

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
February 14, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT and this a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This meeting is in person as well as virtual and it is a public meeting so there will be time for public comment on the agenda and the meeting is also being recorded so please make sure you identify yourself before speaking. I'll now go through the roll call. Paul Tang?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

George Hripcsak, MD, MS, FACMI – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. David Bates? Christine Bechtel?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Christine. Neil Calman? Art Davidson? Marty Fattig? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Leslie. David Lansky? Deven McGraw? Latanya Sweeney? Charlene Underwood?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Amy Zimmerman?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Amy. Tim Cromwell? Joe Francis?

Joe Francis, MD, MPH – Veterans Health Administration – Chief Quality and Performance Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Joe. Yael Harris? Greg Pace? And Rob Tagalicod? And with that I will turn the agenda back over to you, Paul and George.

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

Thank you. So, today it's a very important day – we're embarking on sort of a re-exploration of some of the approaches we're taking to meaningful use. As you know Meaningful Use Stage 1 and Stage 2 are now final rule. I think our original framework we developed in 2009 has served us well. There has been a significant uptake in this technology and it's meaningful use

We had always discussed having Stage 3 be a transition from more of the getting the programs installed and in operation and starting to exchange data for Stage 2 and being more oriented towards outcomes in Stage 3. Some of the feedback we reviewed on our last call basically had the public wanting us to go more towards outcomes as well.

And so today we're going to look at some of these different approaches, alternative approaches not to substitute for the meaningful use program as it currently exists but potentially to offer alternative options as people start innovating around achieving high-performance.

So, the outcomes we have of today are to come up with essentially a couple of options or approaches to Meaningful Use Stage 3 that we would have small groups flush out by our next face-to-face meeting on March the 15th. At that time what we hope to do is essentially pick alternative options and reframe our meaningful use objectives employing the new options as well.

So, as I said, it's more likely to be somewhat of a reframing of our current objectives and certification requirements rather than tossing them out, we're not expecting to toss them out and/or offering an alternative option to qualify for some sections of meaningful use by demonstrating reaching some performance or threshold or some improvement threshold.

So, by the end of today we'd like to have let's say the two options that we think are the most promising and have small groups assigned to flush them out. We do have another call at the end of this month and the proposal would be for the small groups to take advantage of that time to start working on the flushing it out. Does that make sense? That happens to be on February the 26th, 12:00 to 2:00 Eastern Time.

Okay, so what I thought I would do is review some of the things we talked about, one, start out with the principles we've always had and some of the principles we developed as a result of the last call and then start going down some of the draft approaches we talked about on the call and we are open to adding more to that. But by the end of today we want to have two that we really want to drill down on.

So, just remind ourselves of the original MU objectives and this is for all stages. One, that we support new models of care that is its team based, its outcomes oriented, its population management; you heard a lot of that from Charles Kennedy for example yesterday. Two, that it addresses national health priorities such as defined by the National Quality Strategy, Million Hearts and other HHS initiatives.

Three, that it has broad applicability. So MU is a floor but it's a floor that exists for all geographic, rural, urban, primary care, specialty care, regardless of what patient health needs are and so we want to try to – it is very broad by the nature of the program, so we want to be a floor not a ceiling and we can't push the whole country to be somewhere where it's just physically not possible within a matter of a few years.

When something is already achieving a high use then one of the concepts that NQF, for example, uses is if a measure is topped out we are assuming, and we talked about this last time, that people were not going to stop using something that's useful, but we don't have to keep it up as a qualification for achieving meaningful use.

We also strive to certify requirements in products where the standards to exchange them amongst products are mature and want to be adopted. So, sometimes we have to press on that a bit but that's our goal.

So, the additional things we talked about last time are one, to address key gaps that still remain despite Meaningful Use Stages 1 and 2, examples include interoperability among systems, patient engagement and reducing disparities.

Another concept in terms of what we want to address key gaps that the market is not going to drive alone but that are essential for all providers. So, you think of it as sometimes the market won't act because you want – a vendor won't want to do something unless everybody else is doing it. So, it's sort of like create a level playing field.

Another reason to regulate, remember we had individual, we had societal mores and we have regulation as the last resort. Another reason to regulate would be to – where if you don't get a critical mass going then you won't have the network effects.

And a third reason is there's something that is just good for the public that you don't want to burden anyone group with something that really has far-reaching public good.

Another way of approaching this is we have a number of meaningful use objectives and if we can consolidate, so if you achieve a certain thing and that its implicit that you're achieving some other objectives, let's reduce the administrative burden of proving that you're achieving a certain objective and so that's sort of the consolidate approach.

And finally, we talked about alternative pathways where if you are already performing at some threshold or you demonstrate that you can continuously improve then one of our original assumptions for the entire program is you probably can't do this relying on paper so you probably are using an electronic health record or HIT in a meaningful way. So, don't make you – not only in addition to performing well, make you demonstrate that you've gone through all the hoops, because people at Stage 3 have already gone through the hoops of Stage 1 and Stage 2.

So, those are some of the things we talked about last time. Any further thoughts on those before we start off looking at some of these options and sort of flushing them out?

Okay. What I think we ought to do is try to look at each, describe an option and then look at some of the questions that we want to flush out, and as I said we won't necessarily get the ... flush them out now but these are the questions that the small group would be expected to do before presenting it to the full workgroup on March the 15th.

So, let me start out with an example and this is the alternative pathway that is deeming based on performance. So, the description is that, one, we're saying in order to be a high-performing group it's not possible to do it without being an effective user of HIT just because it's a very data intensive profession. Therefore, if you are achieving good outcomes or significantly improving then you'd be deemed in satisfaction of the relevant section of MU.

So, some of the work that remains is what other relevant sections that you probably have had to use in order to achieve high performance. A relevant section could include for example CPOE, CDS that supports the decision-making process, having access to lab test results, being able to plot lab test results, working with your patients let's say in health maintenance.

So, if you're working on preventative services it's not possible to do that without the patient's being aware of it and getting motivated to have that service performed. So, there's a lot of things that are implicit. Can it be done in other ways, I suppose, but it's just a lot less efficient to do it in other ways without using an EHR and the functions for that.

Some examples that we need to flush out, are there example quality measures that stress the system and require effective use of EHRs? The whole exemplar approach. Should the waiver be structured around absolute performance threshold or improvement or both? What would you map if you're going to focus on achieving a certain result on a quality measure then how do you map that to what functions of the EHR you're deemed basically in compliance with in the meaningful use program.

And interestingly, if we offer this pathway what happens if you don't make the performance that you expected to make than it's a bit of double jeopardy not only do not find out until you measure it at the end, but you can't do anything about the process measures. So these are things – you know, this is the devil in the details kind of stuff.

Well, one example, I mean, just to give an example of how you think this through maybe the reporting period is before – it's not a full year so that you have some time to go back and take the normal hoops methods, the process method if you aren't achieving a certain outcome. But, anyway these are the kinds of things we have to – the small group would have to drill into and offer up options of how to address these questions, again, for a larger group discussion.

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

One more element to that is then what is the relationship to clinical quality measures then as an element in thinking – I mean, is it one of those that they're improving one, but again, it can't be a separate track, if you will.

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

Correct. So, I think the assumption, we sort of carried this assumption with us, is that it would be a quality measure one of the existing quality measures that if you not only report it but you do achieve some threshold or improvement then you're deemed having passed the following MU objective.

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

Okay, all right.

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

So, maybe the quality measure deems you having met the functionality... I mean, in a sense...

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

Exactly.

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

Of having to prove that you met the functionality.

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

Exactly right, exactly right.

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

Okay.

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

Exactly right.

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

Paul, probably as you're describing the scenarios I think it might be helpful to be mindful ... because there are probably certain minimal concepts we have to think through in all cases. What happens if you don't perform and you find out later it's one of them, what happens, how does that apply to specialists? Is it the same for EP versus EH, you know, like, so we probably could start cataloging as we're thinking through that both groups need to go through kind of some test questions, I don't know what to call them, but where we have to make sure that these parameters are addressed.

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

Exactly. It's not going to be easy. Other comments? So, let's do a little bit more due diligence on the questions that is questions that we think we would need to answer before proposing this as a part of the meaningful use program.

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

And Paul could I just clarify?

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

Yes.

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

What we're doing right now is just coming up with the questions?

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

Correct.

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

The small group is going to try to put the strategy to answer the questions and the structure?

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

Correct.

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

So, all our charge now is to think about ...

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

Right.

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

Okay.

George Hripcsak, MD, MS, FACMI – Columbia University

I have another question, how do we know what the QMs – will we know the QMs in time to decide what they cover?

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

Could you repeat that? I couldn't hear you.

George Hripcsak, MD, MS, FACMI – Columbia University

Will we know the QMs in time to know what objectives they cover?

Jesse C. James, MD, MBA – Office of the National Coordinator

We could start with the ... measure set Stage 2 CQMs sort of as the floor and work backwards from them for what functional objectives you might consider satisfy with a score either some threshold or the top decile, top two deciles.

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

So, another question I have, and it goes back to a little bit of what we heard yesterday or maybe I'm mixing the two up, to the extent – I assume that we won't get push back on this, because it eases the burdens on the providers, to the extent though that there is concern that documentation in the record doesn't adequately, can't adequately be used for CQMs, which we heard some of yesterday, and I'm not sure I can think of examples where that's the case, does that impact at all what we're doing here or would we try to pick measures and CQMs where there is much more clear direct relationship where people feel that we could ... that the CQMs are reflective of what's in the record and a good measure?

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

We would choose the latter obviously, we'd try to find the ones that are not only good measures of performance there is a very strong mapping to EHR functionality that gets you there.

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

So, I think that needs to be another criteria ...

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

Correct.

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

For the group working on this to think of those in that context.

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

And in the – I would say on this particular option the strength of relationship between whether you can really do this with or without those functions enabled and then what is ... so what functions are pretty essential to the process would be sort of the first things and then what functions are left out I would want to see that in order to understand how some kind of a hybrid might be needed or something like that.

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

Let me comment on something that Jesse mentioned, one of the push backs you would expect if we go – he used as an example a percentile that harkens back to other programs where it's really, it is a pay for performance in a sense. And one of the things we want to be sensitive to is this never was designed to be pay for performance and if you made it truly that then you could be in a double jeopardy either – at any rate, so, one thought would be to publish a threshold ... let me just make it up.

Let's say it's the ... even the 50th or 70th percentile, something that we're saying, "Oh, you're doing really better than average." Then probably – and you use a certified EHR then you're basically – you're using it to perform well but not exemplary. So, we're trying to back off from exemplary meaning like 90th percentile and see percentile you never know until the end too, like how's everybody else doing.

If you have an absolute threshold than you're saying everybody has a chance to meet that. So, we're trying to get away from the double jeopardy of pay for performance. We're trying to put the ... I mean this is just a thought, you put the threshold high enough where it's really both, it's really hard to do it on paper alone and it's very inefficient to do that.

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

But, can you explain what your concern is on double jeopardy because already if individuals aren't meeting the CQMs then they're not meeting meaningful use even if they've got the functionality.

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

All you have to do is report the CQM you don't have to perform on the CQM.

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

So, report only.

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

But, that...

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

So, the problem is you wouldn't want – so there are obviously pay for performance programs out there including ones run by Medicare. You wouldn't want there to be two penalties for not meeting some threshold.

