

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
March 18, 2014**

Presentation

Operator

All lines are bridged with the public.

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

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

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

Here.

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

Hi, Paul. George Hripcsak?

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

Here.

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

Hi, George. Amy Zimmerman?

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

Here.

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

Hi, Amy. Art Davidson?

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

Here.

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

Hi, Art. Charlene Underwood? Christine Bechtel?

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

I'm here.

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

Hi, Christine. David Lansky? David Bates?

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

Here.

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

Hi, David. Deven McGraw? Greg Pace? Marc Overhage? Joe Francis?

Joseph Francis, MD, MPH – Associate Director – Veterans Health Administration

Here.

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

Hi, Joe. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Hi, Leslie. Marty Rice? Marty Fattig?

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

Here.

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

Hi, Marty. Mike Zaroukian?

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

Here.

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

Hi, Mike. Neil Calman?

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

Here.

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

Patty Sengstack? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Hi, Paul. Stephanie Klepacki? And are there any ONC staff members on the line? Okay, with that, I'll turn it back to you Paul.

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

Great. Thank you very much Michelle and thanks everyone for attending. We have just a few objectives for today's meeting. One is we'll go through the recommendations that we had approved at this last meeting last week. We're not reapproving and we're not changing; there are a few requests to make a little bit of edits, mostly for clarification. We'll go over those today. And then we will start planning – I think I got this right – planning our listening session. The goal of the listening session is to get additional feedback on our recommendations, it's not to change what we submit, but it's to continue to give us feedback so that we'll incorporate that going forward, when we respond to the NPRM that is due to come out in the fall.

So it's one of constant listening and constant adjustment as we go towards the Final Rule next year, and that was on purpose, because we have a timeline we're meeting for 2017, for the implementation of Stage 3. And we want to take advantage of sort of on the spot information, particularly, let's say, as we hear more and more about stage – the experience with Stage 2. So we're trying to meet both ends, we meet the lead-time that people asked for us for each stage and yet get as much evidence as we can support on the experience from the past. Any questions or other agenda items? Okay, let's move forward, next slide, please. And that's just a reminder. Next slide. And next slide.

Okay, so those who either listened in or were at the meeting know that we had the recommendations approved. We had some concerns that were expressed during the voting procedure, the super-majority did vote to approve it and we're trying to incorporate some of the comments that – of those who didn't vote for it, so that can be expressed in the transmittal letter. They actually were on both sides, some thinking that it was a lot going on and also fast timing, and others expressed the opposite opinion, thinking that we aren't going far enough, particularly, let's say, in the quality measurement side, the longitudinal care and the interoperability.

So, it is a tension that we feel, both what we need to accomplish to get to the better outcomes that we're shooting for, as well as the realities of how hard it is to do some of this work and some of the other things that are going on at the same time, such as ICD-10. What Karen has expressed is, with the approval, that starts a number of other things going forward, such as more input from the HIT Standards Committee, the official input from this group towards the rulemaking for the NPRM rule writing and getting feedback and reactions from others and, as input, for example to our listening session. So that's the thing that's started down the track. Next slide, please.

Paul Egerman – Businessman/Software Entrepreneur

So Paul?

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

It's Paul Egerman. You mentioned the transmittal letter and showing some of the like minority comments in the transmittal letter. Will we have a chance to look at the transmittal letter?

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

Umm, yes. At – you're basically the transmittal letter primarily is – are the slides that we used and that you're going to see some of the edits. Some of the folks will get a chance to look at the comments that we're submitting, such as you expressed some of the concerns that were raised.

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

Just to point out – this is George – there are two different "we's." There's "we" the Meaningful Use Workgroup and officially, not really and then there's the HIT Policy Committee and whatever we set up for them is yes.

Paul Egerman – Businessman/Software Entrepreneur

Okay, so I just want to make sure I understand. So the transmittal letter will get circulated among the workgroup, so that we can make sure that our comments are reflected in it.

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Okay. And the other request I had made of the transmittal letter was on each of the objectives that it would show the votes that were taken, because I think that's also useful information to know that some things were solidly – everybody wanted to keep and there were other things where there was less of a consensus.

