnoses, meds, allergies, goals are a short list that we're kind of leaving purposefully vague at this point in time for this comment period.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Comments? Marc?

Marc Probst – Intermountain Healthcare – CIO

Yes, so again, it was great, George. Thanks. The 30% of external providers in the primary referral network, that might be a little bit difficult to measure, and even attain, so that's for proposed stage three of HIE.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That's a good comment.

Marc Probst – Intermountain Healthcare – CIO

For instance, there may be providers that don't even want that in your primary referral. Well, I guess it wouldn't be in your primary referral network, so it's just definitional, I think. That one seems a little bit challenging.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes. I'm a little worried about the definition too.

Marc Probst – Intermountain Healthcare – CIO

Yes, the definition of that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

But we tried to make it easy for stage two, which is the one immediately at hand where you just have to get one provider connected.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Judy?

Judy Faulkner – Epic Systems – Founder

Just one comment on the perform test of HIE. If someone is in an area where they simply aren't connectable ready yet, perhaps you might want to add, be able to demonstrate an NHIN or NHIN Direct capability.

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

That's already in stage one.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That is stage one. The question is, does there need to be an exclusion if there are zero providers in your area and no HIE.

Judy Faulkner – Epic Systems – Founder

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

And so we'd have to consider that possibility. I don't know whether – we just have to see where we are with that. But I understand the request.

Judy Faulkner – Epic Systems – Founder

Okay.

David Blumenthal – Department of HHS – National Coordinator for Health IT

David?

David Lansky – Pacific Business Group on Health – President & CEO

Just point of clarification, on the 30% of the primary referral network, that actually came from Neil's experience, and they did that, and it worked out reasonably well. I don't know if Neil wants to....

Neil Calman – Institute for Family Health – President & Cofounder

The 30% didn't come from my experience.

David Lansky – Pacific Business Group on Health – President & CEO

No, but you were

Neil Calman – Institute for Family Health – President & Cofounder

The idea of identifying a unit that was your primary referral network and focusing on that rather than just having information go everywhere, that was our experience.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, Charles?

Charles Kennedy – WellPoint – VP for Health IT

Just a question on the medication reconciliation one, stage three it says 90% of transactions by receiving provider. Do we mean by receiving provider or receiving provider system? In other words, is this a system process, or are you simply providing multiple medication lists that the provider must reconcile manually?

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

The meaningful use objective is that the provider conduct the activity medication reconciliation. The system must be able to support that, so that turns into the certification criteria, but it is the provider who does the med rec.

Charles Kennedy – WellPoint – VP for Health IT

So that means it could be you look at multiple medication lists from multiple data sources, and you do that manually. That would satisfy the criteria. Is that correct?

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

Correct, and it doesn't specify that it's complete. That you do the activity with the information available typically is going to be the patient.

M

Now there are some vendors who do that for you.

David Blumenthal – Department of HHS – National Coordinator for Health IT

David?

David Lansky – Pacific Business Group on Health – President & CEO

Very quickly, often it's done by somebody else in the provider's team, in many of the most, so that should be acceptable too, whatever language we use.

David Blumenthal – Department of HHS – National Coordinator for Health IT

I want to insert a comment and ask a question here. First a comment: Maybe others have referenced the so-called PCAST report besides Deven. Has that been discussed today? The President's Council of Advisors on Science and Technology last week released a report that was all about interoperability and made some very concrete suggestions for meaningful use stage two requirements. We will have to bring those back here, but they would very much impact what we consider and recommend, and we haven't exactly figured out how to schedule this.

Judy and our team are working on bringing the report directly to you, and also bringing members of the PCAST itself to describe it to you. But it would have very important implications for health information exchange, potentially also for privacy and security and we will have to take that into account, as we go forward. I don't think it would be inconsistent with what's being discussed here, so it might facilitate what's being discussed.

The other question I had is, we have—the PCAST report, which was strongly supported by the president and the White House, is an example of their strong commitments to information exchange and interoperability. I suspect that as we move forward, that theme will continue to surface, and that a forward leaning posture on information exchange will be welcome, and it's one that we've certainly talked about, and one of the most consistent questions I get as I travel is, this is all fine, but no one wants to exchange information. And you can build the capacity, but no one wants to use it. And people have 25 reasons why they can't do it, and sometimes they invoke HIPAA. The privacy and security people will say that's not a problem. You can exchange information if you want. That's the problem.

But I would encourage us, as a group, to think on this particular issue more aggressively than we have on some others, and the reason I say that is that there is no other current leverage that we can exhort as a government to encourage or change the local competitive incentive environment other than meaningful use. Now we have to balance what we require against what's technically capable, we're technically capable of. But if we don't require enough, the technical capability will never materialize. So as we get to tradeoffs, this is one where I think at least the Administration will feel strongly about pushing us to be more aggressive.

In that regard, I wonder whether one external provider would be sufficient as a requirement in stage two, especially if NHIN Direct is by then a meaningful option. And also whether there needs to be some qualification around that that has to do with the relationship between the parties that are exchanging information so that the information exchange doesn't just occur with people within an IBM, or people on the staff of the same healthcare organization. So there is some language about that in meaningful use stage one, but I would want to make sure that we imported that language going forward as well.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Population and public health, I'll cover the next two slides together. Stage one, we had immunizations, so for hospitals and professionals, first it's mandatory to test the system. At least some immunizations are submitted on an ongoing basis to the immunization information system, that is the central public health system, if accepted, and as required by law. We recognized that we couldn't mandate that all data gets sent that way. For example, you might have a patient visiting you from across the country. That state might require reporting, but we don't want to link that to meaningful use for the doctor, for example, so that's why we say some at this point.

For reportable lab data, it's currently menu, so we make that core for hospitals, and then for eligible professionals, we make lab reporting menu. This is our only menu item, so it's hard to say what menu means yet, but since we haven't gotten through the comment process, there may be other things, so depending on what happens, but we're thinking as a first step we'd make this menu. And the professional doing the reporting means either they report it or they work with the lab that does the reporting directly to the health department. That's actually what's stated, and actually should pull into here probably, but it's stated in the stage three objectives. That's what we meant by that.

Syndromic surveillance data, again, move that one to core. And then the other objectives are put off for stage three, that is the public health button and patient generated data being submitted to public health agencies. Just as the patient information going to the EHR was put in stage three, so is this one. Now there are a lot of things one could theoretically do in public health, but we felt that we had to keep it to a manageable number, and this is what we ended up with, basically making it a little bit mandatory, including more providers was really the change to stage two. Comments on that, Art or anybody?

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

Now this could be a place where the federal government can push itself in terms of interoperability.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I'll just make one comment. It does say electronic laboratory reporting, and there are conditions that are reportable that don't require a lab test, so we may at some point – I'm sure there'll be comments about this. There may be a need to broaden that to beyond laboratory reporting.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Actually, I thought stage three was supposed to say that.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Right

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So I'll double-check that.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Right. Thank you.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Reportable conditions, you're referring to?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Any comments on the public health suite? Everyone just wants to go to lunch? Is that the message?

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

Yes. And the final one on privacy and security—

David Blumenthal – Department of HHS – National Coordinator for Health IT

We got a taker here. Okay. Privacy and security, move ahead.

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

We don't have any new objective at this point, and that's in recognition of the fact that NHIN governance is going forward. There's the COTI. Clearly privacy is front and center there. There'll be certification requirements emerging from that. We want to track all that, and it may be incorporated at some future time when we better understand that before the final recommendations from this group next summer. But currently there's nothing. We didn't want to go into dissonance with whatever is coming out in NHIN.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Okay.

M

...disclosure ... at this point?

Deven McGraw – Center for Democracy & Technology – Director

No.

M

It's not?

Deven McGraw – Center for Democracy & Technology – Director

It's not, which is why it certainly wouldn't be any sooner than proposed stage three, and we might have to push it back even further, so it just depends where the regulatory timeframe is on that one.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Charles, concluding comment?

Charles Kennedy – WellPoint – VP for Health IT

Didn't we say that we were going to have some requirements around administrative data and administrative functionality in phase two? Did we make that – was that a strategic shift or what happened to administrative requirements?

