

**HIT Policy Committee
Meaningful Use Workgroup &
Certification & Adoption Workgroup
Transcript
May 3, 2013**

Presentation

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thank you, good afternoon everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a joint meeting of the HIT Policy Committee's Meaningful Use Workgroup and the Certification and Adoption Workgroup. This is a public call and there is time for public comment on the agenda and the call is also being recorded so please make sure you identify yourself for the audio recording. I'll now go through the roll call of both Workgroups starting with Meaningful Use. Paul Tang?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Paul. George Hripcsak?

George Hripcsak, MD, MS, FACMI – Columbia University

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, George. David Bates? Christine Bechtel? Neil Calman? Art Davidson?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Art. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Paul. Marty Fattig? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Leslie. David Lansky? Deven McGraw? Marc Overhage? Charlene Underwood?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Charlene. Mike Zaroukian? Amy Zimmerman I know is unable to make it? Tim Cromwell? Joe Francis? Greg Pace? Marty Rice? Rob Tagalicolod? And the Certification and Adoption Workgroup, Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Larry. Marc Probst? Joan Ash? Carl Dvorak? Paul Egerman, again, yes?

Paul Egerman – Businessman/Software Entrepreneur

Still here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thank you, still there. Joe Heyman?

Joe Heyman, MD – Whittier IPA

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Joe. George Hripcsak we have. Liz Johnson?

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Tenet Healthcare Corporation – Vice President,
Applied Clinical Informatics**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Liz. Charles Kennedy? Don Rucker? We have Paul Tang. Micky Tripathi? Scott White and Marty Rice? Okay with that any ONC staff members on the line?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Michelle and I will turn the agenda over to you Paul.

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

Okay, thank you. It looks like I have to update the slides with the workgroup members I noticed that some – it's not accurate. Okay, our task for today a couple of things want to go over the recommendations as we had them last and we did present it to the HIT Policy Committee. I think by and large it went over quite well, especially one of our biggest recommendations having to do with track changes I think went over well as well.

One the things that we were asked by Farzad whether we had discussed or not and we had not has to do with are there functions – so one of the causes for concern is there has been an increase in the level of intensity of the codes, I think that's over time, but also there is some matching of the increase and the adoption of EHRs, so one question is do EHRs themselves increase the level of coding intensity, the level of intensity, coding for level of intensity?

And of course there can be multiple reasons for that one is well actually you're documenting things that were always true but it's easier to document now. Another is patients could be sicker and another possibility is yes there are features of EHRs that could contribute to code, you know, increased coding level of intensity of a service and that's what we want to try to tease out.

So, Farzad's question is, are there functions in EHRs or you could imagine could be in EHRs that literally would induce up coding that are not justified and of course that's fraud. So, that's one of the things we want to consider on this call.

Hopefully, someone has – I listened to most of the listening session today, there was one on this very topic particularly related to billing and I was not able to listen to the panel that had to do with standards, coding standards that AHIMA was one of the presenters on, but maybe somebody else was on the call. Any other additions to the agenda for today? Okay, let me go over the recommendations as we presented them and see if everything sounds fine still.

Joe Heyman, MD – Whittier IPA

Could you – Paul?

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

Yeah?

Joe Heyman, MD – Whittier IPA

Could you tell us which document you're opening because I can't get onto the website?

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

Okay, why don't you look at, let's see it's called, it's the Word document for recommendations.

Joe Heyman, MD – Whittier IPA

Okay.

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

Got that one? Okay. You could also look at the PowerPoint either one has the same things.

Joe Heyman, MD – Whittier IPA

Okay.

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

Okay, so recommendations, the first was to move clinical documentation which as you know is a menu item for EPs to core in Stage 3 or at least make a recommendation for that to be done. The second is more or less a recommendation to the Meaningful Use Workgroup suggesting, you know, the panelists did not recommend that we either proscribe specific things that have to be done in clinical documentation or prohibit certain methods to not be done.

The third one was our "track changes" recommendation that is to help identify for the reader, if you think of the perspective of the reader, you would like the reader to know where this text came from. If you copied and pasted it from a lab report or a radiology report make that known. If you copied it from a previous note make that known it's not that it is wrong or inappropriate it's just that the reader now has better understanding of that material and can interpret it in his or her mind.

In response to Paul Egerman's questions, at the Policy Committee, we did not mean that you would have to track the source of text that appears in the radiology report. So, if you copied and pasted information from the radiology report into your encounter document that would be tracked but the way that the radiology report itself was constructed in the ancillary system is not something that undergoes tracking.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul Egerman, and that's correct it's not just radiology that comment is directed to.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

I mean, it could be consultative notes or –

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

Correct.

Paul Egerman – Businessman/Software Entrepreneur

You know, possibly op reports, but you know basically documentation from other sources.

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

Other sources, right.

Joe Heyman, MD – Whittier IPA

This is Joe.

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

Yes?

Joe Heyman, MD – Whittier IPA

So, let's say I do a note on a patient and I cut and paste something and it's tracked into the note.

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

Yes.

Joe Heyman, MD – Whittier IPA

And then I send that note to the primary care doctor and they put that note into their record, they cut and paste something from my note into their record.

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

Yes.

Joe Heyman, MD – Whittier IPA

Does all of the tracking have to be there or is it just, you know, I track what I cut and pasted, they track what they cut and pasted?

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

It's the latter. So within a system –

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

That's the same way it would – that's how Paul's question comes into play. So, within your EHR when you move things around the viewer, remember it's at the touch of a button, would be able to track the changes inside the EHR, it does not – you don't carry that tracking from the source systems or the destination.