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

So, Paul, wouldn't it be easier to think about an improvement threshold, because what if you have somebody who is already a really high performer and they figured out how to provide spectacular care without using their electronic record at all?

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

So, that's why I mentioned that as another option to this. One, I would submit most – I mean, the people that – the usual suspects that come into mind in terms of performing really well they all use EHRs, in fact, they did it before meaningful use, which was part of the reason why this is felt to produce good results.

But, the other approach is, or the alternative pathway for the alternative pathway is to do improvement and that way everybody again can achieve a meaningful result it just gives another way of proving it and then we have to set some threshold of improvement. And interestingly enough it's harder to improve once you're at certain ...

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

Yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah.

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

So one of the ways you ...

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

...

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

One of the ways you counteract that is you take the delta between the goal and where you are and then take a percentage of that. So, that means you have to have a smaller – when you're way up there, but it is, I mean, it is much harder to improve way up there.

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

But maybe you could do ... if you meet ... you either meet this high level/high bar threshold or you do an improvement so that you don't have to worry about that improvement for the very last, you know, 2 percent or 3 percent, which is very hard we all know that.

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

Right, that's another approach.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yes, I think then that organization could say I've already met that and we're moving onto this one ...

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

Correct.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Which I'm not doing so we get a broader movement towards quality.

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

If I was that organization I'd say, well let's pick something that we're not, you know, we don't have where there is that challenge so if there's flexibility for them to choose, which there would have to be, what they work on they would pick something that wasn't topped out.

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

But, remember it's all going to relate back to what other functionalities they don't want to have to document, percentage of. So, I mean, I think there needs to be some choice on there, but then either way you're going to tie that back to certain functionalities, each CQM if we go this way is going to then tie back to certain functionalities that you don't have to prove the percentile on the functionality of meeting. So, we'd have to think about that.

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

Well, which actually makes me think it might be a family of CQMs, might be more than one in a disease condition or something like that.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

For example, in the current 2014 edition CQM I think there were 28 that used the words counsel or educate a patient. Now, those were – you know, it was on a variety of disease states, so that the typical approach to say I'm working on this population of people with diabetes and these are the CQMs I'm attacking, but another slice of that might be bundling it during a patient engagement bundle that says of these...in any disease state I'm demonstrating a new achievement in patient engagement that should have merit or I'm going to look at it by disease state.

So, we want to encourage as we've said earlier the gaps but that could mean both a lateral view process improvement which would generally be around something you don't do today or a quality improvement around the disease state which is something that you're moving to a higher level. Does that make sense?

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

...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right, right.

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

The functionality that you want to waive having to document.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Exactly, which you could do – just in the one example I think there's a counsel diabetes ... a patient with diabetes has been counseled on the frequency of A1c testing and that could be the functionality is the patient's specific education materials that have been given to a patient with diabetes, you'd have to know that and so you could map those two together, but it does work, it's going to take some work to do.

Jesse C. James, MD, MBA – Office of the National Coordinator

It also brings in the potential to bundle measures together that perhaps from a distance don't appear to be related but actually speak to certain functional objectives and if you score well or improve well over that bundle you're also deemed of the functional objectives that are applicable to those measures. That's a great idea.

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

...which is one of the goals is allowing individual organizations to say what's important for us.

W

...

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

Yeah and what – so that's a good thing is instead of saying, you know, you've got, you know, people don't smoke in California, so that's not an area where we would spend a whole lot of time, but we have other issues and let's ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

... would be something.

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

So, this is where we want to go, we want to have organizations to very much align with their local priorities so that everybody gets on board.

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

So, I think it has to be some kind of a bundle or a family of measures and I think we have to probably give the group that's going to go off and think this through some direction about what we mean there, because I do think, you know, if you think about, you know, HbA1c testing you can hit – there's one quality measure that you can do and it's a process measure and it's a stinky one and, you know, okay it doesn't pull in lots of function.

So, if you said, all right, if you, you know, if you want to do an improvement project you need to have a measure that is an outcome measure or a process that's tightly tied you need to have a patient engagement measure, you need to do that, but we have to go through and make sure that those measures exist in Meaningful Use 2014 measures because many of them don't and that's – we're trying to kind of get to a place where we all acknowledge the weaknesses in current quality measures. I think we all agree on the intent here but it's like how do we make this operational.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And that's, I think by nature being specific in getting that map that will help to drive the bundles, right? So, we might have many ... well, that same example I just used, an EHR is collecting the frequency of the test, of A1c tests, they are collecting the diagnosis. There are many other things around diabetes that are related to that patient population that are being collected it's a very rich area and now taking it to a process measure for patient engagement is a great complement to that. Whereas, if I took perhaps there's some – well, actually the cardiac ones are pretty good too; we've got a lot of that data. I'm trying to think of an area where we really don't have ...

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

Well a lot of the specialty areas.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah.

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

I mean, right, you know, specialties where they may have – their society may have a registry and they may have three or four measures that they can report to registry but the registry is a black box, it's – you know, we don't ever see that from a consumer perspective which is a real challenge and so how do you find ... so, I guess that leads me to the fundamental question for this particular idea which is are we really talking about creating a pathway that is an option. So, if you are a specialist and you don't fit, you can't find a couple of measures that sort of get at these dimensions you still can do the traditional Stage 3 approach.

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

An alternative pathway we may not have – and the specialists do complain that we don't have good measures for each specialty.

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

Can I go back to the example you were using. So, let's just hypothetically, and I'm not sure if this what you were saying, so if the patient engagement is, you know, bundling some of the CQMs on or the, you know, on counseling patients were you then saying that you would relate it back to how many times they have a hemoglobin A1c and one would deem the other?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

What I'm saying is that if you have a ...

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

I think providers would push back on that because you can't ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, no, because right now the measure just says you have to provide counseling to patients with diabetes about A1c testing. A measure is how many times you provide – did you provide that counseling, yes or no?

Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services
Right, okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Then the assumption is that if I've provided the counseling I will see an increase in A1c testing to be at a compliant level, that's not part of the CQM measure, okay? But, it also says to provide – and I don't know off the top of my head, but there's also some things that talk about wound care, there's things that talk about self-management tools and other things. So how would ... we could take a look at that and say could that meet a high degree of patient engagement criteria and so we have a patient engagement bundle. And it might go across multiple disease states.

Amy Zimmerman – Rhode Island Department of Health & Human Services – State HIT Coordinator
Yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, if I say that a highly engaged patient is receiving counseling on these five issues I can demonstrate that I meet some of those criteria and it's a mapping exercise that we have to take the CQM, the functions and say is there both a lateral path and a horizontal disease specific path and are the EHR functions there compliant with that kind of an approach.

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

Well, the question I would have is I think we really have to balance the complexity of the ... how we would design with so much bundling in trade-offs that it becomes almost ... that our intention is good but it becomes too complex to be able to get those reports out and figure out, you know, which CQMs then map to alleviating these functions, because I just think we have to kind of try to do this in a direct and simple approach or I think we're going to end up with – I don't want to end up with more complexity than we're trying to solve is what I'm trying to say and I think it's a balance.

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

So, let me take us just in a different sort of approach one way to do it would be to describe some of the attributes that regardless of the area you're measuring you need to have something that indicates patient engagement and you need to have something that indicates, you know, outcomes. You need to have a something that indicates health disparities, you know, that there's an equity across your ... or a health equity I should say, you know, because I think part of the challenge with patient engagement, great idea but most of the measures that are available are check the box, you handed me something, that is not patient engagement, you delivered me a piece of information and there's no correlation between that and increased testing.

So, but the idea that you – we have to keep coming back I think to the EHR, this is also about are you pushing yourself to use the EHR in ways that will drive improvement but also serve some societal benefit like view, download, because you can do all this without giving patients online access.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, George Halvorson brought up something in an IOM meeting a couple of weeks ago and it just is amazing to hear this guy talk about what they've done with the EHR to make sure they have a quality and learning system at Kaiser and he said, you know, as a result of all the information we have available and our practices of using the EHR we have half as many deaths for patients with HIV as a national norm. We have 70% fewer heart attacks for patients, second time heart attacks.

And so it would be interesting perhaps to have Kaiser participate in these small groups to say how have you called data to use them in the quality measures and affect this kind of change, what functions were there that you need to ...

George Hripcsak, MD, MS, FACMI – Columbia University

For here I would just – and I just brought it up, look at the objectives briefly because like if we're going to eliminate three objectives after all this than it's not worth doing it or we can eliminate the three, why not? But if we're 50 percent of them than that's a big deal. So, I'm looking CPOE, would we be willing to deem CPOE because you're doing well? I mean, maybe yes for that one.

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

So, I would say yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Literally, I'm saying go through, because I want to get a feel for what you're talking about. eRx, are we assuming you have to do eRx?

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

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

So, we would deem eRx.

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

Okay, I want to ...

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

For a different reason.

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

I want to let the small group do this.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, but I think it's good to know.

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

I agree, George.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, I think we need a definition. I think we have to charge the small group of doing something, if one of us is thinking we're going to get rid of vital signs and that's it and another person is thinking we're going to get rid of all the quality ones that we need to come to an agreement on that.

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

So, let me – so we can do this exercise, but let me state a couple of things and just put a perspective around this. One, Stage 3 is about avoiding penalties and you basically wanted the other overriding thought ...

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

Paul, I don't think that Stage 3 is the third and final phase of incentives and right now ...

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

... Stage 3 is ...

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

No the penalties are tied to a calendar year not to a stage.

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

I know but ...

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

This is what we need to have absolute certainty on.

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

But you can't – by 2016 ...

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

You only have to be right now, the only thing we know for sure is that CMS has said in order to avoid penalties you need to be Stage 1 compliant.

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

So, that's what I'm saying, by the time you're Stage 3 whether you start in 2011 or 2015, we're talking about folks who are ... already gone through Stage 1 ... already with the program and the last ... let me put it the first thing I think we want to do, this is a personal opinion, is reward good behavior and the corollary is the last thing we want to do is to create additional burden for people who are basically going out there to deal with the primary mission which is take care of patients.

And, so I think we just need to keep that perspective in mind. We're aligning with people who are already on this road and so it's – I think we – in Stage 1, particularly, and Stage 2 we're basically getting people to take the plunge, by Stage 3 these are people who are already well on their journey, well on their journey, they've four or five years at this and what we want to do is make it continue to reward that and make it in their best interest to do well.

So, for people who are doing well this alternative pathway is to say, have a good hunch at how you're doing well, which is to effectively use this tool and it should not be a barrier to them continually to do well with this tool.

The other thing, we're going to get that a little bit later, is this is a program that is raising the bar on vendors, which I think is a requirement because the market didn't push that initially, the market definitely, I mean, regulations are definitely pushing that now and meaningful use has a continuing role in pushing the vendors, setting the floor for vendors because of that network effect for example.

A lot of this has to do with patient engagement, a lot of it has to do with care coordination, but we have to set a floor for vendors. The providers I think will have all kinds of – and we talked about this as well, will have all kinds of incentives. One, do their primary mission. Two, the way they're going to get paid is to manage populations. So, there's plenty of – is not the purpose, the sole purpose of this program particularly in the out years. I mean, so that's just here's a personal opinion. I think we need to ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I kind of like taking a test case like George suggested maybe not go into all of them but take one example like CPOE and say if we were going to forgive that what would that look like? What are we achieving and then maybe that example becomes the litmus test for the smaller group to come back to.

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

I think that's fair, I just want to sort of put out sort of a perspective and a general approach.