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

I think those were all actually under the "QMs," so we were saying that they would, a certain amount of the administrative – there's administrative efficiency. Let's see. Yes, so we had some clinically oriented one like the use of generics where available, like reporting on indications for costly imaging procedures. Those were in the QM side. We did have efficiency in electronic transmission of eligibility in the original, and I don't know where we are from a – presumably it was taken out of scope because it's not clinical. It doesn't necessarily appear in EHRs, and I don't know whether that still applies.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, the final regulation on meaningful use does speak to the intent to bring those back in stage two, the electronic billing and the electronic claim submission requirements, so this committee can choose to recommend them or not, but the Administration expressed its intent to go in that direction in stage two.

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

And was the question of whether it's in an "EHR" addressed in that?

David Blumenthal – Department of HHS – National Coordinator for Health IT

Whether it's in an EHR?

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

Correct, because the EHRs would then have to be certified.

David Blumenthal – Department of HHS – National Coordinator for Health IT

So certified, the EHRs would have to be certified to have the capability to submit claims electronically, and meaningful use would also require that claims be submitted electronically and that demographic information be kept electronically. But this is complicated because it also now in healthcare reform, in the ACA, there's a timetable toward a reconciliation of the claims processes across insurers, which would make it more important for us or for the Administration to require the physicians and other health professionals be capable of taking advantage of the simplified claims process that is required under healthcare reform.

We've got plenty to ask for comment about, and we have, though time is short, it seems like we've got a lot of time compared to the first time we went through this. There are, the quality area is, of course, a big gap in terms of our discussion here, and we are doing a simultaneous request for comment on that area. But we have lots of time to come back to this, and we consider it lots of parallel processes that need to be considered. I guess it's a good time to talk about the timeline. Go ahead.

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

With your permission, and I think there's a fair degree of consensus about going forward with the proviso. I think the main thing was certifying against the patient portal piece. Then we would be planning to issue a request for comment for the public in January, collect those in February, revise our draft recommendations and present that back to you in March, then wait for further feedback from a combination of your survey days, the RAC experience, and early submissions to provide a final draft recommendations for discussion again at this group in the middle of the summer, in the summer kind of timeframe.

David Blumenthal – Department of HHS – National Coordinator for Health IT

The other point I'd like to make is that though the recommendations of this committee coming in the summer will be very important, as they always are, that we have time between the time that you make recommendations, we make recommendations, and the NPRM to look further at experience of stage one. And even after the NPRM, there is time to look again and further still at experience. So before we finalize this regulation, we'll have a year and a half of experience with stage one of meaningful use, and can adjust right up until it's posted in the federal register, and I've seen that happen. I think that you shouldn't feel as though, though we take your recommendations extremely seriously, you shouldn't feel like you are doing things that are irreversible if you're uncertain about them. And the other point I would make is that the aspirational quality of stage three is extremely valuable for lots of observers, and will help, I hope, the industry, both vendors and providers, to think about how they're organizing themselves now and how stage one, what they want to do in stage one, if they have some sense of where they're going to need to be four years from now.

Great. Time for lunch. We'll reconvene at 1:00.

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

Thank you. Actually, David, the last agenda item is no longer going to be there, so if you wanted to have the full 45 minutes, you do.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes. Letting people end early is probably ... yes.

(Lunch Break)

Judy Sparrow – Office of the National Coordinator – Executive Director

We're ready to begin the meeting, if you'd please take your seats. Let me turn it over to Dr. Blumenthal.

David Blumenthal – Department of HHS – National Coordinator for Health IT

For those of you who are listening remotely, we are a little bit short of attendance here, but I'm expecting a surge very soon. We're going to welcome Micky Tripathi, who is always willing to serve. We were very grateful for that, and David Lansky, similarly, on the phone. We're talking today – we're hearing from the information exchange workgroup, and I think we're going to be hearing mostly about directories and issues related to that. Is that correct?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Please go ahead, Micky.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Great. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

David is on.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Great. Thank you to the committee. I wanted to first off give David Lansky a chance to say hello and to recognize his presence. David, are you there?

David Lansky – Pacific Business Group on Health – President & CEO

I'm here, Micky. Thank you for leading us on.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Great. Thank you. David, please feel free to weigh in at any point during the presentation, but I think you've seen it a million times, as I have, so we can hopefully move through it pretty briskly. Today we're going to talk about entity level provider directories, and first off wanted to, as we always do, recognize the workgroup itself and all the members of the workgroup, as well as the provider directory taskforce, which has been very ably led by Jonah Frohlich and Walter Suarez, who have done a ton of work and, in the past week, it feels like we've done about a month's worth of work in the last four or five days with all of the comments. But we are now in a position to make some recommendations about entity level provider directories and the policy levers that we believe would be appropriate to instantiating entity level provider directories in the market.

You may recall that the information exchange workgroup generally has been focused on two, and I'll put them at a high level, different types of directories. One is what we call the entity level provider directory, which is about addressable entities, clinical entities on a network, and then what we've been calling the individual level provider directories, which would be directories that list individual clinicians, individual clinical users, and we've broken that into two categories, and we're phasing our deliberations accordingly. So we focused on the entity level provider directories first with an eye toward ELPDs to support meaningful use stage one.

At the last Policy Committee meeting, we presented and was approved by the Policy Committee recommendations on the characteristics of entity level provider directories and our recommendations about what entity level provider directories ought to cover, what ought to be sort of their general parameters. And today we're going to discuss a set of proposed recommendations related to the policy levers that we believe would be appropriate to catalyze the creation and use of entity level provider directories in the market. For the February Policy Committee meeting, we will present recommendations on the individual level provider directories. Give ourselves a little breathing time for the rest of December and January to catch our breath and then move to that topic.

Just a little bit of recap before we get into the specific recommendations, this is the framework that we've been using to guide us in the provider directory conversation. This is a slide that we've presented now a couple of times before the committee. On the left-hand side, what you have are the different elements or dimensions of the characteristics of provider directories that we've been sort of attacking one-by-one-by-one, and that was sort of the framework that we used for the set of recommendations that we made last time. And then, as the slide depicts, the idea was to first come up with a set of characteristics that we thought made sense, and then to consider what policy recommendations we would have about levers that would accelerate the establishment and use of entity level provider directories. That's where we are on the right-hand side now.

There are four key questions that we use to guide us here. One was which business model should the government promote. What are the potential government roles and levers? What's the appropriate level of depth in policy recommendations, specifically related to all of the workgroups, but also with an eye toward our anticipating that we would be handing off a set of recommendations to the Standards Committee for their guidance and input on the technical standards related to this and wanting to sort of, within ourselves, understand how far should we go before handing that off? What are the appropriate sort of policy framework to hand off? Then finally, what's critical and necessary to meet our goals? What

are the minimal necessary principles where we think of principle being spelled correctly as opposed to how it's spelled on the slide there?

Moving to the discussion here, at the last meeting, as I said, the Policy Committee approved recommendations on the characteristics of provider directories. That was related to users, minimum functions, content, and the business model and operating approach. As I said, we will now be focusing on the policy levels. Some key framing questions that we sort of thought through about how far do you need to go, one was related to how far do you get into the sort of technical parts of it, but really a more basic question about how much intervention is needed to kick start a market based ELPD service? If you start with standards, let's say, that could be the minimal set that you say we want to articulate a set of characteristics, and then we want to articulate a set of standards, and then you could step back and say we think that the market could take over from there. Or do you need to go further and say that we also need to spur creation of some initial infrastructure, that just having standards wouldn't be enough, that there needs to be some initial infrastructure to be able to launch this thing.

And then, finally, is that enough, or do we need to keep going forward and have a set of incentives, a set of considerations about how we would encourage use given that you've created standards, created an initial infrastructure? Do we think there's still more sort of push that's needed or pull, however you think about that? The conclusion in general of the workgroup is that policy levers on all of these dimensions would need to be undertaken in order to catalyze this and get the use, particularly with an eye toward it having any hope of aligning with meaningful use stage one, and so that's what guided us in our thinking.