Joe Heyman, MD – Whittier IPA

It's a good thing, very good.

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

Okay. The next piece is we recommended that the function view, download and transmit would include progress notes as a certification criteria not as an objective against which you measure the user behavior. So, just to state that a little bit better, this is a certification only requirement that an EHR permits you to include progress notes as part of view, download and transmit.

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

So, Paul is that like contained or, you know, there could be a lot of progress notes by a lot of different people, so that's sort of like, you know, you've got the – you know, a whole range of people writing progress notes so is that contained or –

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

It's a good question.

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

All over –

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

Okay, here is how we answered the question and let's see if that tests out. It would be for EPs.

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

EP's progress notes, but I mean could it be a nurse practitioner?

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

Correct.

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

Because, I mean, they are going to be – they get paid, right?

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

Well, the people who are included, I mean this was the way we phrased it, are the people who are covered under EHR incentive program, so that would be the EPs.

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

Yeah, EPs and nurse practitioners are also paid.

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

Yes.

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

Yes through Medicaid right?

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

Like it wouldn't get the respiratory therapy notes or dietician etcetera.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And then Paul you're saying that would not, by this description, would not apply at this time if recommendations went forward to EHRs and their progress notes?

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

You know, we were asked that question where we left it is that we did not exclude them. So, I think that's something we can talk about, but we hadn't, in our last conversation, excluded them explicitly.

Paul Egerman – Businessman/Software Entrepreneur

And Paul, this is the other Paul, I mean; the state of the art is a lot of the inpatient progress notes are not entered into the computer system.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Paul Egerman – Businessman/Software Entrepreneur

For a large number of reasons. I mean, it's usually somebody will write a two sentence summary or a comment.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

– yes.

Paul Egerman – Businessman/Software Entrepreneur

They'll just hand write it into some record or something or a document and so – I mean, that's just an observation plus I –

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

I think the inpatient progress – what's called an inpatient progress note has got the same name as an ambulatory progress note but it's kind of like a different thing.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

It's sort of like a different animal, I kind of wish it had a different name.

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

So, Michelle, can you just confirm the menu item currently in Stage 2 is EPs only, correct?

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, Paul, it's what only?

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

EP?

Michelle Consolazio Nelson – Office of the National Coordinator

No, I think, at one point I think I had said that but I was wrong it's EP and EH.

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

Okay. Then that's in Stage 2 though right?

Michelle Consolazio Nelson – Office of the National Coordinator

It's in Stage 2, yes.

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

Yeah, so in some sense we've already covered that water is that right? So, in other words if it's not in – it has to be in Stage 2.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

The quandary becomes do we move it to core, e.g., over to core in Stage 3?

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

Right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Because it's different when we're trying to figure out how to do it and we have some options versus we now have to do something and I think Paul is right we have definitional issues.

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

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think this focus was intended to be a technical capability, right? This was meant to be certification only?

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

Number four was but Liz is also bringing up in number one we move clinical documentation and since it was menu for both EH and EPs –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Got it.

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

Move both to core.

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

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

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

So, Paul, its Charlene again, just add – had we discussed, and I just don't recall, at least starting to get the content of the discharge summary available? You know, rather than four days later? I thought we maybe had thought about limiting it. Did we have that discussion?

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

So, I think that's in the Meaningful Use –

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, so –

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

That would be in our Meaningful Use discussion.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, this is Michelle, yeah, it was a Meaningful Use discussion and Paul you had asked that the Subgroup 1 look at that and they did, and they decided that it shouldn't be limited to discharge summary, that's what the Subgroup decided. It doesn't mean we can't change that.

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

It just seems like, you know, it would be – here's my case, it's like Paul said, you know, still a challenge in the inpatient environment to capture this and hopefully by Stage 3 it will be there and we want to incent that, but at a minimum it would seem as a floor if we could get that discharge summary starting to be available that would be a huge step that's all.

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

Okay, so can you state the – so Michelle, can you state what's being – what change is being requested and what is being recommended by Subgroup 1?

Michelle Consolazio Nelson – Office of the National Coordinator

So, for Subgroup 1 they've recommended that it move from menu to core for both EP and EH.

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

Just the discharge summary?

Michelle Consolazio Nelson – Office of the National Coordinator

Oh, just the discharge summary piece of it?

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

Are you talking about?

Michelle Consolazio Nelson – Office of the National Coordinator

No, they didn't distinguish, they didn't say, they decided they didn't want to limit it to just the discharge summary, sorry.

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

Okay, so let me make sure that – is that what you're asking Charlene?

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

Well, no I was just saying if for this particular case of what we're trying to do, you know, if it's too much of a challenge as you start to think of all the progress notes on the inpatient side what is it that you really want in the view, download and transmit? Do you want all those progress notes there and does that really make sense? So, I was trying to narrow it to something that would be pertinent to what you would want to share, which would be the discharge summary.

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

So –

George Hripcsak, MD, MS, FACMI – Columbia University

Well, remember Stage 1 is, this is George, is one note of 30% of unique patients for office visits and then one note I guess per admission for 30% of unique patients on the EH side. So, from the objective point-of-view that's easy then you're just saying, well if they do this they're not going to do one note they're going to do a million notes per admission and then should that be in view, download and transmit. I think the only thing to think about is there a mechanism – I mean, as we put more into – as people are able to download their chart, which will be voluminous, is there a user interface that allows them to shift through this.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, today on the view, download and transmit, and this is Leslie, under the Blue Button standards they're getting the equivalent of a consolidated CDA which includes in it discharge instructions if there were some as well as for the patient, patient education and labs.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

But it does not include the summary.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

In the consolidated CDA?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

It does not include the physician's dictated summary that's why I think we are in semantics here maybe.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And just includes the discharge instructions?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Correct and the discharge summary, the way I think about it, is much more comprehensive than that.