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

This is Christine, I'm very glad you did, Paul because I think it is one that we have to remind ourselves of constantly assuming we agree and, you know, I do agree with that. I do think that, you know, Stage 2 is a significant step up in many respects from Stage 1 and there were some advancements I think particularly for patients and families that are going to make a huge difference, right?

Because the other lens I think I'd like to suggest we also incorporate is not just, you know, patients and families but also patients and families as taxpayers too. So, you know, there has been an increasing amount of political pressure on this program in particular we have bills that have been introduced to repeal it, right?

And part of the narrative behind that is not that HIT is bad, it's that this investment hasn't paid off yet. So, I think there is...I fundamentally agree that we want to continue to reward people on the path and we want to make sure that they have the tools they need to perform in a healthcare system that is changing whether or not it's ACOs or PCMH we don't care, we know the themes are the same, care coordination outside your walls, engagement with patients and families.

So, we want to make sure the tools are there, which I think says to us that we have to think hard about the functions we really want and at least require that they're certified so that they're available and then pick off those that, you know, can help to show not just rewarding good behavior in the sense that you continued Stage 3 and you didn't do much beyond that but we'll give you the third payment anyway, I'm less interested in that.

But I also agree with you that this isn't as much that Stage 3 can begin to move away from accountability, which was a big theme in Stage 1 and 2, right, because the incentive dollars were larger. So, I just want to add the lens of there is sort of a – there is a need to demonstrate that we actually can use information technology to improve care and reduce cost, you know, Congress being particularly focused on the cost issue.

And that while we want to reward we also want to be sure that it's equitable and there are probably – the two things that concern me the most are health disparities or health equity and patient and family engagement. So, I just want to put those lenses out there as well.

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

I think that's – and the way that would manifest itself is by the measure of deeming. So, the way that would manifest those priorities is the way we pick the ways you get deemed in qualification, so it's essentially the "CQM" or whatever measure there is, so, some performance measure that would reflect our priority about care coordination and patient engagement and disparities.

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

If we do agree that a patient and family engagement and health disparities are critical I'm not sure that the existing quality measures do a great job at that. Now maybe in the way you can report might get at some, at least disparity, but not quite health equity issues. So, I want to hold those out as two areas that we probably have to give additional thought to along...and I agree you laid them out in the beginning, interoperability, care coordination, you know, being the other.

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

Okay, so I think we're – now let's go to George's exercise of let's see does this hold water, can we figure out some things, what could we imagine?

George Hripcsak, MD, MS, FACMI – Columbia University

Like security on the one end, would we deem security? Just trying to take some ... because we don't have to go through all of them, because as you said we go through examples. So, would privacy be one that we deem and we'd say, "No, we're always going to do privacy?"

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

No, we're always going to do privacy.

George Hripcsak, MD, MS, FACMI – Columbia University

So there's an example of a case where we're not going to deem.

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

Correct. I think going down the path ... to perform well you really are going to have to influence the behavior, the ordering behavior of physicians and other licensed professionals and you're going to have to influence the behavior of patients and so that's why I'm drawing that.

So, for example, and the way you do that on the physician's side is CPOE, CDS, having structured data in there to drive the rules. So there's a lot of deeming that I would say could happen and these are major things. CPOE, CDS, structured lab, problems, medications, allergies.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, perhaps for instance a shared decision-making measure that says, you know, if you're demonstrating shared decision-making with patients you could probably deem a lot of things, right, underneath there, that the education has been given, that the orders have been done, that the labs have been reviewed, that the patient has had access to their records, that the – to do that you've got timeliness of data, there's a lot in there. That would be very broad.

George Hripcsak, MD, MS, FACMI – Columbia University

Is the deeming only for – I know you said this, but I'm now thinking of the question, did they definitely do Stage 2 already?

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

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, so we know they did Stage 2?

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

They did Stage 2.

George Hripcsak, MD, MS, FACMI – Columbia University

All right, okay, so that makes it easier.

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

Can I make a suggestion that a lot of the subgroup one items are the functional items, so perhaps – so, there are CQMs for smoking status and cessation, documentation of current medications, BMI, but then there's also closing the referral loop and then functional status assessment. I think, you know, some of those you could really consolidate a lot of what is in subgroup one into some of those measures that exist. There is also immunization one. So, there's a few places that we have those measures that perhaps we could get rid of the meaningful use measures that we suggested.

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

... that mapping, that would be really helpful, I think.

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

So prevention is a good example. One, it is – it's just a front, center and heated. Its front and center in payment. I mean, it actually has a dollar value the amount of stars, each star is worth X amount of dollars. So, there's plenty of incentive in the market to do this and by golly they are going to use every tool they have available to get this done and the likely candidates are going to be CPOE, CDS, I believe it will also be the patient engagement things, the patient resources, the patient messaging. That's the only way you're going to get people to come in.

So, I – and again, it's in some sense the reward people for doing good, you're going to give people the benefit of the doubt because they have – they've already through Stage 1 and Stage 2 documented the process of using this and by Stage 3 they just have more available to them, it's highly unlikely that they would turn that opportunity down if they are already scoring well.

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

Can I just come back and say so what is the BMI measure exactly? And I don't know about BMI so I'm asking, but there are a couple of measures that Michelle listed that are documentation only, its check the box, there's no do well on them.

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, obviously we wouldn't value the BMI one isn't an outcome measure, it is a process measure, but there is value in process measures. I think it's a fallacy to believe only an outcome measure is important. There can be groups of process measures that are important like if you as a clinician if you're scoring in the top decile and closing the referral loop process measure and medication reconciliation process measure you should be able to deem some of the process measures that the functional objectives are.

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

So, Jesse, I said, documentation measure. I agree with you there are some very...

Jesse C. James, MD, MBA – Office of the National Coordinator

Well closing the referral loop is a documentation measure.

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

Right, so, but let's – smoking cessation documentation that you asked the question do you smoke or not, I'm not trying to globally debate whether a process or a documentation measure is good or bad. I'm saying that you can do a lot of documentation measures by using only the documentation function of your

EHR and so in this context it either has to be a suite of multiple different types of measures and some are documentation but not all of them, because how else are we going to know if you're not just – you know, like secure messaging is a good example.

You can do really high-performing stuff without ever giving patients online access or doing secure messaging or doing ePrescribing or whatever, you know, so, I mean, we just have to very specific about understanding what the measures are that we're really looking at and being careful that they're not predominately documentation measures that are only going to really require certain very basic Stage 1 level functioning.

Jesse C. James, MD, MBA – Office of the National Coordinator

Yeah, I don't understand entirely your concept of the threshold between a documentation to higher type of process measure. But it depends on your system how you code a measure and what action a clinician has to make for whether you capture an action through a claim being processed for that action or you require the physician themselves to check a box to see that that action was done.

So, I'm not sure that there's a clear threshold at the practice level of the difference between a documentation measure and what I tend to think of as a process measure. But I think there's absolutely a lot of value in deciding which process measures or which groups of process measures are so important themselves that a high score on those processes would allow a clinician who's at Stage 2 moving into Stage 3 to be deemed for some of the functional objectives behind it.

And, I think maybe if the group agrees on that it might make sense to – you could give the subgroup an example or template and say, well let's look at longitudinal blood-pressure improvement and think about which functional objectives that might deem for.

And one more point, I think starting with the 2014 list is important because by 2016 or over the next three years we'll have data on the 2014 measures and also have a better idea of which we spoke early on which measures, the quality of the quality measures, so there are certain attributes on how well the measures discriminate between the physician population and what the data quality is inside of the measures.

But thinking about the 2014 measure set allows you to also think what types of measures we want to use and what type of data we'd like CMS to be able to provide to the committee to allow the committee to make a more informed decision on which measures are going to be part of this flexible approach.

George Hripcsak, MD, MS, FACMI – Columbia University

... concrete ... I don't know what the adult BMI...here's the child BMI, right, NQF 24 in Stage 2, do I have that right, you guys?

Michelle Consolazio Nelson – Office of the National Coordinator

No, I was looking at 421 which is a little bit – it takes it a little bit further, its preventative care and screening. So, it's not only capturing the BMI but then it's actually following up with the patient when ...

George Hripcsak, MD, MS, FACMI – Columbia University

...

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, so it's a little bit ...

George Hripcsak, MD, MS, FACMI – Columbia University

...

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

Another example, I think – does anybody else know the CAHPs CG which is for ... does that have ...? I think it has online access.

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

... bringing this up, so patient experience surveys there is an HIT CAHPs module and it is largely – I mean, there are some good questions on there but the first questions are sort of is your doctor doing these things and do you understand, like if they have a website is it understandable to you?

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

Right.

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

But there is – do you get secure messaging, do you get online access? So, but what occurred to me as a thought and because of the infrastructure required for implementation and the methodology around mail and blah, blah, blah we have to think through and hope that CMS and ONC could support some of this, but you have the PCMH CAHPS is probably the most meaningful from a consumer perspective for primary care and that would be relevant. You have a hospital CAHPS. You have an HIT CAHPS module that I wonder if, because not all the CAHPS questions would be applicable to a specialist, but I would imagine that all of the HIT, and I can look at it, questions would be.

So, I almost wonder if you had some quality, traditional quality measures but then if we were able to add this lens of patient experience I think that would be pretty interesting.

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

Well, so that's ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

An example would be that if the patient had completed the experience of care survey and it is in the EHR we have deemed that they are doing ... receiving patient generated health data.

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

No, because that's not health data, that's feedback data, it's not health data.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Oh, you're right, experience care is.

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

Yeah, it's not, but it would get to care coordination, shared decision-making.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

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

And actually give the provider important performance data.

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

... point was getting the patient's experience of care as – it's not a proxy, it is online access useful to you ... that's the outcome we're interested in and stop measuring denominators and numerators, and creating that burden that Joe talked about. I mean, that's the elegance, that's the opportunity to be elegant in this stage, I think.

W

...

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

Yeah.

Jesse C. James, MD, MBA – Office of the National Coordinator

I would suggest being as broad as possible and then waiting on the data on the CQMs to pick out which flows you don't want to use but at this point it's so early.

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

Yeah.

Jesse C. James, MD, MBA – Office of the National Coordinator

Be creative, think about practically for every measure what they might deem to and you can pick out ones that don't make sense as you go along, but I'm not sure if it makes sense to decide ... which measures aren't quite good enough without knowing enough about the measures, like allow yourselves the opportunity to be broad and for the public to comment on how broad you've been and then narrow as you go ahead. But I think narrowing so early it might miss some opportunities and the feedback from the RFC was we want flexibility.

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

I should clarify. So, my reservation is that there are just a lot of crappy measures that aren't meaningful to consumers and purchasers and we need to be careful of that. I'm not trying to knock particular measures off the table right now without understanding where they fit within the larger rubric for a particular condition or whatever we're measuring.

I don't think we know anything yet to really have a sense of let's remove NQF1229 or whatever, I'm not suggesting that but I'm saying that I would hope that we can agree that the suite of measures whatever they are need to be meaningful to consumers and purchasers, that if you're going to get paid for doing this it can't just be the standard status quo things that represent ... for example there are a number of measures that represent just basic standards of care, you know, we have to be careful and cognizant is all I'm saying.

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

I think we – from just a peer process point-of-view and I'm not – George, I appreciate you wanting to do it today, although I think it's going to take more time and it may just take someone or a few people sitting down and either starting with the functions and then looking at the measures or starting with the measures and thinking about what functions feed into that measure.