As I said, this is just a recap. I won't go through the details. It's really just provided for your background, but these were recommendations that were approved at the last Policy Committee meeting related to the characteristics, and there were three sets. Again, I won't go into too much depth on them except on this last one, which is on slide 13, which is related to the business model and operating approach where the business model that we proposed is an Internet style model, Internet style architecture with nationally coordinated federated approach with accredited registrars, some national guidelines, an eye toward registrar reciprocity and publication to a single national registry system, so the idea would be have a single registry system with multiple registrars who are able to enroll qualifying entities into the registry. The reciprocity idea is that that ought to be seamless from the perspective of the user, that when you enroll with one registrar, all registrars know that you're enrolled. You don't have to go to multiple registrars if you're in multiple states or what have you, that you have a single place to go.

Now let's move to our recommendations. I wanted to just cover quickly the bare bones of that business model because it's important to an understanding of the recommendations, and we have three levels of recommendation here. The first is related to the creation of standards, so the overall recommendation is that the HIT Standards Committee should be directed to identify technology, vocabulary, and content standards that will create an entity level provider directory with multiple registrars and a single, nationwide registry, as I'd mentioned earlier. The single nationwide registry must be accessible by EHR systems. That would be sort of a minimum criteria. The acquisition of a security credential, i.e. a certificate, and discoverability of the credential using the ELPD must be included in the technical approach. So the idea is that you have to have a certificate, and that's related to a requirement that was passed from the privacy and security working group at the last session as well that having a certificate as a requirement. The importance for the entity level provider directory is that it needs to facilitate discoverability of that certificate, so I know that this is a known entity and that they have a valid security credential would be the two parts of the discoverability there.

The technical approach must also include a process for certification of ELPD functionality in electronic health records, firstly, so it's very important that electronic health records are able to consume the information at a minimum. Going forward, you may imagine that electronic health records could be involved in perhaps populating registries or what have you, but we're really just saying right now that there is a certified functionality that we need to instantiate in the systems. And, secondarily, we need a

technical approach for accreditation of registrars. There's obviously a broader accreditation process, but there would be some technical requirements associated with that, which we would like the health IT Standards Committee to weigh in on.

Then, finally, this is more of a process point, we recognize, as I described earlier, as we were thinking about, this, we ourselves had conversations within the workgroup about how far do we go in the way of specifying an architecture or particular technical approaches, and it kept jumping back and forth. One of the things that we would like to convey is that we recognize that there are probably some unanswered policy questions here, and we'd be sort of shocked if that's not the case. And what we would like is to make sure that there is a back and forth with the Standards Committee, as necessary, to insure that the standards development is aligned with policy because we think it's critically important that the policy of this get appropriately manifested in the standards.

That's the first broad set of recommendations, and just sort of a discussion point here would be that the working group, I think, feels pretty strongly that the infrastructure for an effective nationwide directory includes the registry itself as one part of it, a robust process for managing the registry entities, which is about the accredited registrars, and then, finally, the means for users to access registry information, which is the EHR part of it. I'm just putting it in lay terms. That's really what we're trying to get to here at the end of the day, and that's what this set of recommendations lay out. Let me first ask David, did you want to comment at all on this one before I move forward?

David Lansky – Pacific Business Group on Health – President & CEO

No, Micky. You've done a great job. Thanks.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

I just want to make sure you're still there. Would you prefer that I go through the whole thing? Okay. The second recommendation, and now it's going to challenge my eyesight. The second recommendation is really related to the levers that one might use. The first was about creating a technical framework for it. The second is about, the sense of the workgroup is that the government really ought to use the strongest available levers to require registration in, first and foremost, and encourage use of the nationwide entity level provider directory. But it really is sort of two parts. How do you get people to register, first and foremost? And how do you encourage the use?

The reason we characterize it this way as the strongest available levers is that there are a variety of levers, many of which are still sort of in the early stages, in ... stages of the consideration, so we felt less comfortable having very specific requirements about it should be this or it should be that without being able to sort of step back and say, we see that there are a variety of levers here. We see that they are working their way through the working groups. And what we want to be able to do is make sure that the thinking about an entity level directory is incorporated in the thinking of each of those processes, as we move forward, without trying to jump ahead of that process and say it should be specifically this or specially that. In particular, we believe that registration and use should be incorporated in meaningful use stage two and three, as well in NHIN participation requirements, which is, A, part of the meaningful use workgroup set of considerations, as well as the governance working group.

In particular, we would recommend that the meaningful use working group should work with the information exchange working group to determine the best approach for incorporating registration and the use of meaningful use stage two and three. And I'll describe in a second why we're sort of phrasing that that way. As another sort of parallel track that the governance and participation should be included as part of the NHIN conditions of trust and interoperability and used as a lever to establish NHIN governance. You could certainly imagine that being one of two flavors or perhaps both.

One would be that requiring ELPD registration for participation in NHIN Exchange and NHIN Direct and creating an accreditation process for registrars within the context of other similar processes, for example the certificate issuance process. That those don't necessarily and nor would we necessarily say that they

are the same organization, for example, of accredited registrars and certificate authorities. But at a minimum, we want to make sure that they are complementing each other or there's a consideration about how they work together and how they fit together. There are other pieces as well, as we go forward, I think, that we want to make sure that we're covering.

In lay terms, what are we trying to get at here? One is that we see meaningful use and governance as being really complementary levels. That meaningful use has greater reach and more immediate relevance in the market, and we think that that's very valuable, particularly as we think about wanting to get this done faster and being able to support providers with meaningful use incentives. Whereas, on the other hand, as you think about NHIN governance, technical requirements going forward, they're likely to have a persistence that's beyond the HITECH incentives, so that they do seem to sort of complement each other in that way.

We do strongly support incorporating the registration and use in meaningful use in stage two and three requirements. However, we do recognize the details of how to incorporate that really need to be worked out and integrated with other health information exchange infrastructure requirements, so first and foremost. There are a number of other requirements. This isn't the only one, and we recognize that. And the second, we also recognize in discussions with the working group as well that, in general, we want to be moving away in the meaningful use requirements from sort of process requirements that say you should check off the box on this technology, toward more sort of outcome or clinically focused requirements. That takes a little bit of work, and we're confident that we can work this in, in a way that would sort of fit in with that approach. But given that that's sort of a process that's ongoing right now, we didn't feel comfortable making a specific point requirement at this point saying registration ought to be a meaningful use requirement, but really just saying that we feel strongly that it should be in there somewhere. We need to work with the meaningful use workgroup to really understand what's the best way to put it in.

We also believe that it should be part of the NHIN participation requirement, as I mentioned before. And in discussing a little bit with the governance workgroup, it seems that it could perform two vital roles. One would be that it could be used either to validate potential NHIN participants, so you could imagine that there is a validation process that goes with being an entity listed on the entity level provider directory, and that the governance process is able to use that as a validation for broader participation in the NHIN. Or you could imagine that, on the other end of it, sort of an ex-post, it would be the recognition of someone having gone through some type of validation process, perhaps through another means, and the recognition of that is that you're listed on the directory, and that's how people know that you've gone through the process.

Certainly, and then the last point is, and we were not able to really get enough of a deep conversation, I think, with CMS about this, but I think the workgroup does also feel strongly that we need to be able to leverage CMS processes, certainly other processes, but CMS in particular. I think, in all of the conversations we've had going back to really the summer of a year ago where we had a large, the NHIN workgroup at the time, had a day-long hearing on provider directories and heard over and over again that it's certainly possible that the NLR and PECOS and other existing or soon to be existing databases maintained by CMS probably have sort of the greatest single place that one could get almost all the information or the most available information in a single place than any other place you could imagine in the market. So being able to leverage that might be sort of a path towards acceleration here that ought to be explored further.

The last recommendation is related to the levers of the other programs that ONC is managing right now. In particular, the state level HIE and beacon programs should be required to incorporate the national registry in addressing their provider directory needs. As I think everyone knows, both of those programs have been, the recipients of those programs have been very, very strongly encouraged to use their program dollars to create directories and, indeed, part of the urgency of our deliberations and the reason the information exchange workgroup has been involved in this with such urgency over this timeframe is

because of a need that's been sort of bubbling up from the states in the beacon programs. The two specific recommendations there: one, that ONC should require conformance with the ELPD standards and technical guidelines once the Standards Committee is finished with those. Then, second, ONC should encourage state level HIE program grantees to become accredited registrars and to promote the establishment of accredited registrars in their states and regions.