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

And that certainly would be useful to –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Correct.

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

It's at least useful in the transfer of care.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

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

The summary of care and it certainly could be of interest to the patient as well.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

And that's probably far more valuable than having all of the notes inside of an admission.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, this is the other Paul, but in listening to this I'm just trying to understand from the stand-point of an inpatient how useful the inpatient progress notes are to the patient especially, you know, sort of like after-the-fact.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

And you have the discharge instructions are, discharge summary might be, there is a lot of important information there that the patients and their families would want to review, you know, whatever progress notes are in by say the hospitalist at 2:00 in the morning may not be useful to the patient.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, that's what I'm thinking.

Paul Egerman – Businessman/Software Entrepreneur

And may be confusing actually.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, I'm thinking their SOAP'd and for someone who is not accustomed to reading it that sort of format could be very confused. I mean, I'm all for –

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

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

Okay, so let's –

Paul Egerman – Businessman/Software Entrepreneur

Especially if the inpatient progress note includes like a comment about a medication change.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Paul Egerman – Businessman/Software Entrepreneur

And then somehow there is that comment there and then that's perhaps confusing to the patient as to maybe that's inconsistent or not mentioned in the discharge summary.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

That might, I don't know –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think until we have real-time access it's better to do the summary that level document.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I think so.

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

It sounds like there is a lot of emerging consensus around in the hospital setting making the capability for VDT to include the discharge summary but not each progress note in the inpatient setting. Is that true? People agree with that?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

True for me.

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

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Yes.

Joe Heyman, MD – Whittier IPA

I'm comfortable with it.

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

Okay and for the outpatient setting we still do mean in fact the progress notes for EPs. Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I think so.

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

Okay, I will correct that and that's the change. So, let me just revisit recommendation number one where we were moving clinical documentation which is menu for both EPs and EHs moving that to core in Stage 3. I think we had no question about EPs. Then for EHs the way it's written it's just one note period, right, whoever was reading it, I think George?

George Hripcsak, MD, MS, FACMI – Columbia University

Yes.

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

Yes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And could that note be discharge summary Paul or is it a note?

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

I think it said note but do you have it in front of you George?

George Hripcsak, MD, MS, FACMI – Columbia University

It doesn't say in this box. Our intent was not a discharge summary which happens after the admission.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

So, that was clearly not our intent, I'd have to look at the original language to see if it excludes it or at least make sure that it occurs during the hospitalization not after it.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, I think you're –

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

It almost seems like this is not – the definitions are so fuzzy and the use of “one note” is – the value of that is so unclear that I wonder if we probably should move it to core for EHs?

George Hripcsak, MD, MS, FACMI – Columbia University

I don't know how the word progress note got in there in the first place to be honest. I think, didn't we, Michelle, recommend clinical note because on the outpatient side we called them visit notes, on the inside we were saying, well it could be like an admission note or this note or that note and usually when people say progress note they specifically mean the things, the incremental thing you write after your admission note but not a transfer note, you know, each day.

Joe Heyman, MD – Whittier IPA

This is Joe; I think the way that discussion came up was somebody, namely me I think, pointed out that sometimes the summary that EMRs print out for a patient that a patient would be better off receiving the actual note rather than the summary.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, so Joe, so I agree with that 100% and I think I was thinking of that – so maybe that's why they said it, but I was thinking the visit note was a note and the visit summary is something that the computer, you know, pieces together.

Joe Heyman, MD – Whittier IPA

Exactly.

George Hripcsak, MD, MS, FACMI – Columbia University

So, I see what you mean. The H&P and plan, actually I'm looking now at the final rule for hospitals, Paul you asked –

Michelle Consolazio Nelson – Office of the National Coordinator

So, this is Michelle, my suggestion would be that we change the language for Stage 3 instead of entering a progress note that we change it to what we feel is appropriate for eligible hospitals.

George Hripcsak, MD, MS, FACMI – Columbia University

So, just looking at it now it doesn't really rule out a discharge summary as counting as a progress note because it doesn't say the time of it, it just says it has to be text searchable.

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

So, what is it? What is the phrase that is “it” is it a clinical document or what?

George Hripcsak, MD, MS, FACMI – Columbia University

Enter at least one electronic progress note, enter at least one electronic progress note created, edited and signed by an authorized provider, the eligible hospital's inpatient or emergency department for more than 30% of unique patients admitted to the eligible hospital during the reporting period, electronic progress notes must be text searchable.

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

So, it does sound like it's not a discharge summary.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

What you could do is –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But is this – , this is Leslie –

George Hripcsak, MD, MS, FACMI – Columbia University

It wasn't in our intent, sorry?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I'm sorry, this is Leslie, I remember the discussion being this was all about the input and didn't assume or presume what output under the Blue Button was as they are two different issues. This is, hey, we need to get more documented electronically in the chart.

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

That's correct.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, just an input side of it.

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

Correct.

George Hripcsak, MD, MS, FACMI – Columbia University

So, we could on this one Paul in a clinical note and for EH define it as admission note, progress note, transfer note by one of these providers. I mean, in theory we could do that and exclude the discharge summary because we already answered for that elsewhere and this was not the intent of this rule. And for outpatient we could call it clinical note also and say that this means the provider's H&P and assessment and plan not just the, you know, the clinical summary that the computer assembles from all the other parts.