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

Umm, I guess I didn't hear that as one of the things – for example, what you might be – let's see, what you're seeing on the screen now is what we're – we plan to include as part of the package. The internal votes, I'm not sure, because there are lots of – who was there, how many people were – there are a lot of things that I don't know is as important to be in the transmittal letter as the final vote.

Paul Egerman – Businessman/Software Entrepreneur

Because I look at what's on the screen, the clinical decision support, and if I remember, the votes correctly, it was like very high, there were like 14 people with 12 of the 14 people said, keep that in. Whereas one of last ones in the screen related to registries, it was the opposite, there were only like 3 or 4 people who wanted to keep it and there was a greater number who wanted to either remove it or consider it for removal. And so I just think that's useful information for ONC to have, to understand where there's like a great deal of consensus and enthusiasm and where there was less consensus.

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

Well but the problem procedurally – this is George. That's the workgroup not the Policy Committee and the Policy Committee didn't vote on these individually and say which ones they supported –

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

Yeah.

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

– which is the author of the letter. They would have to vote on showing those percentages, which I think was part of our process. I agree it was very useful and maybe we should have shown it, but I think that's our work product and it's not a – this group is not necessarily representative, as Paul said. So, I'm not sure we can or should show the numbers.

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

I think it's a part of our work process, as George was saying, and it was helpful for us to come to some consensus of what we present. It is available; it's posted, because it was part of our work product. So –

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

That's true.

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

– as you know, ONC ha – ONC and CMS and everyone has access to the process we went through. I think it was quite a rigorous process and they're – Karen participates in these things. But I think the formal letter that goes forward really is the result of our deliberations and it is much more – much cleaner. Okay?

Paul Egerman – Businessman/Software Entrepreneur

Okay.

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

So, on clinical decision support, really the only change here is a change from user response to user action, which seems to be more descriptive and a little bit less vague. Next slide, please.

Same thing here, and I think it was Paul Egerman that raised the question of, is it the people who put the device in or is it the people who end up with the device. And this is – we're trying to use the language to clarify it's the entity that puts the device in is responsible for recording the UDI. Next slide, please.

Here was the reflection of the request to consider HHS Demographic Data Collection standards and the SOGI questions. There aren't standards yet, but there are questions that HHS uses. And I actually did hear from NCHS about this exact topic. And NCHS, the people who maintain these vital statistics, actually use this – what's shown on this slide. So, that's a pretty strong endorsement and so we're just including that. Next slide.

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

Paul, can you say more about that, how they use them.

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

They use it in their data coll – so, NCH – National Center for Health Statistics runs all these big surveys like MEPS and Health Interview Survey I think it's called. And they use what's described on the screen as part of their data collection.

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

I mean, I guess I'm confused about we – what is described on the screen?

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

HHS Demographic Data Collection standards.

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

Okay, so they – right, but Meaningful Use Stage 1 and 2 were the OMB standards.

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

Correct.

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

Okay, right, thanks. So for –

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul. It seems to me the discussion we had at the Policy Committee was also about the importance of standardizing this data.

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

Correct.

Paul Egerman – Businessman/Software Entrepreneur

And so maybe you feel you've captured that with consider using HHS Demographic Data Collection standards, but that seemed to be what the issue was, I mean, it's – you don't want to just collect SOGI, you want to actually have a standard set of responses so you could compare –

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

– the data.

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

So, the infor – the communication I had, and I can clarify it even more but, it's all within HHS, is they u – they do have standards that are somewhere between the OMB standards and the IOM recommendations. And they – while there aren't SOGI standards, they have standard questions. So we're going as far as they are right now and as I mentioned, that's what they use in their standard surveys – what we're suggesting is that they align those.

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

I –

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

But that's really a decision for them.

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

So I think the big difference is actually in the race and ethnicity standards. And Michelle sent a – had a link sent out on the day of the Policy Committee that compared OMB to HHS. So one of the examples was the OMB standard, which is currently in Meaningful Use, has a category that says Asian. HHS breaks that down into Asian Indian, Chinese, Filipino, Japanese, etcetera, so it gets to more granularity in the race and ethnicity standards more than anything, I think, which is really helpful for health disparities.