As I mentioned before, the idea is to have multiple registrars in a single registry with a fairly open definition of who could become a registrar. We would strongly encourage that the HIE program grantees become registrars. And we think that this can provide a foundation on which to build the individual level provider directories, which is really where most of the states and beacon grantees who are thinking about this are thinking about individual level directories. But we think that this could provide the foundation for that. In essence, sort of hooks to hang things on, as well as could provide that foundation for other sub-national public and private registries. And while it might be desirable to require that state level HIE grantees become registrars, we recognized in our discussion that there's a lot of variation in state law that might prevent that, as well as the potential for many organizations to become registrars that we think obviates the need to make that as a requirement, which is why we framed that as an encouragement rather than a requirement to the beacon and state level HIE fund grantees.

I think that is our three sets of recommendations. Let me ask David Lansky if there's anything else, David, you'd like to add.

David Lansky – Pacific Business Group on Health – President & CEO

No, Micky. I think we've come a real long way in sorting out issues that are of concern to the state HIEs and providing a framework within which they can understand the role that we think would make sense. And I think the clarification about the role of the standard setting process is really helpful. But I think we've laid out a large, high-level framework, within which I think there's plenty of room for implementation going forward.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Thank you. Thank you, both, for a very clear, concise presentation, and obviously representing a huge amount of thought and processing. Any comments, questions? In the postprandial slump here, are we going to rise to...?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Caught you in a perfect time.

David Blumenthal – Department of HHS – National Coordinator for Health IT

ELDPs and postprandial in the.... Yes, sorry.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

...back pocket recommendations we'd like you to take a look at.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Nice job, Micky.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Thank you.

Art Davidson – Public Health Informatics at Denver Public Health – Director

On this last recommendation, number three, you specifically point out the state level HIE and the beacon programs, and it may be that these are the ones best to – that'd be required to incorporate, but I just wondered, had the workgroup thought a little bit about how the RECs might promote the concept of entity level provider directories and maybe there could be something addressing that on this slide.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Sure. I don't remember specifically. I think it did certainly come up in the conversation, and perhaps it was my omission more than anything else in not including that, but I think it's safe to say that there would be broad support in the workgroup for that.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Other comments, questions? Yes, Neil.

Neil Calman – Institute for Family Health – President & Cofounder

Can you just go over like the definition between these entities and the individuals and what the dividing line is? You had clinics listed as an entity. So if I'm in a two-person group practice, is that an entity, or is it an individual?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

The practice.

Neil Calman – Institute for Family Health – President & Cofounder

The practice is an entity?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

The practice would be the entity, and in the cases where I'm a solo practitioner, let's say, my father, Dr. Vinod K. Tripathi, he would be the individual, but Dr. Vinod K. Tripathi, Inc. would be the entity.

Neil Calman – Institute for Family Health – President & Cofounder

So the purpose of the individual is only – the individual identity is only to identify individuals within an entity.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Within an entity.

Neil Calman – Institute for Family Health – President & Cofounder

But if you are an individual practicing like that, then you're also the entity.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Right. Exactly.

Neil Calman – Institute for Family Health – President & Cofounder

Thanks.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes. And the reason we think the entity level provider directory will provide a foundation for that is, as you create the individual level ones, they all ought to map to recognized entities in the entity level provider directory.

Neil Calman – Institute for Family Health – President & Cofounder

Can I follow up with that?

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

So if I'm an individual when I practice within multiple entities, that's where, that's what brings the importance of this, right?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

So that the information will flow to the entity and then to the individual, so I might have information flowing to me as an individual provider through a number of different entities.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Right, and that, indeed, that's why in various places like in New England with the New England Health Exchange Network, they've created individual level provider directories to resolve this problem that you have physicians who practice in four or five settings, and they need to not only know the clinician's name, but the entity with which they're associated in order to route the information properly.

Neil Calman – Institute for Family Health – President & Cofounder

Thanks.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Jodi?

Jodi Daniel – ONC – Director Office of Policy & Research

Thanks. I had a question. I'm just trying to understand what you're thinking and how this all fits together. I understand the various like state HIE programs with the individual registrars, and then you talked about, in recommendation one, a single nationwide registry, and I'm wondering how you see that operating and rolling up and what mechanisms would be in place in your discussions to kind of pull that up to a nationwide registry and connect all of those dots and how....

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes, sure. I think, in general, whether it's physically a single database in one particular place or a virtual database that has – sort of is federated in its structure, but really represents a single registry. I think that's really just a technical and architecture consideration, but the idea is that you have multiple registrars, multiple entry points to what you as a user would see as a single registry. You could think of it as almost being a single file. Paul, it looks like you wanted to weigh in on this as well.

Paul Egerman – Software Entrepreneur

Sure. There's simply an Internet analogy for this right now if you think about how Web services work or e-mail works. There are multiple registrars. If you wanted to register an e-mail server, and there are multiple registrars where you can register it, but they publish, in effect, to a single directory, a DNS directory that helps the user actually direct the information ... it's a common technology.

Jodi Daniel – ONC – Director Office of Policy & Research

Would this be something in your view that would be – who would be pulling that all together? Is that something that is a government responsibility, or is that something that somebody else...?

Paul Egerman – Software Entrepreneur

It's not necessarily that anybody has to put it all together. It depends on the technology. You could public to a single file as it were that could be made available for multiple sources. Again, if you look at how DNS works, a lot of people in affect have the authority to publish to it, and so if a registrar has the authority to publish into the directory, but it's a single common directory that everyone can access.

Jodi Daniel – ONC – Director Office of Policy & Research

And one other question, if I may, so I understand you're talking about using different levers like NHIN participation or meaningful use as a way of getting providers to participate or to register as part of this. I'm assuming, correct me if I'm wrong, that the goal would be to have a broader net than that, not just folks who voluntarily participate through the NHIN or that are eligible providers, for example.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Absolutely....

Jodi Daniel – ONC – Director Office of Policy & Research

But the goal would be to have it be as broad as possible?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

To cover all clinicians and all clinical entities would be the goal so that those are the levers immediately....

Jodi Daniel – ONC – Director Office of Policy & Research

...I just wanted to make sure I understood this is certifying.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes, right.

Jodi Daniel – ONC – Director Office of Policy & Research

Thanks.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, Neil.

Neil Calman – Institute for Family Health – President & Cofounder

Do you contemplate some sort of a search function then that's going to – if you use the Internet analogy, we don't know the Internet address of every place that we want to know, but we have a search function that enables us to go out and say a patient comes in and says, I use such and such a place. And how would that integrate with the concept of having the directory in multiple locations?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes, so the idea would be to have a search function that's hopefully mostly machine-to-machine, but I think it would allow, and I think we certainly had conversations about use cases where a manual lookup might also be something that would be useful, so we've contemplated both and imagined that both would be useful at some level.

Paul Egerman – Software Entrepreneur

If you think about the example that we looked at for meaningful use where you want providers to connect to external referral sources, this could be a use for this kind of a directory. If you want to refer it to some organization, this is how your computer system, not you individually, your computer system finds out the address of the other computer system so that they could have whatever computer conversation the two machines want to have with each other. I knew you would enjoy that comment.

M

Hopefully it represents what we're interested in ... talking to each other.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Neil, one of the use cases that came up actually in a conversation I think that came out of one of the representatives from Epic about use cases that they see in the market all the time are that a patient is at a hospital, and their information is at another hospital that they know familiarly, but they certainly don't know the specific IP address or domain name, so they know that it's at Mass General. They have no idea really what the domain name is. But from a machine exchange perspective, you clearly need to know what the IP address and what the domain is so that that would allow that search, based on familiar names, to something that is machine-readable.

David Blumenthal – Department of HHS – National Coordinator for Health IT

A couple of questions: First, there is a kind of optimism from a policy perspective here that meaningful use and participation in the NHIN would together be sufficient to get providers to voluntarily become part of the 21st century – have a way to be located electronically. Presumably this would be a certification requirement of an electronic record that it create that capacity for a provider to register. Did you think beyond the optimistic scenario to a more pessimistic one, or did you kind of put that in that category of policy issues to be discussed later on?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

I guess the optimism is related not that meaningful use and NHIN participation will be what sustains it, but that it needs the jumpstart, and that it will have value in and of itself once it gets created. We heard from enough players around the table, both from the vendor side and from the provider side. Many providers don't feel that it's enough. They would really like the individual level provider directory. But we're starting this as a phased approach to say that this is the foundation that could be nationwide, which is a benefit to everyone, and that hopefully with those two or three sort of jumpstarting kind of efforts that it will start to demonstrate the value on its own, much like things like the blue button initiative, things like that. The hope is that once you start to create information and create a basis for information that doesn't yet exist in the standardized way that people will start to do things with it you can't imagine.