Joe Heyman, MD – Whittier IPA

This is Joe, I thought I remembered that, and I may have this wrong, but I thought I remembered that what we sort of ended up with was that either a discharge summary, either the visit summary or a clinical note either one would satisfy it, but not that they were required to do both, not that the person who is doing it is required to do both. They should have the ability to send both if it's possible but they're not required to send both. I think the vendor is required to make it possible that they can send both, but maybe I've got it wrong.

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

Well, actually as Leslie pointed out, this actually is a data entry requirement not a transmission.

Joe Heyman, MD – Whittier IPA

Ah.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yes.

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

So, I think we and the Meaningful Use Workgroup and particularly Subgroup 1 can work on the language. I think the only thing that we could use from this combined group is an indication of whether we think that clinical documentation for EHs should be also moved to core?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So –

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

Let me just use the term electronic clinical note, as George proposed, in other words it is not the discharge summary.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Paul, if I were going to try and apply that to, you know, where, at least the 50 hospitals that I'm working with are, it would be that either, and I think the other Paul gave or George gave some examples around admit note, history and physical, I mean, I presume any one of those.

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

Any one of those would qualify.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And then if you – so the question would be if our physician used nuance or whatever product dragon product whatever and dictated the note and then it was transferred into the electronic record and it was text searchable.

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

That would qualify.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

It would qualify and I think a lot of people would qualify. I mean, I know I'm with you all, we want to try and get a more complete electronic record that is searchable so we can, you know, then get to the outcomes piece of this.

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

Right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I think that works. Charlene from your experience with – I mean, like I said I only represent a small number?

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

Yeah, no, I would concur with that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

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

Okay, so I think –

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

– to go that way.

Paul Egerman – Businessman/Software Entrepreneur

Sorry, this is Paul Egerman, if we're still talking about terminology and definitions on the EH side and maybe on the ambulatory side also, I think you want to include operative reports.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Good point.

Paul Egerman – Businessman/Software Entrepreneur

As examples of clinical documentation, you know, you look at places that do ambulatory surgery for example or even like community hospitals.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

It seems like the op report might be a useful document that the patient would be interested in reading.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, so it's useful, yeah, that's a good idea.

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

Yeah, so let me, off line, I'll work on the language and potentially George can help, so we'll make sure that it's a clinical note that includes any of those things as long as it's text searchable and as we discussed before opening up the line vendors would have to be able to accept entry of any of these clinical notes in order to comply with certification. Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It might be interesting to look at what's in the consolidated CDA, it has several document types and we've been touching on some of them. So, if it's valuable and accurate it might be nice to align our language with what's in there.

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

That's a good point. Okay, let me just finish recommendations so we can make sure we have enough time to discuss our main topic. So, recommendation number five was we suggested in this whole realm of clinical documentation we certainly heard that it's not really – in addition to the work of getting text into the system the payback is to be able to find the information you want and there needs to be better tools potentially more innovative tools in meaningfully displaying the information that is represented by that text.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Can somebody forward the slide please? Thank you.

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

It was in – it should have been in the meeting –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

There it is, yeah, it's here, we got it, thanks.

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

And number six is something that also came up in the listening session today, we're really trying to fix a coding system and coding criteria that were developed out of the paper world and certainly in the fee for service world and wouldn't this be a good time to start instead of chasing the past to move towards the future in an area which is based on team-based, team-care and really episode or problem oriented care instead of fee for services rendered. So, that is something we would make the same recommendation. And finally, that HIT Standards Committee can help us describe what it means to maintain a legal medical record in the electronic sense.

Okay, let me move to the main subject of today's call which is, is there a way to describe functions in an EHR that we might actually want to prohibit, it's a little bit hard to describe but we can take a chance, a shot at it. Let me just throw out a strawman just to sort of give an example, one could say it's fine to have a retrospective calculator is the way some vendors describe it as saying, okay, for what I've entered in what would you calculate the level of service to be and there are certain parameters you have to meet, so that's in a sense doing what the human is doing or the human coder, the specialist that codes these things is doing is saying, hey, what was done and what criteria, what level of service does this documentation meet? So, that seems like just an electronic or computer-based way of doing what the human normally does.

An example that might be beyond the pale, as Farzad would describe, is as you enter in things you have this real-time coding classification that's showing up in some window and it says what you have to do to get to the next level that seems like something that's excessive and invites abuse. First of all let me see if people even agree that that is something beyond the pale?

Joe Heyman, MD – Whittier IPA

This is Joe, I guess the way I feel about coding is first of all lots of hospitals and lots of large institutions hire people to make sure they're getting paid at the rate they're supposed to be getting. So, they look all the time to make certain that they're at the highest code level they can be at using the notes they have.

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

Right that's an important distinction.

Joe Heyman, MD – Whittier IPA

That's what humans do without an EMR.

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

Right.

Joe Heyman, MD – Whittier IPA

And the other thing I would say is that lots of institutions have their physicians automatically dictate this ridiculous thing at the end of the note that says that more than half of the time was spent in counseling so that it's documented so that they can use that to prove that they've been entitled to some code.

It seems to me that humans are doing the coding and that they're making the decisions and that you're only using a tool that helps you to make that decision, but in the end it's a human making the decision and I think it's crazy to require the EMR first of all to act as a police person and second of all to expect it to be accurate all the time. I just think it's crazy.