But in the absence of some sort of matrix or table ... because I think even getting consensus on ... I think it's going to be a challenge to get consensus on here's the CQM, which is really reflective of these measures or vice versa, but we need to kind of ... if that's work of the workgroup it's ... you know, I think it's going to be a lot of work just time-wise, but I think – or we need to get someone to start to do that table as a starting point for us and I don't know if you guys can do that and then we can work through it and debate it and try to get consensus.

Jesse C. James, MD, MBA – Office of the National Coordinator

Yeah, we have consensus that someone is ...

George Hripcsak, MD, MS, FACMI – Columbia University

And we're talking in theory now – I'm sorry, go ahead.

Jesse C. James, MD, MBA – Office of the National Coordinator

... someone.

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

So, is that already partially ...

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, it has started. Farzad, Steve Posnack and the Office of the Chief Medical Officer we started looking at measure to functional objectives and we haven't been exhaustive in the entire set of measures and I don't think we thought as much about bundles of measures that could also flow back to the functional objectives. But it's been started at a conceptual level for a few measures but for the entirety of the 94 eCQMs, no, not yet, but take this as a charge.

George Hripcsak, MD, MS, FACMI – Columbia University

We're just going to oversee what you guys do then I'm okay with that, but if the process is that we're going to do some of the work then I think it's worth looking at two examples because I'm telling you, when you talk in theory about measures and never look at a single measure when you then go a week from now and try to have a phone call you're going to look and say this is nothing like what we talked about last week.

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

So, do you want to start with two measures?

George Hripcsak, MD, MS, FACMI – Columbia University

So, let's look at a measure, BMI 421.

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

Why would you pick BMI? Why don't you pick ...

George Hripcsak, MD, MS, FACMI – Columbia University

Because as I mentioned first, because it's not for patient engagement, this is for just say ...

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

Why don't you pick control of something like control of hypertension?

Jesse C. James, MD, MBA – Office of the National Coordinator

Yeah and what are the outcomes maybe or outcome improvement like longitudinal blood-pressure improvement that might be a good one.

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

Yeah.

Jesse C. James, MD, MBA – Office of the National Coordinator

Or suppression of viral load for HIV that's another outcome measure.

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

Do you what the longitudinal blood pressure control is?

Jesse C. James, MD, MBA – Office of the National Coordinator

Oh, let me – it's a de novo one so it doesn't have an NQF number.

George Hripcsak, MD, MS, FACMI – Columbia University

Control of high blood pressure, no that's a different one.

Jesse C. James, MD, MBA – Office of the National Coordinator

We can do control of high blood pressure.

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

I thought you ...

Multiple voices

Jesse C. James, MD, MBA – Office of the National Coordinator

Oh, 18.

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

Try that one and let's just go with that.

George Hripcsak, MD, MS, FACMI – Columbia University

Percentage of patients 18 to 85 years of age who have had a diagnosis of hypertension whose blood pressure was adequately controlled less than 140/90 during the measurement period.

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

And that's a wonderful one. So, one it's ...

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

If you scored at some good performance or had some improvement what functions do we think that could be a proxy for?

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

...

George Hripcsak, MD, MS, FACMI – Columbia University

Go ahead.

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

Well, one it's a Million Hearts so it's addressing a priority with a CMS initiative. So, already it's in a good – and why is it a priority because we have a huge gap. Half of the hypertensives in the country are uncontrolled, great, there's no way you're going to bring a significant amount under control without CPOE, CDS, outreach to patients, measuring their blood pressures, actually doing it correctly ...

George Hripcsak, MD, MS, FACMI – Columbia University

Patient records.

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

Pardon me?

George Hripcsak, MD, MS, FACMI – Columbia University

Or patient lists, lists of patients.

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

Patient lists for outreach that's part of the problem.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right or patient-generated health data for a home score.

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

And I think eventually you will be getting to home blood pressure monitoring. So, this is just a great track and trajectory and I would be generous in deeming what this, what you had to use in order to accomplish this.

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

So, if you – so now, again, I'm just really trying to get concrete and help us get concrete and wrap my brain around it because that's how I think. So, would – and this is a question, would – if you scored really well on that, however, we have this scoring.

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

Yeah.

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

Improvement or capping out at, you know, 90% or whatever, would that one measure allow you to deem for all functions or would you need more than one measure to deem for multiple functions? I mean, I think we have to think through how – and I don't mean to say how easy or difficult it is, but how reflective it is ... are some of those measures – if you have clinical decision support, I mean, I'm assuming it's not likely to have it just for hypertension and not for other things, but that's the kind of question I think we have to be asking ourselves to make sure that we don't lose ground and we gain ground. So it's a question I don't have the answer to.

Jesse C. James, MD, MBA – Office of the National Coordinator

I think that's good, it also shows the value in the exercise and that it brings forth questions that we might not have thought of otherwise.

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

So, I wrote that our as a question, this is a question for the small group.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, Paul, just to track blood pressure over a period of time do you really have to use CPOE, do I really have to use clinical decision support?

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

For decades we've had good blood pressure medicine, the country controls half the hypertensives, that means left to our own devices we aren't doing it. There's no way to significantly improve that without knowing who is uncontrolled, putting it in front of your face, getting the CDS the alerts right when the patient's in front of you ... speaking as a practitioner, this doesn't happen on its own.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

No, I'm not asking – I wasn't asking that. I was asking specifically the like could I monitor this without doing CPOE. I certainly could do it in the outpatient setting without doing any CPOE. I could certainly improve that measure without doing clinical decision support, right?

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

No, I would say that you can't.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay, that's all, you know better than I do ...

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

So, this is Charlene and ONC just announced that they are having a webinar or whatever on Friday; EHR and quality data to improve hypertension against being one of their areas of focus. So, you can learn but I'm sure that it will tell how they use the EHR to be able to do that. So, I think it aligns clearly – I know Farzad has been talking about the 40 Million Hearts and that kind of thing as part of his campaign.

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

Just – I'm sorry, help me, so let's take CPOE on that one, is the CPOE for that one ordering the medications or is the ... because I would say that's eRx or is the CPOE ordering – like, where does the CPOE ... I'm just not a clinician and getting how the CPOE affects tracking and monitoring blood pressure – what's the ordering that you're doing there?

George Hripcsak, MD, MS, FACMI – Columbia University

Its' not monitoring blood pressure it's improving blood pressure.

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

Yeah.

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

I understand but what the ordering that would go with that?

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

Okay, so it's ordering medications.

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

So, it is ordering medications.

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

Pretty much the majority of folks who are uncontrolled will need medication and you – the only way you would know that they're on medication is if you order medication through CPOE. So, there's some indirectness going on and there's also ... people would not out of their way to do all this on paper and have no record of anything to hurt themselves.

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

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

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

So, I mean, you sort of have to know this workflow and you have to know what it takes to not do the workflow to say they're going to do this.

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

Yeah and I wasn't challenging it, it was more just for my understanding of ...

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

Yeah, I understand.

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

Of the conversation we're going to need to have to understand how certain things relate to others.

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

Right.

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

Especially being a non-clinician.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, could there be then in this idea of deeming, could we also take Meaningful Use 3 requirements. For instance, a lot of what you've just described is patient adherence, right? Patient education, it's follow-up, it's saying that, hey I'm calling you on week five are you still on the medications or for instance maybe we talked about one area the integration of PBMs into the EHR, well, boy I'd sure know whether or not that drug was actually purchased because I've now integrated the PBM, so that's an advanced feature promoting this activity. Could I take an advanced feature that's not yet a requirement or a menu item and include that in that bundle for deeming? And then you're really advancing things, right?

You're saying not only are we improving the blood pressure for CPOE and the things we already know in Meaningful Use 1, 2 and 3, but we also know that because you're tracking what the patient's actually purchased through the PBM I have that. That's just a question. I think this is a wonderful model that could not just advance the ease and burden of reporting but also promote more of the future events advances that we've outlined.

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

So, Paul and George, I sent you a document that kind of maps, reverse maps here is the outcome and then here's the functionality maybe we could use that as a tool to kind of go through this process. Again, it was looking – I sent it to you a couple weeks ago, it was something that had mapped the stages and it said, let's reduce asthma here's the kind of functionality that you need. So, I think there's something that we could, you know, that you would map into ...

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

Yes, exactly.

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

It was from a vendor perspective, here's the tool that you need to be able to accomplish a certain outcome, I don't know if you recall getting that.

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

That would be helpful.

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

I sent it to you and George.

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

Okay.

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

But, I think then that reverse engineers the functionality to outcomes and maybe we could – it was a lot of work, you know, to have that done so maybe you could look at that as a tool to help us do this.

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

You know, you might even ... if we didn't ...

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

Bring it?

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

If you want to send it again, yes.

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

I'll send it again.

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

But, yes.

George Hripcsak, MD, MS, FACMI – Columbia University

I have the vendors ...

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

What was the motivation for doing that? It sounds useful.

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

Well, this was early on in the process when the vendors were trying to say let's move to outcomes and actually, Meditech did this and again, it maps let's reduce asthma, here's the kind of functionality. So, it mapped functionality to accomplishing an outcome. So, maybe that can be a tool to help us, it's not targeted to hypertension but, you know, there were different heart disease, different particular outcomes it was mapped to.

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

So, I think a combination of that with what ONC is developing in terms of mapping from the quality...

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

So, I'll send that around so you can look at that.

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

That would be a very good substrate for us to try to ...

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

Right.

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

And, we're not going to be exhaustive by the way this small group, it's to show, hmmm, I see how this working and yes this is a good approach and then the exercise for the reader is to continue to do that by the time we get to our final recommendations.

George Hripcsak, MD, MS, FACMI – Columbia University

I did get your email.

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

Yes?

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

George do you want to go ahead?

George Hripcsak, MD, MS, FACMI – Columbia University

Well, no, if you wanted to make a comment, I mean, I just would go to another measure.

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

Go ahead, George, because this is a little different.

George Hripcsak, MD, MS, FACMI – Columbia University

So, if I move and then hemoglobin A1c where you want to have it low not high would be another one like hypertension I guess.

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

Well, control.

George Hripcsak, MD, MS, FACMI – Columbia University

Because, that's what that one is, no control.

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

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

Hemoglobin A1c is ...

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

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

So, then I moved onto preventive care and screening, clinical depression, patients aged 12 and older who have been screened and if positive a follow-up plan is documented on the date of the positive screen, so we have to decide how valuable that one is.

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

Right, I think we would be focusing more on control of the surrogate outcome measures. Like we know that by studies how A1c is tied to mortality and morbidity, we know from studies how blood pressure types that's really good and so – but we don't know and it's onerous to get the "oh, I've done this and then I've written something" that's what we want to avoid, because that just introduces more burden. It's one of these necessary because it's available but we wouldn't pick on that measure to do this deeming.

George Hripcsak, MD, MS, FACMI – Columbia University

All right, so we'll stay away from plans and then this one is documentation of current medications and ...

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

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Medical record, that could deemed.

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

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

That one thing specifically, but it wouldn't deem broadly.

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

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, let me go on.

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

Paul, for – I'm going to make the assumption that for the public health measures deeming wouldn't really work for those. So we're going to still hold the public health measure – can we just sort of make that clear because it would be important to make that clear for the group? But if there's this whole category, and I think public health is different and is not appropriate for the deeming, personally, so we should just make that explicit so that people don't sort of ...