Paul Egerman – Businessman/Software Entrepreneur

So maybe we need one extra sentence in the discussion simply to say, it's important to standardize the data for all of these areas.

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

But we're saying more than that, Paul. This is Neil. We're saying that it's important to get as granular as we can and I think the granularity is more important than finding the four categories that everybody fits into, and I think that's going to be true for the SOGI standards and I think it's going to be true for – we know it's true for race and ethnicity standards. So, I think this stuff just needs another look; it's really evolving pretty quickly.

Paul Egerman – Businessman/Software Entrepreneur

Okay, so you think the wording here is adequate. I mean I agree that it's important to be granular, I just didn't see – understand that's what it said here. But if you think it says that, that's fine.

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

I think –

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

Right, I think we're suggesting that ONC actually transition to the HHS Demographic Data Collection standards and the SOGI questions, as opposed to OMB.

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

Yeah, and I think they definitely heard that, they were sitting in the room, and this says that and as I say, HHS has its own – I mean NCHS is the standard data collection agency within HHS, so, they have all the material there and this is just a good pointer.

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

Right, so I think what you're saying is if we're all fine with it, and I think it sounds like there is agreement, once we understand it, that we would say in the transmittal letter that we would point this out.

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

It would be just what you see on the screen.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, that's my question, does what we see on the screen capture what we just discussed, in terms of the granularity?

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

I think it is..

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

This is Art. Maybe it would be helpful to add to that discussion line, the recent – the difference between OMB and HHS regarding race ethnicity –

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

Well, we –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. Or just simply say, consider transitioning from OMB standard to HHS.

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

Yeah, because it's more granular. Yeah, I think that would be good.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and to include the reason, which is, we would like to have a more granular approach.

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

Yeah, I agree.

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

Consider using the more granular HHS, etcetera.

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

Yup.

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

Okay. Okay, next slide, please. Here was a clar – so I answered a question, and I don't think I answered it correctly. So I think Devin was asking, is the – he was saying 24 hours is tough for hospitals. And I thought what our 24 hours related to was the discharge summary, because at one point we did have discharge summary, which got consolidated into this in our transition to Stage 3.

Christine pointed out that actually there was an enumerated list of data that needed to be – to meet the 36-hour timeline in Stage 2. And it turns out that list is not – is more comprehensive than what's traditionally called the discharge instructions, the sheet of paper that patients have to have when they're discharged. And yet it's not the full set of data that's included, let say, in what we call a discharge summary, which happens a couple of weeks later, and sometimes later than that. And so that would be tough to get in, there's just a lot of logistics to get that within 24 hours. So the li – this refers – the 24 hours actually refers to a list that was present in Stage 2, and the change here is making it from 36 hours to 24 hours, which is 12 hours shorter and the time of discharge, it does tighten it up significantly.

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

Paul, can I make a clarification? It's – you're not suggesting changing it at this moment; it has been changed since the – back in the day, a year and a half or so ago when we did the subgroups. So we didn't make this change subsequent to the Policy Committee meeting, it's been 24 hours the whole time.

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

That's –

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

The change is over Stage 2.

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

I guess the words been there, yes, knowing what they referred to – clearer, at least to me.

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

Well I guess I'm going to – I mean I can't dispute your own clarity, but I would say that the structure of this objective has never changed since Stage 2. So it's always been that same set of information, the timeline is what changed from 36 to 24 –

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

Right

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

– in the recommendations.

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

Right. So that's what we have before us, I'm just a little – I regret making wrong statements about my assumption that was the discharge instructions.

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

So I think, so we had some email traffic about this and my suggestion was that we because the Policy Committee approved it and we have approved this many a time, without raising this issue that we leave it go for – and let people do public comment on it, and they may. I think as I mentioned to you Paul, I did my own research with folks and it was very mixed. Some people said, yeah, that's going to be hard and other people said, well, actually we have to do it within 36, it can't be that hard anyway, given the specific list of data that's in there, and much of it is generated in more real-time. And so my suggestion would be not to change it in this conversation, because that would be a pretty significant change over what the Policy Committee approved, but to let it stand for public comment and ONC can do what they need to do with it.