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

Well, I think what you described is a computer oversight that replaces a human but the important piece is the person performing the services documents what he or she did and then after the fact there is some review whether it is by human or computer that codes according to the coding criteria. So that seems totally legitimate.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, let me jump in and –

Joe Heyman, MD – Whittier IPA

As long as you can change the code because for example if – when I do a review of systems I do what I call a GYN review of systems which has a certain list of things that I know. When it's all negative I don't list all the negatives in the note because I'm quite capable of defending my note and I just put down there GYN review of systems is negative. If it's a general review of systems and the entire thing is negative, I mean, I've been saying that same review of systems for 40 years, if it's all negative I know what it means when it's negative I don't list all the negatives. Now, my EMR, if I don't put in each individual negative then it codes it down because it says I didn't do a review of systems. So, as long as I'm capable of overriding whatever it is the EMR has decided is the appropriate code I don't have any problem with that.

Paul Egerman – Businessman/Software Entrepreneur

Paul?

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

Yeah?

Paul Egerman – Businessman/Software Entrepreneur

This is Paul Egerman, actually I have a question about this whole issue from a different stand-point which I mean our focus is Meaningful Use of electronic health records and is this whole issue of, you know, what constitutes coding abuse and coding fraud, and over coding, that's an interesting issue but is that within our scope? I'm not sure that involves Meaningful Use of electronic records. I think it's just a separate interesting issue.

Joe Heyman, MD – Whittier IPA

I would agree with that. I would even go a step further and say I'm wondering if all the things that are listed in Meaningful Use are really Meaningful Use, but I won't go there it's a broader statement.

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

Well, thank you Joe.

Paul Egerman – Businessman/Software Entrepreneur

I'm looking at this very sensitive issue and I'm saying – I'm asking the question is it within our scope to worry about E/M coding and what the EHR system is doing about that. I'm just not sure that's a Meaningful Use issue.

Joe Heyman, MD – Whittier IPA

I would say the way – let me suggest that one way that it is – that it does pertain to us is that we constantly hear the complaint that it's difficult to read these records because of all of the extra stuff that's put in there because people want to document that they deserve the code that they chose.

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

Let me just –

Joe Heyman, MD – Whittier IPA

So – we could do to make them more readable if that means somehow changing the way we require the codes to be done might be something that's reasonable to think about with Meaningful Use.

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

So, Paul Egerman, I think the reason it's been brought into this discussion is one because congress has asked for it and the assertion or the concern is that it's possible that what congress and the administration has asked people to do, i.e., implement and use EHRs could be driving up the cost of care that's the assertion or that's the concern. And so we want to make sure that the features that we're requesting or building into the Meaningful Use objectives aren't inadvertently doing that and if so are there ways you can certify EHRs so that they don't have things that cause more harm than good.

George Hripcsak, MD, MS, FACMI – Columbia University

Paul, this is George, can you please repeat the specific question, which item you're – you said let's try this one first? So, what is this one again? Since you put forward a function that we're supposed to say is this –

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

Oh, well, okay, so one way of looking at – the idea is, is there some criteria we can use to say this seems like a legitimate thing for an EHR, for a computer to do that does not violate coding criteria set by CMS. Is there also a way of saying and if it does the following it does look like it would induce behavior that is contrary to what we're trying to do with EHRs.

So, the first one that seemed, I think, straightforward is if you take existing documentation all the things that are entered by the clinician, the EP and retrospectively use computer tools to help analyze what criteria, what level of service criteria does the documentation meet everything from the orders to the text documentation, it can help – it's sort of computer assisted coding level of service. I think what Joe would say is also and if the human can override that, which mostly it's the human that's bearing the risk, that would be fine.

The opposite it seems like is if there was real-time coaching of the provider to enter in things to boost the score, boost the level of service that seems like something that we could consider beyond the pale to use Farzad's phrase.

George Hripcsak, MD, MS, FACMI – Columbia University

So, let me think about that, let's say you have a practice that's going out of business because they're consistently under coding and so this computer helps them correct codes. Let's say they're being prompted for something...I mean, so, you know, I'm not sure what we're saying is that people are incompletely coding is what they're doing today and the price is going up because with computers they can completely code then what they will do is they will eventually adjust the rates to normalize the thing which is what's been going on for the last 15 years.

But it's not clear to me that it's wrong to correctly code your thing, you know, even if it's – what we're saying is if it encourages you to lie and that's something, you know, I don't know, even on the paper chart you could always put down more symptoms than you really – you know, you can always lie in the paper chart too. I don't know how we're going to avoid lying. But if it's just –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think, this is Leslie, I just think computers aren't inherently corrupt they're informative and so we have to have that distinction between them and visibility always increases opportunity to be more accurate or if chosen to doesn't necessarily mean being more corrupt.

So, I think that we should encourage electronic health records to be visible complete and accurate, but not use it as a way to mandate or stave off potential corruption or fraud. I mean, we might be using natural language processing in the future that codes our records and gives us more information. One side-effect is we've got great information for research and better records. Another side-effect could be that actually we have more information and we missed a code or we used too many.

George Hripcsak, MD, MS, FACMI – Columbia University

So, let's –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I'm nervous about prescribing even a governor on this that keeps us from advancing technology for better clinical gain because we're concerned about corruption.

George Hripcsak, MD, MS, FACMI – Columbia University

So, that's exactly right. So, in other words let's say there's a care plan, you know, a pathway and I'm treating an asthma patient and it says "did you ask the patient this question" because in fact, you know, that's one of things you should be doing in order to decide what the next medication or what the next step is but then the vendor has to pull it out because in fact if they do ask that question it might up code them slightly. The reason you're doing it is because you want to adhere to a care plan, but it increases the number of physical findings you just put in which just up coded you.