David Blumenthal – Department of HHS – National Coordinator for Health IT

The answer is you didn't deal with the pessimistic....

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

No. I just didn't want to say no.

David Blumenthal – Department of HHS – National Coordinator for Health IT

The second question I had, and this probably requires a dialog between the tiger team and the HIE workgroup, and that has to do with registration and authentication and how the two relate to one another. Are registrars also going to have the responsibility to say yes, that clinic is a real clinic, and we've verified that it's a real clinic using this following process? Is that something you've thought that the Standards Committee would deal with or something that you thought the tiger team would deal with? Have you thought that out?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes. That was related to that point that I'd made in one of the recommendations about that this needs to be considered in the context of other processes, and it calls out the certificate issuance process that I don't think all of those have been sort of thought through enough, and we don't know what some of the other ones are to know. But it's certainly a question of, if the process for issuing certificates has a very robust validation process, and I'm on the privacy and security workgroup. Both Deven and Paul are on this workgroup. So there was certainly a conversation there about how much validation does a certificate authority need to do to issue a certificate? If that ends up being something that is robust enough to say that would also overlap directly with the requirements for participation in the provider directory, then you're able to say that would constitute the going in requirements. Conversely, if you decided to go the other way, that there are certain things for a certificate authority, but perhaps leaving on the table other things that validate the integrity of the organization itself as a licensed organization and all of those things. The certificate authority could rest on ELPD registration to fulfill some of those requirements. I don't know if Paul and Deven, you have other thoughts on that.

Paul Egerman – Software Entrepreneur

I think you just did a great job of describing it, Micky. The privacy tiger team's recommendations on authentication are coordinated with this, and we didn't specifically say the registrars would do both, but it's likely that's how it'll turn out. It depends on how the Standards Committee makes certain technical discussions, but likely the registrar will do them both at the same time.

David Blumenthal – Department of HHS – National Coordinator for Health IT

And do you see the registrar converging with the validation authority for the governance?

Deven McGraw – Center for Democracy & Technology – Director

I think it could be. I think part of the issue is that we have separate workgroups with some common members, and we're sort of teeing up recommendations that all have some sort of common – the Venn diagram might be the right illustration. And, at some point, since they're all sort of being teed up almost simultaneously, there's a need to sort of wrap them up together and see where complementary roles might be played by the same entity. I think that's completely valid.

David Blumenthal – Department of HHS – National Coordinator for Health IT

We need a wrapping working group.

Deven McGraw – Center for Democracy & Technology – Director

We need a wrapping workgroup, right.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

So we're all very good at pushing the alarm bell on the overlap.

David Blumenthal – Department of HHS – National Coordinator for Health IT

That's with a W, not R-A-P.

Deven McGraw – Center for Democracy & Technology – Director

Yes, I don't think we have anybody qualified for the R-A-P, but I could be wrong.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, Paul.

Paul Egerman – Software Entrepreneur

...to respond further to your question about the relationship between this and governance. If you took a pessimistic view, and you had somebody who was not abiding by the regulations, one could view a situation where this could be a vehicle the government could use, either to revoke their certificate or revoke their listing in a directory. So this is eventually a governance tool, but in the recommendations we really didn't go that far. You're asking a great question because when you talk about validation, you're not just talking about validation, whether or not the entity exists. You're actually talking about validating that they abide by all the NW-HIN regulations, and that certainly is possible. But we do not, in the recommendations, go quite that far.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, Gayle.

Gayle Harrell – Florida – State Representative

The only other thing I'd like to add to this is when you talk about validation of the entities. The states play a significant role since they are, for the most part, the licensing agency that handles a lot of these entities that would be registering through the registrars. For that reason in particular, I think we have a very valid policy lever with the state designated entity and the amount of money that we are giving to states that we can really impose upon them to some degree. I shouldn't be saying impose, but as a condition of their responsibilities and the significant amount of money that we are giving to states that we do use them as a validating agency and encourage them in the whole process of creating the registrars, and perhaps have an oversight view of their state registrars.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes. There's another angle, which you brought up, but I would encourage the group to think more about, and that is the relationship to Medicare and Medicaid. It occurred to me because there are major new authorities in the ACA, the American Accountable Care Act, that are encouraging the Center for Medicare and Medicaid services to increase their ability to validate the entity of providers as a fraud detection and prevention device. So there's been a real ramp up in the thinking in CMS about how to use existing online and other information. Right now the way people are often validated in someone drives by the clinic, so it's not a kind of 21st century validation technique, but it works. But thinking about how CMS is validating people and whether CMS validation should have some implication for this process is another route that we might want to explore, at least at the staff level.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Sure. Happy to. With 21st century, that use Google street view to validate

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, that's right. Now you've got to watch to see if anyone goes in or out of the door. That's the....
Gayle?

Gayle Harrell – Florida – State Representative

I'd like to tag onto that since Florida and Miami in particular happen to be the capital of Medicaid fraud, that I think you want to be a little cautious in how you use Medicaid and especially and Medicare. There's a lot of Medicare fraud out there as well, so you don't want to get too tied into a network that does have significant fraud aspects to it. Again, perhaps more eyes watching things the better in some things if you have CMCs, and you have licensing bureaus within different states, as well as Medicare and Medicaid. Let's be cautious. There are a lot of bad guys out there looking for money and looking to be involved, and there's a wealth of information in these registries, and the ability to access additional patient records through them.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Any questions? Are we ready to consider these recommendations? I think I'm just going to ask, is anyone opposed to accepting these recommendations? If not, then I think we can proceed, assuming they've been accepted and move on to the next working group. Thank you--

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Great.

David Blumenthal – Department of HHS – National Coordinator for Health IT

--David and Micky very much.

Deven McGraw – Center for Democracy & Technology – Director

Here we are once again at the end. We almost jumped the line earlier, but lost our opportunity. We actually do not have specific recommendations for this meeting. What we are instead going to just talk very briefly about is the hearing that we had last Thursday on patient matching, matching patients to their data, the right data. Just to give you a list, it was a public hearing. Here are our tiger team members. We didn't ask all these people to testify. Here's the list of the folks that we had present testimony to us. Most of them also submitted written testimony, which is available on the Web. We also had a tiger team that happened to already be on the schedule immediately afterward, and we discussed the issues that kind of came up at the hearing in a little bit of depth.

But what we're going to do today, in the interest of time, and because we're not quite ready to do recommendations yet, is to give you really a top level summary of the sort of key issues and considerations that came up. So for those tiger team members who are here, you'll see this doesn't even go into as much detail as we went in on our call, but we're preserving all of that good feedback for the time when we do get to recommendations. And our hope is that we'll be able to do this possibly at our

January meeting, although our next tiger team call is almost just before that meeting. The next policy meeting in January comes up quickly, but we're always in an effort to be timely with our recommendations and to be as ahead of the game as we can be, so stay tuned for more.

You should know that we prepped our witnesses with a sort of list of proposed questions, and this is generally where we're going to target our recommendations. What level of accuracy should be established for patient matching? When we say patient matching, we mean matching patients to their data. What standards, if any, might be needed in order to help us gain greater accuracy and patient matching to do it better? And are there best practices that should be recommended to assist with patient matching? Again, what we're doing here is top line summary of the discussion, and then, of course, an opportunity for you all to give us some feedback with recommendations to come later. Paul, take it away.

Paul Egerman – Software Entrepreneur

Thanks, Deven. I thought I was supposed to do that slide, but anyway.

Deven McGraw – Center for Democracy & Technology – Director

No, that one is mine. You get the next two.