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

That's what's before you, Christine.

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

Yeah.

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

I'm sorry.

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

So I would second –

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

That's what's before you.

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

So I would second that.

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

Yeah. Because I think that's exactly what you said.

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

Yup.

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

Right. I think we all agree.

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

Yeah. All right, let's move to the next slide, please. Here it's just further clarification, this gets discussed a lot, wha – to make sure that it's not onerous in terms of implementing this, either the development or the tracking. And it is intended just to figure out – it's almost like a thread of email and you can trace, oh, this person responded to this at this time and so on and so forth. And that's all that this objective is trying to accomplish in the certification criteria, not that you try to do what may be impossible and say, oh actually, in the phone message 5 days from now, is actually related to the online request that came in last week, so on and so forth. So we're just trying to give people essentially an audit trail of the responses in the same thread. So that's how we –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie. So you're looking basically in that first bullet point for like a return receipt expected or – rather than just an –

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

No.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– acknowledgment of the receipt, I'm not – sure how you understand expectation.

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

Okay, so let me suggest you look at that in bullet two, then bullet one. So one of the issues that comes up, and this is something that other folks on the phone and we have worked on is, how do you make sure that things don't fall through the cracks and that people get a timely response. Those are good objectives, but it's often hard because let's say, someone may send a request online and then you pick up the phone and call someone, I've done that. And it's hard for the computer to figure that out, so that's why we clarified in the second bullet that you're just tracking the responses in a – in one thread.

The second bullet point, because the other question that comes up is, someone is giving you feedback, they don't really need you to reply back, the patient doesn't need it. So, how do you – someone for not replying when there wasn't a response expected? So the bullet number one was saying, the patient can indicate, I don't need a response to this one, and that's the way – the only reason that's done is so the computer knows that that doesn't really need a response, so the response rate is not relevant, that doesn't appear in the denominator.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you, Paul.

Paul Egerman – Businessman/Software Entrepreneur

Who gets this tracking information I'm just curious?

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

Well, the – it's almost like an audit log, nobody "gets it" unless you want to track something. The purpose here is to make sure that, as I said, messages don't fall through the cracks, they're sent in but they go into a black hole, and that people get timely responses. So this is just a tool that providers can use, that's why it's a certification criteria, it's a tool that people can use in order to accomplish those two objectives.

Paul Eggerman – Businessman/Software Entrepreneur

Okay

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

Okay. Next slide please.

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

Paul, this is Art, may I make a comment.

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

Sure.

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

On the previous slide we have two thresholds elaborated, threshold for availability and threshold for – I wonder if it would be helpful on all slides to designate which threshold we're talking about. Because it just says threshold on some, as on this slide we're just talking about, and I don't really know which one we're referring to.

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

Okay, so the slide you're referring to Art that has it separated is what, number 7?

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

The view, download and transmit, yes, 7.

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

Is that the previous one – could you move back to the previous slide please. Ah, yeah, so this was – this occurred because we consolidated objectives, so there used to be the availability – sort of accessing something. And in our original Stage 1 we said "provide," and provide really meant make available. So everybody really, I mean it should be 100% really once you have these portals up. But in Stage 2 we introduced the concept of well, they not only should make it available to patients, but a certain amount of patients, a very low percent, because there's a lot of circumstances that may cause people not to have a high thre – high use, that people actually log in, go through the enrollment process and log in. So in a sense it's an artifact, Art, of combining multiple objectives.

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

Well I –

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

– it's like – go ahead.

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

I was just suggesting that we be explicit in this, in this slide number 8, where we talk about secure messaging, it's threshold for use, right.

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

Oh, okay, just use the term "for use."

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

Right, yeah in all these thresholds, so we know which one we're referring to, because like back on the slide about the unique device identifier, it says threshold high. Are we talking about availability or use?