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

Well, let me make one possible exception to think about is flu vaccine.

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

Yes.

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

We know almost everybody, lay and professional, knows the importance, we know everybody, lay and professional knows the importance of the public health registries immunization is probably the richest and most successful. So, you could argue that if you're achieving really good flu vaccination rates – I mean, I'm just making that up as an example, and we would love to get to that position where really good flu vaccines, really good HPV then that's a public health good and eventually we'd like to get there.

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

So, I think here's where I would – so, yes, I mean the ultimate goal is the outcome to get the public vaccinated. But we're also spending a lot of time – we're also – these measures have also been used to make sure that the data gets to public health entities and agencies and I wouldn't want to have, from a pure public health point-of-view and knowing the investment and time, and the challenges public health departments, local, county and state, and CDC and others that are relying on this data to like be able to start to negate after all the time and money that's going into do the reporting at the state level. I think we'd have to just think about that.

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

So, I guess implicitly what I was thinking is if you achieve good rates in your catchment area you can't do that if you don't know who in your catchment area hasn't been immunized, but that maybe a – do you see what I'm saying? I would have almost of had to have relied on community registries to know who I have to reach.

Jesse C. James, MD, MBA – Office of the National Coordinator

And maybe we preserve the ... maybe you decide to preserve the electronic submission of immunization data even if you do very well in some of the public health measures like if you're a rock star family doctor who has all your patients getting their colorectal cancer screening on time, cervical cancer screening, your immunization both for children and adults, and you're at the head of your local group for doing that or at a national level for doing that I think it does make sense to deem some of the patient reminders and patient list and checking ... well, maybe not the vital signs, but to deem some of those patient engagement type measures because you're getting your people into the clinic to get what they need to have done for a public health stand-point but perhaps not to deem the requirement that you submit immunization data because that has a broader goal, a broader meaningfulness to the nation.

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

Right and that's where I was going because the public health measures have been ... when I talk about the public health measures I'm talking about the ones that have mostly been related to reporting or interaction with state, local and county health departments and I wouldn't want to see that altered because I think we're trying to drive that even more here and think about how to do that in a better way.

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

I think it is fair to accept what you said for Stage 3 it's not likely for us to deem these public health measures, because we're just that far along.

George Hripcsak, MD, MS, FACMI – Columbia University

So, I think in the process of doing this small group should actually have the measure and then the objectives and the link between them, like some of them I would actually document and I'd say like direct.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Absolutely.

George Hripcsak, MD, MS, FACMI – Columbia University

Like some of them as a direct measure of the things you might as well deem it and others are more indirect, so I don't know what to call it, but like if it's a strong outcomes measure we're more likely to deem more of the process measures. If it's just a process measure on the QM side we'll probably be a little more limited on the objective side.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

That's right.

Jesse C. James, MD, MBA – Office of the National Coordinator

So, George, quick question, are you saying deem for an outcomes measure also other CQMs that might process CQMs like there is an HIV viral load suppression measure which is an outcome but there's also a visit per year measure for the same denominator and a PCP prophylaxis?

George Hripcsak, MD, MS, FACMI – Columbia University

Well, that's not a bad idea. I wasn't going to put in scope for this small group. It's not a bad idea though, if you have really good – well actually, depression is an example where there are outcome depression measures we have to have resolution of depression within a year. If you're doing that you probably don't need to check your screening. So, that's a good idea too.

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

Well, you may not count the denominator.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay and cataract has outcomes, complications within 30 days of cataract surgery, that would count I think as an outcome measure though, it's a percentage of patients who have complications within 30 days after cataract surgery that's probably a legitimate outcome style measure.

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

The limitation actually is ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

You've got op note, you've got ...

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

They exclude anybody with a comorbidity which is an interesting approach, but at any rate.

George Hripcsak, MD, MS, FACMI – Columbia University

That's true of hypertension too.

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

So, when I go thinking about patient and family engagement we talked about the HIT CAHPS survey, right? So, here's what it would assess if you'd have to think about performance not just administration of the survey, but it assesses secure messaging including how, you know, whether the provider was actually responsive, it includes whether or not the provider used the computer to actually show you information in your visit, so like when you're in the office.

It asks whether or not the provider used the computer to look up test results or other information about you, so pretty basic. It asks about ePrescribing whether or not they are doing ePrescribing. Whether it – they ask whether or not they put labs and another test results on the website for you to see so that would begin to get at online access, asked if the patient looked them up, so it gets to the use, which we have in Stage 2, right? And also asks if they got visit notes either on paper or online. So, it covers...

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, Christine, I missed what you were reading from?

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

This is the HIT CAHPS Survey.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

George Hripcsak, MD, MS, FACMI – Columbia University

So, you're suggesting these would be suggested to the Quality Measures Workgroup to put into meaningful use or what?

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

Yeah, I mean, right, so here's the question is it would be really interesting to think about a quality measure plus HIT CAHPS. Now HIT CAHPS is specified for clinician and group but it would include specialist, which is good. It's not specified for hospitals but the hospitals have ... you know, maybe the visit note changes to discharge summary but it shouldn't be that hard to figure out how to do in a hospital setting.

You would have to, I think, think through – there's three things, what's missing from the new elements of patient and family engagement for Stage 3 would be the ability to amend the record, the language support objective and the communication preferences, right? So, those are missing.

The second thing is you would have to think about the infrastructure because it is ... there are some methodological issues with online administration of the survey, although I'm not sure that we're as concerned about that but there's like a whole jihad over this, so we have to be a little ... we just need to learn more, because I think it's not fair to ask the providers to basically spend the incentive money they would be getting to administer this survey, right?

So, the question is whether CMS and ONC they do have, particularly CMS, they have provided the infrastructure for patient experience surveys in other context like CPCI, the Medical Group Demonstration Project, things like that. So, if they're willing to do that for meaningful use, you could really kick out a significant number of measures.

The third and final thing is you would have to think about people's answers to these questions so it would have to have some performance elements but you would not want to have all those questions probably feed into performance. So, you know, we didn't for example put – I mean, I'd love to see, you know, there are some questions around how easy it was to use your online access and was the information understandable to you, that might not quite weigh as heavily as did you get online access, based on at least our construct.

So, you have to think through those issues but, I mean, I'm frankly excited about that because it would be a lot easier and a lot more meaningful for consumers.

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

Christine, would you then, on that CAHPS survey, would you have to have scored a certain ...

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

That's what I'm saying.

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

You'd have to score a certain amount.

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

You'd have to think through, because ... right, but not on the whole thing I think that's probably not fair. So, to be reasonable and rational and reward good behavior you'd want to say like on these six questions.

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

Your percentage of responses was ...

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

It needs to be over ...

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

You know, yes or whatever.

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

Yeah, exactly, but for these it could be a little different.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

...

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

Neither.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

We had it in our original recommendations.

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

Yeah, it was in the Tiger Team recommendations back in 2010 on quality measurement and we specifically asked ONC to create an electronic platform that could be adaptable for multiple types of instruments including multiple task modules and then we had talked about it originally as one of the patient generated health data kind of the things.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah, I think ...

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

But what we did was – well this is a good point – some CAHPS person is going to call me very angry, but we did create this ability for certification criteria for a structured or semi-structured survey.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

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

Now that has lots of methodological issues because when the doctor asks you if was easy to, or if they ePrescribed, you know, there's a lot of evidence that says the consumer doesn't want to speak poorly about their doctor in a way their doctor would learn, because what if there are ramifications for your care.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

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

So, we have to think those things through but if the group agrees I think it's worth really thinking it through and exploring with CMS and ONC what they're willing to do.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I do too, because I do think its...I think...questionnaires as an example as an experience of care survey to...and sort of over to you at the standards group to say how do we get that and get that back into the record, because that's one of the things we were looking at under the patient generated health data standards.

W

...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Oh, sorry.

W

All right.

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

Could you get closer okay?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

... chocolate ...

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

I feel like we should sit in the center because ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

What I was just saying is that I think in our recommendations in Meaningful Use 3 under the patient generated health data section we had surveys and had as an example the experience of care survey. So, I think that would be – as Christine suggests that there are a few things that it gives us the ability to deem many things as result of it and advance the future direction because it's actually a requirement under Meaningful Use 3 as a menu item. So, this idea of taking and advancement and deeming together you get a twofer would not be a bad idea.

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

So, have you gone through enough examples to get a sense?

George Hripcsak, MD, MS, FACMI – Columbia University

Yes.

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

Does the group feel like it's possible?

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

Yes.

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

It's possible for I think like a lot of the functions, but I think there are going to be ...

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

Not all.

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

A couple that will be interesting, yeah.

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

Right, not all and I think public health is one of those that we aren't – we're not ready to cover yet.

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

Yeah, I agree.

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

But, it's exciting to be able to think we're talking about getting – I mean, asking patients whether they're using, I mean, that's ... that's what you've been wanting all along.

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

Yes.

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

And if we go there let's stop the numerator and denominator stuff. It would be so wonderful and then what happens, we're putting the sites right where it belong too instead of right now because there's so many requirements, they're looking at these as tasks and it's – you know, we're missing the boat. So, I think we did exactly the right thing in Stage 1 and Stage 2 to get here and now let's open it up.

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

Can we do something for ... take an example that is specific to a hospital though, because we've been talking about measures that are very ambulatory specific?

George Hripcsak, MD, MS, FACMI – Columbia University

Got it.

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

You guys have an example for hospital.

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

So, I mean, I don't know if you want to pick something big like readmissions.

Jesse C. James, MD, MBA – Office of the National Coordinator

I didn't hear the question.

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

Do you have an example that comes to mind for hospitals that we could try to map?

Jesse C. James, MD, MBA – Office of the National Coordinator

Oh, hospital measures. We put in the ED there's some of the – there's aspirin and beta blocker at discharge so you would need reminders for those.

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

That's probably good.

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

What?

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

Aspirin and beta blockers.

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

I thought the performance on those was fairly decent in there.

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

Oh, okay.

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

Which one?

George Hripcsak, MD, MS, FACMI – Columbia University

Discharged on statins, they're all process measures.

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

There are good ones in there I just don't know them off the top of my head.

George Hripcsak, MD, MS, FACMI – Columbia University

Education, patient education is in there.

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

Education again, we would like to – and I don't know whether HCAHPS has it. You'd like to ask the patient: Did they get education? Because that's the better test.

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

I mean, the HIT module doesn't ask that.

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

So, what about HCAHPS?

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

Yeah, I don't know, I'll look.

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

Okay, I think ...

Marty Fattig, MHA – Nemaha County Hospital

This is Marty; HCAHPS does not ask that question.

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

Okay, thanks, Marty. So, I think we have enough on this option to explore, i.e., deeming based on performance to say, well let's have a small group look at this we've got a little – we've tested a few examples to say, hmmm, I could see how this could offload a lot of important functions. So, let's get a small group to do that.

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

Paul, can I ask one other question on that and I think I raised this last time we were on call. From an audit perspective for auditing for CMS or for states for Medicaid or whatever, the auditing would just be on the measure, it wouldn't track back to any of the functions deemed, right?

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

Correct.

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

So, that however you're going to audit the measure – the difference is now the measure is just reported but you'd have to actually have some evidence of audit ability for the actual calculation.

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

Correct.

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

Okay.