Paul Egerman – Software Entrepreneur

Also, I want to make sure everybody understands the topic of this hearing was patient matching or patient linking, and our real interest in it was around information exchange, so it's sort of an issue of if you have a patient, Jane Smith, at one healthcare institution, and you send that information to another healthcare organization, how they link it up correctly with data they may or may not have on that same patient is very important for a lot of issues, but especially important for coordination of care when we think about accountable care organizations and how things are going to work in the future. As we went through this discussion, we have this little diagram of four things that can happen, which are, you can match it correctly, or you might not. And so the two possible bad outcomes are the things called a false positive and a false negative. False positive mean that you inadvertently put two different – information about two different patients in the same record. A false negative means that you missed the opportunity to do a match or a link, and you, in effect, create duplicate records. These are the two things that can happen.

Before we go further, I should also pause and say this is something that is a question that was asked at the hearing. Did this ever happen in manual or paper record systems? And the answer was yes, all the time. In fact, there was some reference to PCAST a little bit earlier. I watched the Webcast, and I noticed that Larry Summers spoke. He actually gave an example of this where he talked about a healthcare situation that he was involved in personally, and there was something that appeared to be bad going on, but it turns out somebody had handwritten a name "Simmons" and misinterpreted "Simmons" to be "Summers," and so this does happen also in paper records. This is not unique to electronic medical records, and hopefully we do a better job of it.

We had very interesting discussions from a lot of people. As usual, we had people from Veterans Administration. Sara Temnitz did a terrific job of describing VA because somehow they always seem to do everything correct. There were some common themes that we had, which is sort of to state the obvious, there are a number of benefits to doing this right, including improved patient outcomes and patient safety, efficiency. The very issue that was just talked about, about for Medicare and Medicaid, is fraud detection this is one of the vehicles for involved with fraud is to use other identities, so this is something also we felt was very appropriate, so there are a lot of common themes.

Am I doing this one too, or are you doing this one?

Deven McGraw – Center for Democracy & Technology – Director

I'm doing this first, and then you get it back. Actually, I did steal one of his slides. I realize we're back on the old plan. You still get the last two.

Paul Egerman – Software Entrepreneur

Thank you.

Deven McGraw – Center for Democracy & Technology – Director

That was, that Paul just went through, that was what we called the motherhood and apple pie list. We heard this exhaustive list of potential benefits for improving patient matching, but this is not easy, and achieving greater accuracy and linking is a big challenge, and there's a long list here too. The first being, we were told by our testifiers, don't expect to achieve perfection here in part because this isn't just a technology problem. There's a significant human component to appropriately matching data and catching errors in data during patient encounters and otherwise. Poor data quality, both with respect to how accurate it is, as well as how complete it is, significantly inhibits the ability to accurately match data, so the data quality issue came up time and time again. If we improve data quality, we will improve matching.

There's no one size fits all solution in terms of improvements here, and that acceptable margins of error are going to vary based on the purposes for which you are engaging the data, the different populations that are under consideration, as well as the settings. And so taking your mind back to the slide that Paul showed you about sort of the false positive and false negatives, where the margin of error is in terms of whether it's more acceptable to have a greater percentage of false positive versus false negatives or vice versa again is dependent on purposes for clinical treatment. Whatever is the acceptable level of error may be in one direction, whereas for population health it could be another, which is going to be ultimately a challenge in thinking about solutions in this space.

The other thing that was clear from our testifiers is that the data linking challenges will increase as the data gets further removed from the source, and also when you introduce more sources of data, which is exactly the environment we're trying to get in with respect to health information exchange and increasing the number of entities involved. And then the last point that came through clearly is that universal identifiers could be helpful, but are not a panacea, again in part because it's not just a technology problem. It's a human problem, and there isn't any one size fits all solution either. Paul, I don't know if you want to add to that before you take us through some of those suggestions or recommendations.

Paul Egerman – Software Entrepreneur

No. I think it was good comment. The comment is there is no panacea. There's no silver bullet, at least not from the technology side to solve this issue. And then, from this, we had a number of areas that we think we're going to be talking about going forward. The first one, interesting, possibly to broaden the scope to realize the issue is ultimately about data quality. That's interesting is it relates to the PCAST recommendation, which is really very much of a sort of heavy data recommendation. The other interesting observation is to start thinking about consumers and not just patients in this process, especially as we move forward to a world of universal coverage in terms of how we're going to match people up.

There was a second comment about measurement that ultimately the way to address this is organizations should be able to measure how many false positives and the rate or percentage of false positives and the rate or percentage of false negatives, and have improvement techniques, improvement cultures around it. The third bullet here, very interesting, about standards and demographic data, very interesting, as it relates to what we heard this morning from the meaningful use group about that as an area for meaningful use. There was a lot of clear discussion at the hearing about demographic data and problems in various EHR systems and how that's collected and, as a result, difficulty matching it later on. And if you would link, if you had standardization, if people did something as simple as what's called normalizing an address so that you compare an address from one to another, you can make a difference, and then dissemination of best practices.

Then we also talked about transparency. A lot of people have some great algorithms for how to do this, and those need to be made available, although I will say we have representatives from Microsoft and SureScripts who are completely forthcoming and told us a great deal about how their algorithms work,

and that was extremely helpful. There are various issues about accountability and liability concerns developing evidence that works. The role of consumers in improving data quality is something that's extremely interesting.

Importantly, ending our hearing with a presentation from Timothy Boomershine, who is from Fair Isaac, basically an organization that deals with the entire world of finance, a totally different world. In his testimony, he said in the financial industry, we don't have these problems. Basically the data that is obtained is obtained of uniform quality. There's almost no variability in terms of the size of the organization and the nature of the organization in terms of the data that's obtained. I listen to that and I wonder why finance is so different than healthcare where there is such great variability and what are the differences. One of the main differences in the whole financial world is consumers have access to everything, so consumers get both electronically and in paper their credit card statements, their checking account statements, and they check them. It's unacceptable to have an error. I think that's one of the reasons why there is sort of uniformly fairly good quality of the data is because the consumers wouldn't accept anything else.

And so one of the certainly the conclusions that I at least came to in terms of going through the hearing was that the process of having patient or consumer access to the healthcare information is a critical component in terms of getting all of this straightened out and getting it correct. Consumers and patients will find problems. They will be the force that will ultimately cause healthcare systems to collect the data correctly and accurately.

And the other issue that is also an interesting issue that we will be possibly talking about is how are corrections propagated. What happens when a record goes from healthcare organization A to healthcare organization B? Healthcare organization B determines there's an error. How does that correction get back to A, or what happens if there are multiple organizations in the chain? Those are the areas, a fascinating topic, and we do not have any recommendations for you yet. Our hearing was only last Thursday, but I don't know if people have any comments? Do you want to add anything, Deven?

Deven McGraw – Center for Democracy & Technology – Director

Yes. No, I don't have anything to add. You did a great job. I think I want to make sure that any of the tiger team members on the Policy Committee, if they want to add anything in particular. It was a really interesting hearing. We had some terrific testimony. We're continuing to receive things from members of the public, including vendors, who have developed certain solutions that will circulate that will help us reach some recommendations in this area. But as you say from Paul's presentation, there are multiple avenues in which you could go here, not all of them sort of confined necessarily to the traditional policy levers that we are accustomed to calling on, but I think we're likely to make some broad based recommendations, and then using the policy levers where we can, but we'll see. We do have to get to consensus on them.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Questions? Yes, Marc.

Marc Probst – Intermountain Healthcare – CIO

...any information on current measurements of false positives and false negatives? Are there any studies out there on that?

Paul Egerman – Software Entrepreneur

There are a few. I guess there was a Rand Corporation study that had like 8% to 12% for false negatives, which are duplication rates. And at least one person who testified said that he had done an analysis of his organization. It was ... organization, Catholic Healthcare West. He had come up with a rate I think slightly less than 10%, but it was consistent. It was very interesting, again, as Deven suggested. The rate though is determined a lot based on the nature of the organization. When people start talking about the false positives, they would tend to talk about try to do it like one in 100,000 or one

in a million. And when they talk about the false negatives, you're talking a number like 10%, one out of ten. And the issue there is in many, but not all healthcare environments, there is such a fear of the false positive that there's a tendency to err towards the side of the duplication, which has its own series of problems, especially when you get to decision support and you're making decisions with incomplete data because you're ... the wrong patient. I don't know what you think about those numbers, if those numbers seem high or low to you.