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

Ah, the majority are use, I would say.

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

Yeah –

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

So in the one in front of us, it's a use thing.

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

Right. And I think, we as a group probably understand that, but maybe –

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

Right.

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

– for others coming along, it might be helpful just to be explicit.

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

It's a good point. I think the VDT is the unique thing because of its consolidating multiple objectives, but – that might not be right. Okay, we'll watch out for that going forward, but this is – fortunately this even has an e.g. so it's definitely a use. Next slide, please.

Okay, summary of care, here we're really this red under discussion; it's really clarifying words again, to make it as clear as possible, it – because it sounded like it was even conflicting before. So in a sense, we've always wanted, just like Paul Egerman has emphasized, we want to use standards for coding data where – if at all possible. But sometimes there are things like the narrative and well there's no standard for that and free text would be acceptable in those cases. The other comment that was pointed out during the meeting was, well some people – somebody was saying, their vendor made it easy on themselves saying, okay, I want you to fill out this form and it has to be filled out in entirety each and every time, regardless the purpose.

Well, what was pointed out in the comment is, maybe it's not required that in order to get your toenail looked at, you need to know your HIV status, which may be one of the fields. So that's the point and it's awkward to say, but that's what meant by the i.e. not all fields need to be completed for each purpose. We struggled to make this clear, but those are the concepts. It's where possible, use structured and standardized codes, but that doesn't mean everything has to be coded. And that not all fields in a template have to be filled out, it depends on the purpose.

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

We say "not all fields" twice, so I just noticed that.

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

Yeah.

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

So we should just forget one of them, sorry about that.

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

Correct, the first – maybe take out the first paren. Yeah, because I think the second sentence is more dedicated to that concept.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, the other situation that I heard about was some people had their EHR systems had preceded Meaningful Use and they had, for example, their problem list in free text, so when they go to –

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

Ah.

Paul Egerman – Businessman/Software Entrepreneur

– print the transition of care documents in Stage 2, they have a problem...

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

Yeah, that's a good point.

Paul Egerman – Businessman/Software Entrepreneur

– because some of their stuff was in free text and it's not all in SNOMED and so, it's labor consuming and sometimes very difficult to recode that, so that was one of the reasons why it is important to provide some flexibility.

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

That's a good example.

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

Well you know, I think it's a good example, but I think by Stage 3, that's six years after the beginning of this Meaningful Use stuff, that's enough transition time – I don't know how long we should let free te – it's just not useful, for example, in decision support to have free text there.

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

No, I agree.

Paul Egerman – Businessman/Software Entrepreneur

That may be the case, but if you're a big institution, it may not be easy to go back and re-code or code all of that stuff and sometimes maybe if you may decide it's important, but maybe it's not relevant for CDS, it's up to them to decide.

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

I don't know that it's allowed in Stage 3 or even Stage 2, but Stage 3 says SNOMED –

Paul Egerman – Businessman/Software Entrepreneur

It's not allowed in Stage 2, it's one of the reasons why they're having trouble with meeting the objective. It's not the only reason they were having trouble, but it was one reason.

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

Paul, this is Amy. On a different note, the measure for this is just that it was sent, it's not – I'm thinking from like an audit perspective and a tracking perspective. I just want to confirm that this is – I'm just refreshing my memory. This is that you send a certain percentage, not that it was all the right fields or that it was structured versus text in terms of meeting the criteria, correct.

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

It's correct.

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

The reason I'm asking is because if we're saying, fields can be completed for each purpose, I'm just thinking, I always think of it from a state perspective and from various perspectives and from auditing, from like a Medicaid audit perspective. So, if they're having to go in and verify some of this stuff eventually if someone's getting audited, I want to make sure that what we're setting out is clear and auditable as well. And that would be, how many were sent, numerator/denominator versus what was in them, because you would never be able to know what was appropriate based on purpose.