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

So, I think, George one way to look at the example you raised is if you do this completely driven by your clinical guidelines or clinical practice that's fine it's when you put the dollars in front of the person in an interactive way that certainly could have the potential of inducing people to do things just for the level of service code rather than as clinically warranted.

So, the example you gave of if you, you know, you haven't written a care plan yet would you like to do that that's totally legitimate, that's independent of how people code these things. I think crossing the line, I'm just proposing as a strawman trying to find ways where we can set our criteria, where you are showing, interactively showing the coding you're achieving by doing this entry or that entry seems too much to induce over coding.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah.

Paul Eggerman – Businessman/Software Entrepreneur

And this is Paul, I think though you have to be careful because there are valuable software programs that are called like chart completion programs where they do an analysis and say, you know, this op report is missing or, you know, you forgot to put in a review of systems and as a result you can't bill the patient, and also tell you which of the physicians or clinicians who, you know, are up-to-date in their documentation and which are the ones who aren't up-to-date and what they need to do to complete their homework as it were.

And, I'm just saying there are dollars associated with that but those are valuable things also to get done and so we need – you know, there is a part of this process that, you know, that a lot of – there are a lot of people involved especially on the inpatient side, especially when you have a teaching institution and sometimes there is a lot of work also involved to make sure people, you know, simply do their documentation completely and accurately.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

This is Leslie and I liken this to any organization putting in a payroll system. They're always done to find out what an accurate reflection in hours worked cost and it's just normal, it goes up 20-30% because now there is no gray about when you just switched to overtime and when you haven't and who needs a vacation and when they don't.

So, I just think it's a natural side-effect and we shouldn't then eliminate the baby with the bathwater because there are tools that will help us to complete a record more accurately and reflect the care given that provides dramatic value not just for billing but for research and for the patient to understand care.

I'm for I think some transparency so if now you see all of that and let's say patients have access to more of their records they become helpful in adjudicating or saying "hey, that didn't happen with me" or "I might need more" but I just feel that this is somewhat out of task in our scope.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Hey, Paul, when I read the recommendation it – so I, you know, agree with the need for prompting around, you know, evidence-based guidelines to get us to think about do we need to get all this, what do we need to do next all those things are really important to do and better care. The question I thought was on the table was should we encourage E/M coding criteria to stop relying on specific language and so I'm having trouble tying the conversation around outcomes to the recommendation. So, I need help to –

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

Okay, I think what we've done is we've confused you Liz in terms of – you're probably looking at recommendation six?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I am.

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

And that's an old recommendation saying; we're suggesting really to CMS, you know, one of the things that could be done is to update the coding criteria themselves so that we're not so focused on documenting things that we do to patients and more focused on documenting things that make sense for the person's medical care.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, right.

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

So, that's a separate recommendation we're still planning to make. What we're now looking at would be like recommendations number eight and Farzad's question is, did you consider – is there a way to describe certain functions that you would want to certify that don't exist in an EHR?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I see.

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

And so, one way I was trying to, you know, say could we think about it as the timing of when such analysis is performed. So, if it's done at the same time that humans do it now, which is after the fact, you document what you did and then after the fact somebody applies some coding criteria to say, well what's that code up to be in terms of level of service. Then you've not altered what really happened and what's documented to really happen you've just made a judgment according to some arbitrary rule.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

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

Now on the other extreme it seems, one way to look at it is if it's interactive and it seems to be designed to influence what you document, understand you can look at it both ways, you could – but it could certainly encourage when there is dollar signs attached to it for you document for the dollar signs rather than document for care.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

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

And that's the line we're trying to decide and I don't know that there is ever a bright line we can make in this case, but the whole timing and what it does is one way to look at it. So, that would not preclude the clinical decision support from saying, oh, did you make sure that – you know, did you check whether they smoke or not because that's relevant this patient, did you have a shared care plan written because that's something we want. So, none of those things would be prohibitive it's just that you would not have this ticker that goes for – that shows how much money you would make for every piece of documentation. I don't know how else to describe it.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No, I hear you. I understand.

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

It's interactive –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, if you document one more thing we could get another dollar.

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

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I've got you.

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

Yeah, it's sort of –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is Larry, I guess my struggle with this is, you know, for example on the outpatient side there are process measures that look for people to provide more complete care and so we are paying people to do things on the one hand, on the other hand we want them to provide complete care and so if the system prompts them about have certain tests been done or have certain immunizations been given we would say that was part of providing better care.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, if it follows guidelines and all those things that we've been talking about, but there is very obvious tie into – there is going to be increased billing as a result of doing that as well and I think it's naïve to pretend that we're not still in a fee for service world and of course any time someone does more they're likely to be increasing their billing rate.

On the other hand to say we want people to be blind to that is like saying, well, when you order a prescription, you know, order a medication that we don't want you to be sensitive to the cost of this medication because given alternatives a lower cost one that is equally effective is probably going to be preferred by the patient by their payer, by a lot of people so wouldn't we want to give that guidance and help indicate costs.

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

I don't think that's the same thing, one has self-interest in it and one doesn't. So, informing the prescriber about the cost of alternative medications doesn't have self-interests – you know, where you have – so I guess it's a little bit like conflict of interest rules.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

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

It's where you're trying to avoid having self-interest interfere with your judgment, your professional judgment on something.

Joe Heyman, MD – Whittier IPA

Do we do that for lawyers?

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

Well, I can't tell you anything about that Joe.