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

Okay, let's move onto another option we talked about last call and I think Christine may have something to add here. This is basically simplifying the objectives. Clustering, consolidating, there are things – so, again we tried it in Stage 1 – there are certain things we wanted people to have body contact with and use and so we asked for that. When you get more mature than we're saying, gosh if you're already doing CPOE – well, I won't make examples right now.

If you're doing some objective other objectives may be subsumed either because you actually did in fact have to do those in order to do this higher order objective or you could have an implicit assumption that they used these other techniques. So for example, if you are able to run reports that say by rate how are your blood, your hypertensive patients doing, well, by golly you probably had to measure a bunch of blood pressures, you had to record them, you have to have a reporting function that is able to take advantage. There are just so many things that are incorporated that is maybe an example.

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

Oh...

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

Go ahead?

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

You know, and then the other thing too, as the customers have to do this they'll come to the vendors and say, of course, I need this, this and this too, right?

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

Right.

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

So go get creative.

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

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

It spawns other things, right?

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

So, that approach and it these are not mutually exclusive, it would be a good thing if we were to consolidate our objectives and simplify the measure. So, part of it is you've heard, we've heard over and over again the measurement done by each vendor not maliciously but can create the burden and create the disconnect between what's really being measured and how is the data is being entered to the extent that we can relieve some of that, that would be good for the entire program. So, that – let's flush that one out a little bit here and say ... and Christine do you want to talk about your project?

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

Sure, so we've – this is a parsimony idea that we've been talking about for a long time and so I just sort of finally just got tired of it and decided to see if I could find a clinician, physician in this case who has also implemented and used an EHR to help map that out. So, we are in the process of doing that. I don't know exactly where it will go but as Paul said, you know, the idea is and I think there are likely to be two kinds of things that could come out of it.

One would be a shorter list of criteria because what you could potentially do is say that for things like advance directives, you know, if that's part of the standard care summary it doesn't need to be a separate objective it can be part of the care summary, right?

Or, you know, even in ePrescribing where the ePrescribing sort of has two components, one is the transmission and the other is the formulary checking. You don't probably need to require the transmission because formulary checking would, you know, sort of do some of that, but it would also be because if you look at the ePrescribing incentive program that will have been around longer than meaningful use it's probably not necessary to continue to do that, particularly after they've already been ePrescribing for four years, right, under meaningful use alone, plus whatever.

So, the after visit summary would be another example, we'd have to think it through a little bit, but could you make the after visit summary really just part of view download and so that patients can get that either online through view download or they could get it through secure messaging for example. So, you could again create some parsimony there.

You know, or like recording vital signs. If you need them for quality measurements why are you recording them separately? So, that's sort of one outcome would be really kind of more advanced function particularly looking with a very scrutinous eye at the recording related functions and trying to compile those.

The second though piece would be – that my guess is that – so, where we started with looking at what we think is really important for new models of care so coordination and data exchange, team-based care, you know, the ability to do quality measurement things like that. And one of the lenses that came out of that which we've heard now over and over, particularly from the public comments and meaningful use was the need for population health dashboard. So, there I think another outcome of this could potentially be if you had this new thing then you could get rid of, for example, generating patient lists because that function is going to have to be part of the dashboard.

You could, you know, it would facilitate a lot of the quality measurement components and it would be actually better for the deeming approach, right, because then you'd have a shot at knowing before the end of the cycle where your performance lies and if you included on that population health dashboard, you know, something related to public health you might be able to get some parsimony that way.

So, that's what we've started to do, it's harder than, you know, you think, because you can kind of do some things, but our intent was so detailed and specific because, you know, on CPOE, well but it's this new kind, you know, or these orders, oh, but it's these new types and so things like that I think it's a useful exercise, I'm not sure – I think it's a useful exercise if we think about it through the lens of, if you have a deeming pathway that we've been talking about, but you still have to have this alternative Stage 3 this could probably be that and there's – just to simplify an easier version but still maintain the certification criteria for everything as well.

So, I don't know that it's an "and/also" or if it's an "or" but I don't think we will know until we go through that process if that's what people think is a selector ...

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

I mean, I think both talked about and want to do that anyway.

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

Yes.

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

And that that would be well appreciated no matter what else we do. Other comments about that? Okay, a third area we talked about is, and again, this is probably – this is also not an "either/or." So, this is the decoupling. So, we had in our minds, probably because of Stage 1, Stage 1 you have to have certified EHRs you also have to do the following things.

The advantage of Stage 1 was you only needed 90 days to qualify. Well, now it's the advantage of Stage 2 now, but that was one way of buying at least nine months of lead time. There's no real reason, I mean, it's not by statute, that the certification of EHRs has to be coincident with the qualification in your use of the EHR with meeting these functional objectives.

So, we – and we always knew we needed something like 18 months development testing time for the vendors and 18 months of sort of implementation time for the – well, we sort of put them together, even though they truly are sequential, because you can't start working with the thing until we get it out and implement it.

So, if we decouple the EHR certification criteria timeline from the adoption and proving use, meaningful use by the provider, we may actually get to buy some of the time for the providers to implement and make meaningful use of certain things. I'm not getting through quite yet, but ...

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

Can I ask a question, don't they – I thought the reason we always coupled them that way is because they needed functionality in the EHR to be able to meet that stage.

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

One drives another, right, but the timing doesn't have to be the same. So, you could have certification criteria for criteria for 2016, but the first time providers have to demonstrate meaningful use could be 2017 or 2018 whatever it is.

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

All right, so the certification would come first?

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

Correct.

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

And meaningful use would have to come after?

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

Correct, correct.

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

Okay.

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

It doesn't have to be coincidental.

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

Okay.

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

So, that gives us – what happens is that would give us more flexibility and here's one way. One, more flexibility in time, but the other, even menu items create requirements for vendors.

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

Yes.

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

And that's a good thing from a provider's point-of-view, but providers then have more flexibility in what it is they need to use to deal with their local priorities. Do you see, it's going back to how do providers take advantage of what they – so, we determine certification criteria by essentially creating the baseline, the things that are public good, required for network effect, etcetera. But providers have more latitude in deciding what's important to them and when will I apply that.

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

So, the ultimate outcome would be, in all likelihood, correct me if I'm wrong, pushing out when providers have to start to implement Stage 3 because certification – we would give more time to certify to some of the new functionality.

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

So, let's not associate with an end yet, stage end, but it gives – one, it does give providers more time to implement functions that are available in an EHR, but two, more latitude in choosing what's important to them which is it goes towards flexibility and it goes towards innovation, but, we're driving the baseline functionality available in the EHR to them.

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

Can you clarify, Paul, how does it give providers the opportunity to decide what's important to them? Because won't their HER ...

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

Okay, so it's more use of a menu approach.

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

Pull the mike closer, it's hard...

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

Oh, sorry.

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

Thanks.

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

So, it's using the menu approach more.

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

Using what now?

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

The menu approach more.

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

Menu approach, so it's giving them more flexibility.

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

More flexibility.

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

Oh, oh, oh.

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

So, we believed that Stage 1 and Stage 2 essentially is a forced march because we need a certain floor and we needed certain things to happen like interoperability to get the network effects of that, that's why it was a forced march. Let me hypothesize that beyond Stage 2 that we need less forced march, we need to almost have forced functionality, it means everybody gets access to this kind of functionality, but that people pick and choose more of what they want to use at a particular time and the way that's implemented is through menus.

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

So, I want to make sure I'm getting it. I get the menu piece and then separately understand the decoupling certification from ...

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

Yeah.

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

I don't understand how they're related together which gets to where Amy was going.

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

Okay, they're related because you will not get a certification criteria without even a menu.

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

Right.

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

Yeah, so the menu comes – but the timing of when you have to qualify and which menu items you choose, is left up to the provider more.

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

The timing though ...

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

The timing too.

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

It's not ...

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

Well, so in a sense we have – in some sense you're going to look at it from a vendor perspective and say we've hampered them in not giving them final specs, certification criteria, waiting for when we can give providers final specs. Do you see what I'm saying?

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

Ah.

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

We're actually penalizing both parties. We're saying you don't work on anything until I'm ready to give something for the providers and providers you can't do anything until the vendors develop something. It's sort of an – we didn't need to constrain ourselves that much.

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

But the vendors do have to ...

George Hripcsak, MD, MS, FACMI – Columbia University

... two are related.

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

No I think it does now, right?

George Hripcsak, MD, MS, FACMI – Columbia University

... some delay and those are both good but they're not related.

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

They're not related.

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

The vendors still have to put the functionality in for the whole menu set?

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

Correct.

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

No matter who's going to buy what.

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

Because they can't predict which customers need what and their customers have to have the capability to do something.

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

So, you're just saying put more time between when all the functions, the components of all the functionality are the core EHRs and then allow some amount of time after that for providers to then implement and determine which of the menu set functions they really want to turn on or off.

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

Yeah.

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

But if it's more flexible – I think I – if it's more flexible and presumably there's fewer requirements, why do they need more time? The vendors need more time, why do the providers? It seems to me we have it backwards.

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

Okay, I think I've unraveled it, so I think here's a way to solve both problems. You keep it coincident, because you do need the connection between functions driving certification criteria, but, because of the menu, you can implement it today or you can implement it in two years, because it's not a forced march. So, by choosing – so there's – I'm just making this up, 10 menu items.

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

Like the reporting period becomes ...

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

No, let me finish.

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

The last 90 days of the second calendar year or something?

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

That's another – okay, so from the functional, meaningful use objective point-of-view if let's say there's 10 menu items and you only have to implement 2 you're going to pick 2 that are one more ... easier for you to implement today and are important to you, there's 2 more that are very attractive but I can't implement it today I've got so much going on, I'll implement that in 2 years and that's still okay because I've met my smaller number of menu requirements. So, the fact that it's menu gives me a longer time to decide when to implement it. Does that make any sense?

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

Yeah.

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

But only if you're assuming that the number of menu set items you have to choose go up over time. Because otherwise, you could just pick the two that are easiest or you're most aligned with today or that are your ...

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

Well, no they go up over time, but they're not so forced march as we had – they don't instantly become core in two years.

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

Okay, so what you're really talking about is how quickly the menu set moves to core if it moves to core?

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

Or if – okay, so I have 10 menu items, I choose two in 2016 let's say and I have 12 menu items in 2018 and I have to pick an additional two.

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

Okay.

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

But, what I get to do is pick which are the most relevant for my business, my patients and that gives you two things flexibility and time, lead time.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But in your example, you're not decoupling the timing; you are simply saying that more moves to menu.

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

Correct, so I came up with a different way to try to ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Do the same thing.

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

Parsimony.

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

Get more moves, but that's what I'm getting at, so, because more – now I've totally turned my brain into a pretzel, but more moves to menu but they still have the same amount of time to implement whatever menu options they pick or are you trying to extend that out and if you are then ...

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

So, it's the former. So, by giving them ...

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

Okay, so it's just more menu, everything is the same but you got more menu.

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

I got menu which gives me more choices and I can pick the ones that are both more relevant and I can do that today and I can postpone other things because I have much more to choose from in two years let's say.

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

Right, because you know that by virtue of the fact that they're on the menu, the version of software you have is capable of doing them and you can implement them in a couple of years.

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

Correct, whatever is good for you.

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

Outside the construct of meaningful use.

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

Correct, exactly right.

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

Okay, so ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And the pattern is menu, smaller amount, core some of those move to core.

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

No, no.

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

So, think of it not as core, as I'm getting more and more functionality in your EHR.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay.