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

I think that's a fair statement, but I think an auditor would open up the mess – figure out some way, I don't know whether there's a random sample, but open up message and say, there are fields that are defined in C-CDA and these are those fields, and they are filled in. I understand that "for purpose" is hard to define. But I wouldn't expect a blank, just because you hit the transmit button, I –

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

Oh no, no, no, I don't mean blank, I meant, we're not – since we haven't set a certain data set in this case, we're not measuring on that, that's what I'm trying to confirm.

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

Ah. Okay, the content that is minimum are the upper right side, so the narrative, which is free text, the patient goals and – which again are free text, instructions and the information of known care team. So it turns out that those mandatory are not coded. That's –

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

– is relevant. I'm trying to just – I'm not trying to be overly – I'm trying to be specific enough so that we're not setting ourselves up for problems later on.

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

Right.

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

So, it was sort of the comment that, in parentheses, "not all fields need to be completed for each purpose" and then the "as relevant" on the four that are listed there, to understand is there a minimum here and are we clear on what the minimum is? That's what I'm trying to –

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

I think the minimum – yeah, so I think the minimum is – actually the true minimum for all three transactions are – is the first bullet on the right and the – remember when we used to have a table – I don't know, maybe we should have kept the table in. But, the others are at the discretion.

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

Okay.

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

And really, I mean, the winner or the loser is the provider organization, so it doesn't really help to game that, but those are the things that we required as a minimum. The reason this red is a discussion is because we're just trying to point out, it's what Paul Eggerman keeps pointing out, we've got to move to standards, it's in your best interest to do that. And the predicament that Paul also noted is if you use free text in the problem list, you're just not going to derive the full benefit of this.

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

Yeah, okay.

Paul Eggerman – Businessman/Software Entrepreneur

That's right and ultimately, we want the document to be structured, but we also want it to be a useful transition of care document.

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

Yeah.

Paul Eggerman – Businessman/Software Entrepreneur

And some things you just can't structure, or sometimes in the rush of trying to do this, sometimes throwing in a few sentences helps and that's important to do, too.

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

So this is Neil. I dis – I'm still confused about one thing. Is it clear that we're requiring a free text field here? I mean, because it sounds to me like it says it's possible or it may include. I mean, my comment in one of these discussions was I think there should be a mandatory free text field. Is it clear here that there's a free text field that's required?

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

Well it does say required for all transitions –

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

Yeah.

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

– a narrative required for all transitions. See right below it.

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

Right, it says summary of care may include –

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

Right then go down to the first bullet, first sub-bullet.

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

Yeah, I mean these are all language things, Neil and they still – but phrase is intended to say, so these four things, the vendors have to program into their systems.

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

Okay.

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

And you must, for the transitions – the three transitions on the left, they all have to have that first bullet, which is the narrative.

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

Okay, thank you. Thank you.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And Paul, this is Leslie and just to note, the recommendations that went forward for the Consolidated CDA include the ability to have goals of care and care team members identified in that standard. So, I think we're on our way to meet those needs.

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

Okay, thank you.

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

Paul, this is Art. I have a question about this parenthesis "not all fields need to be completed for each purpose." Are we talking about the structured fields?

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

It can include the structured fields, yeah.

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

So, I just wonder, in each place where an eligible provider or hospital is making these decisions, will they be paying their vendors to select which fields need to be added or is there something that we could add regarding certification criteria that would allow the end-user to select the fields to be added to the summary of care document.

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

So, the intent – as usual, every time we try to fix something, it's like pushing a balloon, and maybe this group can decide that we don't need to go this far. We were trying to accommodate the comment that, and I certainly understand how that could happen for a provider, a vendor says, okay here's what you have to submit for every summary of care document. It makes it easy on them, i.e. it does not give, as you suggest Art, does not give the provider a way to configure it. That seemed – that didn't seem right so this paren was to say, you can't just force one document for all purposes on the provider. At the same time, it does mean the provider has to either accept the default, I guess, and had to have it all go, or configure it for different of these cases, types of transitions, what should go over.

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

So Paul, this is Amy, maybe it's better to use the word configure in here so that we're clear that we want the provider to have – we want stuff to be in there and the provider to choose whether to fill it out or pick it or not versus –

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

Okay.