Joe Heyman, MD – Whittier IPA

I think you know you can't change human beings from being human beings and it seems to me that trying to use electronics to do that just doesn't make sense people have to be honest, some of us won't be honest and some will and, you know, we attest to things and if we're being dishonest when we're attesting eventually it will catch up with us.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I don't think it's about being dishonest I think that people can legitimately provide a little more care and it results in a higher payment.

Joe Heyman, MD – Whittier IPA

Right but that's –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That's baked into fee for service guys that's not something newly a problem.

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

Well, so okay, so the question to us is are there features that we are either requesting to be included in the EHRs that unduly influence people's ability to up code in a fraudulent way, okay, and the only concern is the fraudulent up coding not performing more care and documenting it. And on the other hand are there ways that certification can prevent functions that unduly influence people to be – that consequently unduly influence by the potential for revenue instead of the potential for better care.

Paul Egerman – Businessman/Software Entrepreneur

So, my response, this is Paul Egerman, my response is this discussion indicates this is a complicated issue.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

Because you look at something as simple as a suggestion to make another appointment for a patient to come back you could say, well that's financial, but, you know, it also could be good clinical practice to have the person come back in 2 weeks or 2 months or a year or something. And so I say it's a complicated issue and maybe the thing to do after having this discussion is to bring in somebody from CMS or OCR or whoever, you know, really is responsible for handling compliance and basically prosecutes evil doers in this whole area and try to understand what is aligned between, you know, legitimately suggesting the person needs to come for another visit or needs an immunization or that you forgot to enter your review of systems with something that they consider to be wrong and maybe we just need to get educated by somebody who is like an expert on this thing to see if there is something we want to do with it.

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

Yeah that's a reasonable approach.

Paul Egerman – Businessman/Software Entrepreneur

I'm not sure that we – I know I can't accurately describe where the line is between what is right or what is wrong here.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

It can't – a computer can't dictate what is right or wrong it can only dictate what is or isn't there.

Joe Heyman, MD – Whittier IPA

This is Joe, I –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I'm concerned if we go down a slippery slope and then technology changes tomorrow and says, well we've got these advanced algorithms that can detect and determine whether someone's Medicare plan effectively using natural language processing and oh, by the way that care plan is a higher level of reimbursement. Now the next logical step is, boy, I'd like that to be active real-time in care so a provider can know whether or not they're on path. These are all natural progressions and the opportunity to use them fraudulently or inappropriately evolves with it and so I just don't know how we can insert a line, a bright line that will always evolve.

Joe Heyman, MD – Whittier IPA

And this is Joe, I would like to say there are enough barriers to people choosing to use this technology already if you stick in there another thing that has nothing to do with providing decent care to people but instead has something to do with money I just think it's another turnoff for those of us who think we're professionals. I just don't – I think it's the wrong way to go and they'll be unintended consequences.

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

Well, so far it does not appear we are moving towards consensus. We certainly accomplished one of the objectives that was requested of us that is we've discussed the issue. Now we could either say we believe now that there is no way to either prohibit functionality from appearing in the EHR that unduly induces fraud and there is no – well, I mean, I guess maybe that's a statement.

An alternative is taking Paul Egerman's suggestion which is should we get some coding experts and policy experts from CMS to help work with us on are there clear rules or are there clear criteria and guidelines from CMS that could be implemented in an EHR.

So, if CMS says, so I'm going to make this up, CMS could say "you should never copy and paste" so I'm totally making it up just to make sure everybody understands. Then, yeah, we could write functionality into the EHR that prohibits that function. So, it's possible, I don't whether it is true; it's possible that CMS does have some clear guidelines that could be implemented in the EHR and if that were true then we could certainly try to find that out.

But if there are none than it may be true that we end up where we are now which is we don't have a clear bright line to establish and hence we don't have a clear way of saying this function should be in the EHR or this function should never be in an EHR as it relates to fraud.

George Hripcsak, MD, MS, FACMI – Columbia University

Actually, so that's a good example Paul, you know, people have tried to get rid of copy and paste but to actually do it you either have to make it so they can't copy from the record to anything else like a letter so it's just impossible to get data out through the clipboard.

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

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Or you have to make it so that you have to type in using your mouse, you know, those things that you do for passwords so they can't monitor your keyboard, so you either have to make it so you can't get information out and you might have another use for it like writing a letter to a patient or that you can't get it in except by, you know, typing on a keyboard on your screen with your mouse. So, like if we pass a rule that says this is the only way to do it that's the unintended consequence kind of thing.

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

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

It's hard to stop people from copying and pasting just by using the operating system to do it.

Joe Heyman, MD – Whittier IPA

And it diminishes efficiency. The whole idea of these EMRs is to be able to record this stuff efficiently.

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

So, I mean, I think that it's one thing to have a guideline, a guidance that we cannot implement technically that's also a fair answer, but right now we don't – we on this call don't have any knowledge of a specific guideline that could create a bright line and then we can separately decide is there a technical way to help users stay away from crossing that bright line.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And if there is a bright line does putting it in just cause a new bright line to be developed.

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

Yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I mean, I don't think this is something you can resolve.

Joe Heyman, MD – Whittier IPA

I think it has very little to do with Meaningful Use. I agree with, I think it was Paul, at the very beginning.

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

Yeah –

George Hripcsak, MD, MS, FACMI – Columbia University

So, like for example I think a pop up that says, if you erase this thing from your previous note you'll get paid more that would truly be encouraging fraud and I can't imagine a use for that, in other words to a system that comes up and says you can bill more.