Marc Probst – Intermountain Healthcare – CIO

They seem pretty meaningful.

Deven McGraw – Center for Democracy & Technology – Director

In addition to the Rand study, certainly HIMSS has done a fair amount of work on this. But we also heard from – our initial panel were our issue spotters, and many of them testified that the evidence base on this is sorely lacking. It's not often measured, and it's not often sort of systematically studied so that you can gather really good evidence about whether there are levels of accuracy that ought to be achieved or are routinely achievable in different contexts. Again, since it's not – this is a context specific exercise.

Marc Probst – Intermountain Healthcare – CIO

Thank you.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Thank you. This was really great. I especially like your closing thing about propagating corrections. In an area where people are often sort of propagating problems in the system will sort of amplify that. Once things are figured out that these are two separate people or this is the same person, to have methods to share that.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Other questions, thoughts? Yes, Charles.

Charles Kennedy – WellPoint – VP for Health IT

We ran a pilot where we looked at these issues, and one of the things we found was that if you, depending on how you designed your ontology, you could actually increase the match rate by looking across multiple data sources that were reflective of the same clinical event. For instance, we found that when we connected all the systems together, we found the same clinical event on average was represented 4.2 times in the data stream. So if you saw it in the claims system, you saw it in the EHR, you saw it in the ... fairly sure that it happened. Sometimes, depending on how you structure it, you can actually perhaps increase the match right.

Paul Egerman – Software Entrepreneur

That's right. Certainly it's also the case, the more data you have, the better chance you have to match it, although I did make the observation that it seems to me like when you do information exchange, we have difficulty figuring out who the patient is. But when we do research, we can't seem to de-identify the data and hide who the patient is. But the fundamental challenge is that we're sort of dealing at the edges of each side.

Deven McGraw – Center for Democracy & Technology – Director

That's why it's contextual.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Yes. Thank you. I like the idea of this next to the last bullet here about the role of consumers and how they could help improve this. You talked about that last fellow who presented from the finance industry and your assumption is that a lot of it is based on having consumers have access to that. I think a piece of the finance industry also is the use of the social security number in many instances there, and that gets me back to that Rand study, which showed that if you incorporate pieces of the social security, you really can improve the accuracy of the match over time in that Rand study where they went from something on the order of mismatching match one in 10,000 to one in millions based on having access to the social security number.

Paul Egerman – Software Entrepreneur

Yes, and that may be. Again, the sense we had from the people who testified was that the more data you have, the better job you can do. There was no belief, however, that even if you had a universal identifier, that would solve this problem. It's still an issue, and that came across in organizations who are using social security number, and they still have issues for various reasons, but it's a good observation.

Deven McGraw – Center for Democracy & Technology – Director

Yes. We put this in the appendix because we didn't want to cover it, but one of the things that we made sure everyone was aware of is that HHS is currently operating under a law that prohibits them from spending any money on pursuing an identifier strategy, a universal identifier strategy, so we certainly want to be able to provide ONC with a set of recommendations that are actually deployable, at least in the short term. We have work to do on figuring out the consensus recommendation, so whether there will be more on that in terms of a long-term strategy, I don't want to speculate. But certainly with respect to what's doable in the short term.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Other thoughts, questions? Gayle?

Gayle Harrell – Florida – State Representative

The only other thing I would like to add, and Deven certainly touched on in the role of the consumer in improving the quality of the health data, one of the things, especially in the financial industry that was pointed out is that the consumer feels a vested interest in it because it's their money, and they want to make sure that they haven't been overcharged or that that number, that address is correct, they get their statement, or when they apply for a mortgage that it goes through. And they are vested in it. Frequently in healthcare, there seems to be there's not quite that vesting. They want treatment, but the accuracy of the chart really is nothing that they've been that concerned about. So I think that, again, the more we engage the consumers in their own healthcare, the more accuracy perhaps we can encourage them to, as they get there, hopefully secure safe, personal health records that aren't sold somewhere. They will be watching things and be more vested in it too. That's another role for consumer empowerment.

Deven McGraw – Center for Democracy & Technology – Director

Yes. I think we've taken, in terms of the steps we're taking on the meaningful use side with respect to making sure that patients have really proactive access to their data versus necessarily waiting for them to ask for it. I think that's going to be helpful. There are also the California Healthcare Foundation released some survey data that looked at people who are actually now using PHRs and the ability to correct their data was actually pretty high on the list of reasons why they either would open up a PHR account possibly if they didn't already have one, and one of the reasons why they liked having a PHR for those who did, so it's pretty interesting. I think Gayle is right that for some folks it's not, it may not be something they think about on a day-to-day basis, but that the survey data actually reveals that people are quite interested in knowing what's in their record, and we're taking steps to make them more aware in what we've put in meaningful use.

David Blumenthal – Department of HHS – National Coordinator for Health IT

It did occur to me, as I listen to this conversation, that there is another thing that's different about the finance world. I guess it was implied. And that is that the IRS insists that the information be accurate and that there are legal penalties for not reporting income, and there are no and never will be comparable penalties for having inaccurate information on your health record. It also gives the financial institutions the right to insist on accurate information, so they can report to the IRS what your income is. So there is, I think, a lack of analogy between the financial world and the health world that will never be overcome unless we were to have an inconceivable level of coercion around the healthcare in healthcare. I think we should approach these analogies with a certain amount of skepticism about their applicability.

The other thing that I wonder about is given the fact that we'll never get to perfection, and that we're going to be trading off how we go about creating the understanding of this and getting consensus around a level of false positives and false negatives that are acceptable. There always will be false positives. There always will be false negatives, and what the right balance is in order to create trust, so I think that's a matter of, it's a communication question. It's a psychology question. Will the average person be happier knowing that they won't be confused with somebody else than knowing that they will not be correctly identified? And I think that's going to be an important consideration, as you make recommendations to us. Also, I think the real world experience of organizations that have been doing this day in and day out, integrated health systems, VA, Kaiser, etc., and to learn what they've settled on as the compromise might be very valuable. Yes, Gayle?

Gayle Harrell – Florida – State Representative

One other thing I did want to mention was that was discussed at the hearing was also the liability issues. These are not minor liability issues when you have the false positives that create untoward situations so that, as we make these recommendations, we need to look very carefully at that as well, and realizing that this is not a perfect world. It's not going to be, but there are consequences to that, and there are liability issues that go with it.

David Blumenthal – Department of HHS – National Coordinator for Health IT

I suspect that once we set standards about level of identification that those will have a lot of influence on the liability.

Gayle Harrell – Florida – State Representative

That's very important. That's a driver behind setting those standards appropriately.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Yes, Neil.

Neil Calman – Institute for Family Health – President & Cofounder

I'm sorry I had to step out for a second, but there is a middle ground between a false positive and a false negative, which is a possible false positive that could then be verified before being accepted into the record. It's sort of almost like a med reconciliation kind of process. There's a reason why we don't let hospital meds just get driven into our system without looking at them because there's no reconciliation process. And some of this stuff, and we talked about this a little bit, but in some cases you really would want an opportunity not to miss a potential match, but also if it's not 100% matched, to have an opportunity before it's accepted into the record to be able to be verified manually. I think that gets back to Deven's point about how the farther you get away from sort of the interaction with a provider, the more sort of potentially dangerous it becomes. But I think we could create that kind of a scenario, I think.

David Blumenthal – Department of HHS – National Coordinator for Health IT

This is a lot to learn. Every time we turn over a stone, we find great stuff. Thanks a lot. Yes, thanks a lot for this exploratory work. This is very, very important, and I think it's time to go to the public part of the session.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes. At this point, we would like to invite public comment. Anybody in the room wishes to make a comment, please step up to the microphone. And if you're on the telephone already, just press star, one, and if you are on your computer, you will need to dial 1-877-705-6006. Robin Raiford.

Robin Raiford – Eclipsys – Director of Government Initiatives

I'm Robin Raiford, Federal Affairs at Allscripts. I just wanted to make a comment on something that Paul Tang had said from a perspective of the issue of the decision support and ability to track compliance with that rule. I've actually discovered, and the only reason I found this was because I made a cool poster that track compliance of the rule is in meaningful use in the CMS final rule. It's not in the ONC certified product final rule. That got dropped.