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

You have to implement two every – two of these things every two years.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

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

Just make that up, but what happens, you're getting a richer set of enabling functionality in your EHR. You have more opportunity to decide what's going to be the most important thing for you this year.

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

This year and this year being the incentive year and then, you know, maybe next year when it's a penalty year you can pick another ...

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

Whatever.

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

Two off or whatever.

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

Exactly right.

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

So, here's the question, what is – when you think about core and menu is what's in your mind what we had originally gotten public comment on?

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

No.

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

Or is it a set of ...

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

It's probably more ...

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

Maybe more advanced functions.

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

It's probably more – there will be more choices and I wouldn't think of core anymore, I would think – I mean there still maybe a core but the menu set is like you get to pick two every time. You're not going to be all of a sudden forced to do option number 10, because that's the whole problem with the core.

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

Right, there's no movement to core is what you're saying for this cycle?

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

For this...there may be other core things that come along, but there's no in this menu set; there is a number that you have to do.

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

Ah, but there is no core function.

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

Right.

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

But there is a number and this is instead of, in addition to, because, I mean ...

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

Instead of, I guess one way to look at is instead of core.

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

So, you're saying keep menu set items – let me try it this way, you're saying as we continue to build out keep menu set menu set don't require them all to become core because different providers may need to have different menu sets but just make the requirement of which menu set items you do have to be more and/or different than the previous ones.

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

Correct, correct.

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

But don't move them to core?

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

Correct.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, the function overall moves to core because you've got to do two, but you're selecting which ones to do?

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

Correct.

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

Right the number.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

The number.

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

But there's no one size – so it goes against the one-size-fits-all problem.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

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

And we just ... we begin to – there was a forced march that we thought would benefit everybody and we needed the network effects. No longer is that really true because people are on EHRs and they've already passed Stage 2, now it just gives them more functionality in the EHR.

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

And that's assuming that we truly believe that Stage 2 will solve a lot of the core ...

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

Correct.

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

Interoperability and exchange and ...

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

Correct.

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

Goals that we are hoping to achieve with it, which ...

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

Yes.

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

Everyone still ...

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

Now, there still may be core, but that's almost like a separate path. So, let's say, okay now, all 50 states are able to do immunization registries we'll make that core for the entire country. But by and large our method is going to be putting functionality in the EHRs that we think are extremely valuable and letting people implement what's relevant.

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

See, I think part of what Amy's saying and I agree is that there are some societal benefits, network effects that Stage 2 we can't give it too much credit for getting to, so, public health, care coordination probably being those, but if there – but I think, you know, the question then that a raises for me – so, I'm okay with that conceptually, but then I'm a little confused, are we talking about Stage 3 and if we are talking about doing that in Stage 3 then what are the functionalities we're talking about?

Is it what we've already or only some of them or only the more advanced ones? Are we going through a process of, based on our hearings, figuring out new ones like a population health dashboard and then are the vendors going to have the time to develop stuff that's even much more advanced than what we've already signaled to the market? I mean, I get the idea, I mean, it's not ...

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

Right, so, I don't have a ready answer to that, but I might start with a default of, yeah, let's make everything we have a menu and reserve "core" for a much smaller amount.

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

Yeah, right, but I just ... of the ... what's existing in here for Stage 3?

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

We'd have to look at it.

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

Yeah, we'd have to look at it.

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

So, let's say you pick dashboard as one example. Okay, if you're going to – here's a – so if you're going to take advantage of deeming pathways, one of the things you have to implement is dashboards, you know why, because you're going to want to know how well your progressing to that – so it makes sense and that's why, that's a really good reason for me to pick that menu and I'm just making that up.

So, let's see – what if they all became menu and then we look at each and every one of the things, the new ones that we prescribed and said, does this really have to be core for everybody?

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

So, you're basically saying reevaluate everything that we've put into Stage 3 about whether it needs to be core or menu?

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

Yeah.

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

And re-analyze it with this.

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

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But, to do so is also the light of deeming. So, that if I have deemed much functionality it might also include this new advancing menu item. So, if I'm doing this item in advanced menu items I might deem then the following options from core so that we're not just...

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

Yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I don't want to end up lowering the bar.

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

I understand. So, this goes along with the philosophy of let's give people a chance to do what's the most important for their catchment area and reward good behavior and they will figure out what's the best use and what we've done is we've put all these functionalities into EHRs.

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

So, I have no problem with that and I, you know, agree that we need to simplify. There's a part of me that gets a little anxious about not having any experience with Stage 2 and understanding if it's really going to achieve what we need it to achieve to be able to say we don't need something to be core because, you know, whether it's exchange or, you know, care coordination, or patient engagement, if it doesn't work the way we envision it for whatever reason we're already sort of taking that floor out, because if you choose it and George doesn't, and I need you to both choose it, you know what I'm saying? So, there's something here that feels a little unsettling without having more information ...

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

I agree.

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

On really what's going to – how we're going to look once Stage 2 is out there and how easy it is for people to meet it and what it really means. So, on this one I'm wondering whether and I don't know timing-wise whether there's a way to sort of defer this thinking a little bit until we have more experience with Stage 2.

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

Well, we ...

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

Paul, can I make a suggestion, I'm going down the same path as Amy. I think, I get the concept and I don't object to it, but I actually think alone I don't love it but coupled with the deeming approach or coupled with the simplified for advancement approach, so, I would just suggest that we keep this in the parking lot, hold onto it let the group go off and then come back and say, okay, because the other thing that occurs to me is that, that would be a particularly interesting approach to stages beyond Stage 3.

Like, if you think about where, you know, we know that by the time anybody hits Stage 4 were pretty sure that the penalties have started by then, so, you know, that is something where you do want to create more flexibility and innovation.

So, if it was there are 15 things and you have to pick two but they're really meaningful things, they're not like document progress notes, right, I just feel like and where I'm with Amy is I just ... my sense is that there are still some pretty foundational functions that aren't quite in use widespread yet that we didn't hit totally in Stage 2.

So, 3 is probably needs to be the combination of let's get clean up and get those last couple core things that we really need, you know, around interoperability or disparities, or whatever, let's start to think about rewards and through improvement and then in Stage 4 start to think about, okay we don't want to penalize you and in fact really what that begins to be about is making sure you have the tools you need in the new environment that we haven't really seen yet.

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

I mean, I think, the jury's still out and I think, you know, Joe said it before, I'm pointing because that's where he was sitting, you know, about how far providers are going to go with meaningful use in terms of the complexity of it. So, that takes to making the complexity easier and less onerous, but, yeah.

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

Yeah, I agree.

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

Okay. Let's do this. Does anybody need a break?

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

No.

W

...

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

Oh, that's right – I promised them since you all sort of went out and got your own thing and staff was just going on the agenda that we sent out we need to reward good behavior. So, at any rate, why don't we take a ... how long would you ... okay, like a 15 to go get stuff.

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

Go get some food.

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

And what we're going to be thinking about is what other options, so we have three and you actually have a proposal that says let's work on two of them and hold the three in reserve and then so what we'll come back with is do we have any other options to explore and we'll talk those out. Okay? So, when our ...

MacKenzie Robertson – Office of the National Coordinator

So, what time do we want to come back?

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

You tell us how long you need.

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

1:05.

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

Okay.

MacKenzie Robertson – Office of the National Coordinator

Okay.

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

Thank you.

MacKenzie Robertson – Office of the National Coordinator

Operator can you please open the lines?

W

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you and I will turn the agenda back over to Paul.

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

Okay, thank you. On your lunch break did anybody think of another option? Is that a no? Did you think of another option? No? Okay, let me review where we are. We did not do the – so the first pathway was deeming an alternate pathway of deeming. Some of the questions we talked about are, how do you map the deeming measure, it could be a quality measure, maybe it's something you make up, to the relevant MU objective.

How do you deal with the fact that you won't know whether you qualified for deeming until the end of the reporting period? What do you do about specialists who have fewer, at least, CQMs? What you do about hospitals? What QMs would we start with and Jesse was saying start with the 2014 set. A question about bundles and multiple CQMs. Other questions to flush out for the deeming pathway?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

How can we combine both the menu idea and the advancing of a next phase through deeming?

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

Although we might want to – I would suggest we hold off on that until we see what originally they come up with.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay.

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

Because, I think that's a lot of work in a month, I mean, if we need to have those workgroups meet and have something ready for like March 15th which was proposed, I would ...

MacKenzie Robertson – Office of the National Coordinator

Amy, could you pull the microphone a little bit closer?

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

Yeah, no, I was – I'm sorry; I was just saying that I think that we should hold off on what Leslie was just asking for. I think there's plenty of work to be done in the next month on just the questions and sorting through the two options and the questions that we've already – not bringing in the third option in how it relates to the first two.

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

Okay. The next one was clustering or consolidating objectives. And what are questions we want to have flushed out for next time?

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

I think one of the questions is going to be are there any new functions like population health dashboard that if you added them could be helpful in the consolidation, but, again, I think it's double checking against EP/EH that whatever yields from that would work for both EP and EH, and specialists of course as well. I think those are the notes that I have so far.

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

Any other questions?

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

Making sure that both approaches capture the driving the functionality needed for care coordination, health disparities reduction and patient and family engagement, and if they don't making sure that those are preserved as some kind of requirement, which probably means there's something else around health disparities. I'm not sure we really got there in our Stage 3 recommendations.

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

And I would also add health information exchange to that.

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

Yeah, that's why I said care coordination.

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

Yeah, you're including that, okay.

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

Yeah. And then I think to George's point earlier, this is kind of back to the deeming thing, I think there is a strength in relationship between some functions and some measures that is variable and so I think as that group does the work where there's a strong link, you know, we should have a column or something that says the strong link and then there's sort of a, you know, less strong, like should ideally be done or would most efficiently be done, but not a standard the way it's done today then we need to know what those are and I think George's point, at least in context was good, which is that if the measure groupings are lots and lots of, you know, process measures versus lot of outcome measures that may mean different things for how much functionality we're willing to deem, but having the group take that...do the mapping so we see it would be I think helpful.

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

What's the form that your current mapping, Jesse, is between CQMs and sort of functions? Where are you now?

Jesse C. James, MD, MBA – Office of the National Coordinator

How far have we gotten in the list, oh, we did it for a few exemplars, but we're non-exhaustive of the list of CQMs, primarily outpatient based.

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

Can you hand over the few exemplars to get us started?

Jesse C. James, MD, MBA – Office of the National Coordinator

Oh, yes I will.

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

Okay. Okay and what were you looking at, George, was it the briefing materials for this meeting?

George Hripcsak, MD, MS, FACMI – Columbia University

I was looking at the Stage 2 final rule.

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

Oh, okay.

George Hripcsak, MD, MS, FACMI – Columbia University

I just went straight there.

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

Okay. Then we actually are either ready to adjourn or to do some small – well, what are the small groups? And remember we have a few more folks.

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

Yeah, are you going to break us up?

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

So, I'll volunteer for deeming for example.

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

Yeah, I'd like to – do you want to – I'd like to work on deeming too, but do you need me on both?

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

I almost think most people want to work on deeming I know I do too in a way, but the simplification piece is kind of a necessary for all, so I'm happy to work on that.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I would be probably ... I would be happy to work on the ...

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

On the consolidation?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

On the consolidation.

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

Amy?

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

I can do the consolidation.

George Hripcsak, MD, MS, FACMI – Columbia University

So you want me to be on consolidation or deeming? I'm happy to do either one.