Let's say that there is something about increment, you know, and so if this visit is much more than the previous one you can bill more on this visit and the way to accomplish that is by going back to the previous visit and down coding that or some weird interaction and you had an EHR that suggested that you alter previous documentation taking things out of your notes in order to pay more now like that's something that I could say, all right that looks like it's causing fraud, most of the rest we're talking about doesn't cause fraud unless you want to be fraudulent.

Joe Heyman, MD – Whittier IPA

I'll bet you right now there is software that hospitals use that reminds a coder to make sure they've included every possible ICD-9 code.

George Hripcsak, MD, MS, FACMI – Columbia University

Right, no that's –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Absolutely with flags that go on it to go back into the chart and have the doctor review.

George Hripcsak, MD, MS, FACMI – Columbia University

–

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

Yeah.

Joe Heyman, MD – Whittier IPA

But that encourages you to code correctly but it also encourages you to try to think of an extra ICD-9 code. I mean, I just don't think its human beings that do this the fraudulent things it's not the computer.

Paul Egerman – Businessman/Software Entrepreneur

So –

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

Yeah, there may be –

Paul Egerman – Businessman/Software Entrepreneur

Paul, I'm not hearing anybody who is interested in –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Paul –

Paul Egerman – Businessman/Software Entrepreneur

Here's a brief summary of what I'm hearing, I'm not hearing anybody speak in favor of this as a direction we need to go.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, this is Leslie, so I have a suggestion that perhaps a certified electronic health record will indicate time and date stamp any alteration to any record post event.

Paul Egerman – Businessman/Software Entrepreneur

Well, this is – that's a good comment but that's actually a different issue about what is the legal record and what is the audit trail on the record.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I agree, but it doesn't – then you would be able –

Paul Egerman – Businessman/Software Entrepreneur

That's a different issue I think.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

You would be able to audit.

Paul Egerman – Businessman/Software Entrepreneur

I think we've got to focus on –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But let me just finish, I agree it's different issue, but it does say that in fact electronic health records will give you an audit trail. So, if you want to go back and look and see how a record was changed and when it was changed you can do so and that would help to eliminate potential fraud only in that audit trails are easily accessible. So, transparency often reduces fraud, but going in and saying how do you chart, how do you not chart I think is difficult.

Paul Egerman – Businessman/Software Entrepreneur

And we're losing, it's a good comment, but I think we're losing a little bit of our focus we're talking about clinical documentation.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

And now we're starting to talk about fraud and the legal medical record and those are different concepts and I would just encourage us to go back to what is written here in item number six and I think I don't hear any interest in this recommendation is my comment and if –

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

Well we're creating a new recommendation.

Paul Egerman – Businessman/Software Entrepreneur

CMS wants to proceed with anything we need some level of education or guidance, because I don't think is –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Agree.

Paul Egerman – Businessman/Software Entrepreneur

This is not the direction it seems like this group wants to go.

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

Okay, so I have, in the course of George making his comments, thought of ways that the – a function that truly is inducing fraud.

Paul Egerman – Businessman/Software Entrepreneur

Well, I had two. I have two and there are some that are very clear.

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

Yeah. Well, that's in a sense what Farzad was asking. So, for example you do get more credit if you have an additional – you're burning off lesions on the skin you get credit by the number of lesions you burned off, you get credit for the length of the suturing you just did, so in George's – as he was describing these sort of ridiculous scenarios it's possible it could say, hey, you know, you can make more money by lengthening this incision or you can make more money by burning off one more lesion that would be a clear example of inducing fraud. I don't know how you would make it a generalizable bright line, but –

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

So, this is MacKenzie I just want to make everyone aware that the time – we're already 5 minutes over –

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

Oh, I thought it went to 4:30?

George Hripcsak, MD, MS, FACMI – Columbia University

No, no 4:00 o'clock.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Four.

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

Okay, no, sorry.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

So, I don't know if we want to – I mean, we can probably go a little bit longer that's fine I just want to make sure we're all kind of gearing towards some sort of either next action steps or –

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

I was looking at the agenda and it said until 4:30 but let me – I think –

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Oh, wait, sorry, it is – hold on, the top of the agenda that I'm looking says 4:00.

Michelle Consolazio Nelson – Office of the National Coordinator

It's probably my fault, sorry, it was until 4:00.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

It says 4:00 yeah.

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

Okay. So, it's good enough because I think we have gotten to a consensus in the sense that I don't think that we have rather thoroughly discussed the issue and we are not able to come up with recommendations. We either pursue this further by getting some expertise from CMS but I think we can query about that off line and if there is anything new that can contribute we can reconvene the group but it sounds like we're not prepared to make a recommendation on certification that would either include things that would prevent it or restrict things that would unduly induce fraud. If people are satisfied with that statement I'll write something to that effect.

Joe Heyman, MD – Whittier IPA

Satisfied.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

That works.

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

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

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

Can we open for public comment then please?

Public Comment

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Sure, operator can you please open the lines for public comment?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any questions at this time.

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

Okay, well thank you everyone for your counsel and for this discussion. I'll edit the recommendations to incorporate the comments we've made for all the ones that exist and I'll add another comment about our discussion that we don't have a good way to either prescribe or proscribe functions in an EHR that would affect the fraud situation.

George Hripcsak, MD, MS, FACMI – Columbia University

Thank you, Paul.

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

Thank you.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thanks you all have a good afternoon.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Thank you.

Michelle Consolazio Nelson – Office of the National Coordinator

Hey, Paul?

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

Yes?

Michelle Consolazio Nelson – Office of the National Coordinator

Paul you and George and are going to work on language as well right?

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay, thank you.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks everybody.

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

Thank you.