I'll send the exact language to Judy Sparrow so she can send it out to you. There was a third requirement in the NPRM language for certification that said alert statistics automatically and electronically track, record, generate reports. That was dropped in the final rule. That was dropped in the final rule, and the certified EHR technology does not have that. I have to say, I personally have not memorized the 104 CMS FAQs. I've looked at the FAQs from ONC, but unless that was resolved in that, there's actually something that people need to attest to that the certified EHR technology can't do.

And the other thing I just wanted to say from the perspective of CPOE, if that intent was the licensed professional, any licensed professional, when you see the blogs, it makes me crazy as a consumer that we could pass out \$17.2 billion of money for CPOE to be ... to a verbal order to an RN who can enter an order that doesn't have the authority to resolve the decision support that's coming, and I hope that's not the intent. That I we move to stage two that it be somebody with at least prescriptive authority who can resolve the alerts as they come up.

Another comment to what Larry Wolf had said, perhaps maybe rather than delay stage two to 2014 is consider not having stage two year one, one full year of meaningful use because if you add eligibility checking, report a claim, which wasn't in your list, but I believe is in the CMS final rule that it will happen in stage two, and you add, by the way, tracking these alert certificates, you've got give a vendor more than four months' notice to do that. You can't do that. To do all the if/then, if/then, if/then, or you're going to have the if/then statement from hell, people trying to reserve that one rule to fix everything that isn't there. You can't do it in four months, write code that fast. Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director

On the line, please, your name and your organization.

Kevin Nicholson – National Assoc. of Chain Drug Stores – VP, Gov. Affairs & Pharmacy Advisor

Thank you. I'm Kevin Nicholson with National Association of Chain Drug Stores. I'd like to highlight some of the comments you made at the last HIT Policy Committee meeting a few weeks ago by the Federation of American Hospitals. We appreciate the hard work that the privacy and security tiger team has engaged in this summer developing recommendations for the exchange of records, and we certainly don't want to cast any negative light on all the good work that the tiger team has accomplished. However, similar to the federation, we have concerns with some of the tiger team's recommendations that appear to conflict with HITECH and HIPAA, which also provide strong patient privacy protections.

For example, discussions around informed consent for treatment, payment, and healthcare operations seem to indicate that a consent requirement may be imposed in the future for meaningful use requirements. Even though such a requirement has been rejected by both Congress and HHS. Requiring patient consent for these healthcare activities has long been recognized as not being beneficial to patients, as well as unworkable for healthcare providers. Under the HITECH Act, anyone who receives PHI on behalf of a covered entity is considered a business associate and is subject to the same security and privacy provisions as a covered entity. It's not necessary to impose a consent requirement for the

disclosures the tiger team is recommending because PHI is protected whenever it is disclosed to a business associate.

Although the tiger team's consent requirement would only apply to certain situations in the short-term, we're concerned that eventually consent would be required routinely at a point in the future when all providers are interconnected with each other. Healthcare providers and organizations may not be able to share critical and timely health information, which is necessary to protect the patient, protect patient health and safety of the patients they serve.

For example, we anticipate that pharmacies will routinely use e-prescribing gateways to share and receive patient medication information with other healthcare providers. A consent requirement would eliminate all the benefits of e-prescribing, as it would be impossible to obtain consent from every patient before the patient presented at the pharmacy. And pharmacies don't and will not have direct links with every other healthcare provider. Patients expect to have their prescriptions ready when they go to the pharmacy. We can't wait until they arrive at the pharmacy to obtain their consent to fill and process their prescriptions.

We're concerned that the tiger team may inadvertently be circumventing HIPAA and HITECH to impose a consent requirement under the meaningful use provisions, which we view as an inappropriate process for imposing privacy provisions that have been rejected as unworkable by both the legislative branch and HHS itself. We urge the HIT Policy Committee to consider the long history of deliberations that other authoritative policy making bodies have engaged in with respect to patient consent and why they came to the conclusion that consent is unworkable. I would be happy to discuss this with any of the Policy Committee members or with ONC staff. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Mr. Nicholson. We have another comment in the room.

Chantal Worzala – American Hospital Association – Sr. Associate Dir. of Policy

Good afternoon. Chantal Worzala from the American Hospital Association. Thanks so much for continuing your very extensive public deliberations. They're very important. I did appreciate the conversation in the hearing on matching patient data. It's a very important topic and has a lot of operational implications. I was a little bit disappointed that we didn't get an update on the enrollment workgroup because I think there could be some very interesting overlaps there, as we move into health reform and use a hopefully single same process for enrollment of patients into various forms of insurance models to be able to use that potentially to also form a basis for appropriate and positive patient matching to also the care delivery system.

As part of that too, and as your future deliberations, I would encourage you to explore the concept of a voluntary, unique, patient identification process where consumers who value having a consistent, persistent tagged patient record would have the opportunity to voluntarily sign up for an ID that might allow their information to be linked across providers. There may well be a good chunk of the population that would be willing to trade some of the perceived negative aspects of a unique patient identifier against the benefits for them and their care teams for having such a thing. So I think that would be a very interesting avenue to explore and would also just note that the public law prohibiting expenditure of data on this was actually preceded by a requirement that the government make one. I just want to make sure that we have both points of information there.

Then on meaningful use, I'm very encouraged by the commitment to learn from stage one meaningful use before we move forward. Very much looking forward to the implementation hearing in early January, and very much urge you all to give the public sufficient time to comment on the preliminary recommendations for stage two meaningful use. In general, a 60-day comment period is provided for decisions of this magnitude, and I very much encourage ONC and the HIT Policy Committee as a whole to over a 60-day comment period on recommendations for stage two meaningful use.

I would also encourage, as we move forward through stage two, much more written and evidence-based description of these recommendations and why we're moving in these directions, what are the benefits, where are we today, what does it actually take to move forward? Thank you very much for your time, and have a good afternoon.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you very much. We do have one comment on the phone. Operator, can you identify that person?

Coordinator

Yes. Our next comment is from Lynn Scheps with SRS Soft. Please proceed with your comments.

Lynn Scheps – SRS Soft – VP Government Affairs

Hello. I just wanted to point out that measures where the denominator is all unique patients in the EHRs presents a problem for specialists who provide episodic care like orthopedic surgeons. An orthopedic surgeon's EHR is likely to have thousands and thousands of patient charts of patients who are no longer active. And in stage one, the only measure that I think presents this problem is the menu option, so it can be skipped. It was to send reminders to a percentage of patients in the EHR. In stage two, I notice that you're proposing a measure related to the list of care team members, and I didn't notice whether there were any other measures. But I would just suggest that you avoid that denominator because it leaves specialists in a position where they really can't meet that measure.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, and thank you to all members of the public. Dr. Tang?

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

Good. Thank you, and thanks to the members of the committee for another round of hearing and recommendations and approvals, so appreciate all your help and all the workgroup's efforts, and thanks to the public for listening. Thanks. Bye-bye.

Public Comment Received During the Meeting

1. It appears that closed loop medication administration has fallen off the radar for MU. Bar code med admin (computer assisted 5 rights checking) is a great use of technology to save lives and has been available for years.
2. I think the language could change to include patient or authorized caregiver
3. If there is a definition of discharge instructions in the field it needs to be recognized by the committee in lieu of the committee definition
4. It may be outside of the scope of the HIT Policy Committee but it is worth considering the potential mechanisms (accreditations) to influence the reference labs to enable the ability to communicate to providers discretely
5. It would be helpful for the industry to have the HIT Policy committee to acknowledge this in some detail.
6. Note that electronic and structured physician documentation plays a large role in enabling the EHR to capture and calculate the quality measures.
7. Does Patient-Context Sensitivities come from published and unpublished sources for cultures of all cultural groups in USA observing religious and cultural sensitivities?
8. This actually would consolidate the work effort. Currently organizations have to implement reports that are only useful for MU reporting and implement reports that will help them manage adoption.
9. I would strongly recommend that the measures align to reporting that can actually be used to manage adoption. For example no one is going to use the existing MU CPOE functional report to actually manage adoption. They will manage adoption by looking at total orders placed via CPOE by Venue and/or order type.
10. How does one measure patient preference for eRx?