George Hripcsak, MD, MS, FACMI – Columbia University

Paul, I'll do whatever you need.

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

... consolidation. Charlene, what did you say?

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

Well, I wanted deeming, but, again, I can work on any or ...

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

Well, now there's 1, 2, 3, 4 on consolidation.

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

Yeah, we definitely need a clinician, a doctor or a clinician on the consolidation piece.

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

So, I think David is doing deeming. Marty, are you on?

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

I can do either, I'll do either.

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

And who are we missing? We're missing Neil.

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

You're missing Art Davidson.

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

Art Davidson.

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

Who else are we missing, Deven?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah, Deven would be good on deeming.

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

Okay. So, Christine can't meet on the previously scheduled Meaningful Use Workgroup time so maybe that small group will have to meet at a different time. Oh, okay. So, we have Neil, David Bates, oh David Lansky, Deven.

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

David would probably, if he could have the time do the deeming piece I know he's spoken to that.

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

That's true. Okay. Okay, so we'll – about, we'll be about 50/50.

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

Yeah, I mean if you need me to switch because of whatever I can be flexible.

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

No, I think we, it's about right. So, it's the 26th, what's today? Today is the 14th and I probably can't meet next week, okay, so I think the deeming group will try to meet on the 20 whatever it is.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

The ...

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

The 26th, and Christine you want to organize your group's call time?

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

Yes.

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

Marty is trying to get on the call; he says he can't get through.

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

And materials-wise, I think, Jesse, if you can give us what you've got in terms of exemplars that's probably where we want to start anyway, where the control kind of measures, hypertension.

Jesse C. James, MD, MBA – Office of the National Coordinator

Steve owns it and I'll email him to have him send it and I'll send it to the group.

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

Okay, great, great. What else, Michelle in terms of things that ...?

Michelle Consolazio Nelson – Office of the National Coordinator

Christine, what will you need to prepare too? Is there anything that you'll need to help prepare or are you

...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Logical groupings.

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

No, I think I've got them, yeah, I think it's okay, because of the work that we've been doing on this other project I think it feeds in – yeah, so that's okay. I mean, I'm all right for now. I need scheduling help is ... that would be good.

Michelle Consolazio Nelson – Office of the National Coordinator

So, I'm going to take the list and pretty much divide those who aren't here amongst the two groups.

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

And, so for Paul, Jesse and I are meeting on Monday.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Just to kind of go over the list and make sure that we have something to present to you so then we'll share that so that you have time to prepare for the 26th.

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

And then work plan-wise if both of these pan out, then there's a good chance we'll actually be pursuing both, because they're somewhat complementary.

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

Yes, agreed.

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

If one of the other doesn't pan out then we're going to just drop that. So, our test before each other next face-to-face is to see whether we can convince each other sort of like we did here, okay, now that we have worked on some of these questions, maybe not answered all of them, does this still seem like a right approach to go?

So, when we decide that then from then on we're going to come back and fold in our Stage 3 RFC preliminary recommendations, take all comments, which I think you've had distributed to us in our briefing materials for this meeting and start going through all those things in assignment, they're either assigned to be subsumed in the consolidated group or they are – or this is how they would match from a, here's a measure that would be deeming for this group. Is there any ...

George Hripcsak, MD, MS, FACMI – Columbia University

Well, the same measure can be in both.

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

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

You might deem, if you don't deem you still want consolidation.

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

Yeah, absolutely.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, fine.

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

I suppose it would be nice to have the consolidated before we have the deem and it would be but then that would cause a delay.

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

Well, I mean, it's not far, I think if – we're not far off but I can't do it by – wait a minute, is that two weeks?

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

No, it's a month.

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

Oh, by the 15th, oh, yeah that's easy, but I mean, I thought you meant before the 26th.

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

No.

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

Actually, I might – if the group availability is there.

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

Oh, I see, I see, yeah, it could come in handy, yeah.

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

Yeah.

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

But, so we could be on our way and then we reconcile all the comments and our past work. So, we reconcile our past work and the associated comments and fold those in to the new approach. So that's March. I was thinking we probably need a couple months to do that, March/April, let me see if I laid this out here.

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

How does that facilitate the NPRM process?

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

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Do we have deadlines?

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

Late summer or fall is usually ...

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

So, if we – if it takes us a couple of months that would be – oh, here's a draft timeline. So, by the 15th we decide what options where we've decided we have a good chance of working and we're pursuing. We present that approach, so we are meeting March 15th, we present that approach to the full committee on April 3rd, so that's 2 weeks later and if they endorse that then we start the work process of reconciling all of our previous recommendations or associated comments into the new approach and that would be over a period of, I was giving us three months, May, June, July and then report back on July 9th what we think our draft MU3 recommendations look like in the new approach.

We get their feedback and then either turn that around by the August or September meeting with our final recommendations. So, that would put us three, at most four months behind our May schedule, you know, given the feedback, I think Farzad is willing to give us this extra time to get this right.

I think, in a sense we'll know by the April 3rd presentation to the Policy Committee whether this is an adopted, you know, this is an approach, an direction that they would like us to go and if they would like us to go in that direction then essentially we'd be asking for three months extra time to flush it out more carefully.

George Hripcsak, MD, MS, FACMI – Columbia University

This being that...because we won't have done the other thing yet.

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

Which other?

George Hripcsak, MD, MS, FACMI – Columbia University

Incorporate public comments into the ...

Michelle Consolazio Nelson – Office of the National Coordinator

Can you guys lean in a little bit.

MacKenzie Robertson – Office of the National Coordinator

Can you guys lean into your microphone?

George Hripcsak, MD, MS, FACMI – Columbia University

Oh, sorry.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry.

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

We're barely educable.

George Hripcsak, MD, MS, FACMI – Columbia University

That's why you reminders ... information system. I was just saying that by April 3rd, is that what you said?

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

By April 3rd.

George Hripcsak, MD, MS, FACMI – Columbia University

We've decided they're going to tell us whether we're doing deeming or clustering.

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

Correct.

George Hripcsak, MD, MS, FACMI – Columbia University

They're not going to comment.

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

Correct.

George Hripcsak, MD, MS, FACMI – Columbia University

On how we've incorporated the public comments into Stage 3 be we won't have done it by then.

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

Correct and so if they agree with this approach than we will go and do the incorporation, the reconciliation. How does that sound? Sound good there?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

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

Sound good here?

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

Yes.

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

Okay. We may be done, what else do you need?

MacKenzie Robertson – Office of the National Coordinator

So, for the March 15th meeting, it's not on anyone's calendars yet, I can send out an appointment today. Do we want to do a 9:30 to 2:00? How long of an in person meeting do we want on the 15th?

George Hripcsak, MD, MS, FACMI – Columbia University

March.

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

March 15th is a Friday and somebody was just commenting on Fridays. Can we do an 8:00 to 2:30?

MacKenzie Robertson – Office of the National Coordinator

An 8:00 to 2:30?

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

How does that work, I mean, you guys are all here for the...or most of you are here for the Policy Committee, 8:00 to 2:30 on Friday the 15th?

George Hripcsak, MD, MS, FACMI – Columbia University

Wait a minute.

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

The 14th of ...

Michelle Consolazio Nelson – Office of the National Coordinator

Eight will be difficult if people are flying in for the day.

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

Sorry?

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

Yeah, I was – I mean, I'm not here for the Policy Committee, I'm not sure if I'll come the night – I'm traveling earlier in the week someplace else, don't do it for me, but I might just come a little bit late than if I try to fly in and out that day, which I can do, but ...

MacKenzie Robertson – Office of the National Coordinator

Do we want to say 9:00 or 9:30?

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, yeah, because I'm not at the Policy Committee meeting, because we're not presenting and I have something that evening, so I'll probably come that morning, which means – I guess, what time does Neil get here normally 9:15, usually when he's rolling in? Neil Calman, he's on the same train normally?

MacKenzie Robertson – Office of the National Coordinator

9:30.

George Hripcsak, MD, MS, FACMI – Columbia University

So, 9:30 I should be able to make.

MacKenzie Robertson – Office of the National Coordinator

Does that work?

George Hripcsak, MD, MS, FACMI – Columbia University

But you said you're going to start earlier, I'm sorry?

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

Yeah, because I'm already here, but – and I have to leave that day, but actually let's see – although I'm bad at estimating time. If we think we're on pretty solid track, but we wouldn't need to do this due diligence if we really knew that, so I think, George's little exercise gave us a little heads up, your previous work is giving us a heads up that is feasible I think. Okay, because we're going to present. So, let's say we spend 2 hours per proposal, that's 4, if we start at 9:00, let's make it 5:00, oh, lunch, 5:00 that would be 2:30 ...

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

You could do 9:00 to 2:30?

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

Yeah, could 9:00 work? Can 9:00 work?

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, I'll be a couple of minutes late that's all.

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

Okay. Okay, so 9:00 to 2:30.

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

... on the 15th.

George Hripcsak, MD, MS, FACMI – Columbia University

Would we be in DC or here? Odds are?

MacKenzie Robertson – Office of the National Coordinator

We'll be in the DuPont Circle Hotel most likely.

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

I'm sorry, where will you be Mackenzie?

MacKenzie Robertson – Office of the National Coordinator

The Policy Committee meeting on the 14th is at the DuPont Circle Hotel, so I think we have the space on hold for the next day, so it will be in DC, DuPont Circle Hotel.

George Hripcsak, MD, MS, FACMI – Columbia University

That's good, that's a little faster to get to for me. If I were flying in than it would be a great area.

Marty Fattig, MHA – Nemaha County Hospital

Hello? Yeah, this is Marty.

MacKenzie Robertson – Office of the National Coordinator

We can hear you, Marty.

Marty Fattig, MHA – Nemaha County Hospital

Yeah, I finally did get back in; they said all circuits were busy for about a half an hour. So, anyway I am unavailable on the 15th I have an – I sit on a governor appointed committee here in Nebraska that I have to attend that day.

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

Okay, Marty, do you – have you kept up with the two options we're exploring?

Marty Fattig, MHA – Nemaha County Hospital

Yeah, put me wherever you need me on that, Paul, either one is fine.

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

What would you like?

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

Deeming.

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

On deeming, okay, you want to join the deeming one?

Marty Fattig, MHA – Nemaha County Hospital

Perfect.

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

We're going to have a call the previously scheduled time of the 26th 12:00 to 2:00 I think it is, Eastern.

Marty Fattig, MHA – Nemaha County Hospital

Okay.

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

Great. Okay. Is there anything else? Michelle or MacKenzie?

Michelle Consolazio Nelson – Office of the National Coordinator

I think we're all set.

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

Okay. Groups that already have their folks here could meet if they wanted to.

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

I couldn't hear you.

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

He said if you have all your team here ...

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

If your group is already essentially here you could meet if you need to.

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

Well, I can show you guys ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I'd love to see what you've got.

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

Yeah, it's electronic, but, yeah.

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

All right, let's open it up to public comment then please?

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the lines for public comment?

Alan Merritt – Altarum Institute

If you would like to make a public comment and you're listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue.

MacKenzie Robertson – Office of the National Coordinator

We have no public comments.

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

Okay, well thank you very much. Thanks for staying an extra day. Thanks for working on this. I think it's an exciting new direction for us and we will see each other or we'll talk to each other on the phone and then see each other March 15th.

George Hripcsak, MD, MS, FACMI – Columbia University

Thank you.