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

– not have it there, do you know what I'm saying?

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

That's a good way, so we can i.e. the provider can configure the documents for each purpose. Now, they can choose –

Paul Egerman – Businessman/Software Entrepreneur

I don't know what that means; configure the documents for each purpose. That's not the same as filling out – whether or not you fill out a form, configure means you can write – change like the sequence and the arrangement and which questions get asked. Is that what you're looking for? That seems like that that's a change to what we had written.

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

(Indiscernible)

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

So if there are 150 variables, Paul, and we only need 15, we can select the 15.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, but my question is, it's more of a procedural question, that's a – isn't that a new concept? We didn't really have that before, that's not what was approved by the Policy Committee.

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

Well I'm just trying to understand what "not all fields need to be completed for each purpose" is implying. We may not have discussed it, but –

Paul Egerman – Businessman/Software Entrepreneur

I interpret it as what it means, that means there are a bunch of fields and you don't have to – they're not all required entry fields. But to say providers can somehow configure the data entry sequence is – or configure how the report is going to work for each purpose, that's a different – I'm just making the observation that's a different concept that we haven't had before.

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

So, yeah, this is Amy and I have another question, because actually we're dealing with – this sort of came up in a state cont – we have a state cont – a required state continuity of care form, which I always try to think how this fits in. But one of the recommendations from our Director of Health was, for fields where the provider is choosing not to fill it in or not appropriate to not leave it blank and to put in N/A, so someone knows that it wasn't forgotten. So I'm wondering, and again, I don't mean to keep changing the concept here, but I do think we have to understand. Do we mean it's okay to just leave blank fields, and not know whether because it wasn't relevant to that particular issue and leave it blank, versus putting in something that says, not applicable, not needed, not appropriate in this case versus no even have it show up in that particular summary of care form? I think there are like three or four different concepts here.

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

I think –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul. There are a lot of concepts and we have to be careful that we're not trying to – we're not getting too far into the weeds and trying to design how this works.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

I mean the fundamental issue here was to provide flexibility, to simply say, there's to be free text and that the questions that are asked are not mandatory questions. And that's what the discussion was and I think that we should leave it there; I don't think we should try to specify much more beyond that.

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

So I think what we do with this – this is George – is just delete the first "not all fields need to be completed for each purpose," and then let CMS and ONC interpret it appropriately. No?

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

I think that's closer to where – I think the – we're not trying to specify the functionality, and I think actually the discussion is getting down towards that. We're trying to express our intent, which is the flexibility, while implying with standards that exist. And not – and trying to address this comment and maybe this is – we shouldn't actually try to address it in words here, of vendors forcing all the fields to be completed all the time.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, the concept's simple, right, it's we would allow for some free text and we're going to say that not all fields are mandatory.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

And that gives you some flexibility. And we ought to say, it's to provide some flexibility, to make sure that they – because ultimately we want the document to be useful, in other words, you don't want to just check the box. So in order for this document to be useful, these are the discussion concepts.

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

So let me restate George's suggestion and see if that's okay with folks, which is really just to make a correction on the slide and just remove the first paren, "not all fields need to be completed" because it's repeated in the second paren. Would that be acceptable?

Paul Egerman – Businessman/Software Entrepreneur

Works for me.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Works for me.

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

Okay. Great. Next slide, please. Here again it's a clar – it's a clarification and a correction. So we used to specify C-CDA for a registry, and George, you're probably better at explaining this one, so why don't you try this.

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

Well we agreed during the Policy meeting not to pick standards – not to have us pick the standards, so we just say using standards, and it'll be the Policy Committee and CMS and ONC's job to decide whether or not –

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

Yeah.

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

– C-CDA is appropriate. We talked a little bit about what C-CDA is and why it might not be appropriate, and pointed out that the registries from Stage 2 don't use C-CDA. They use CDA, but not C-CDA, because the cancer thing is not part of C-CDA, and that's why it got complicated and that's why we didn't want to specify something that didn't make sense. And then what we presented to the Policy Committee was the fact that the Meaningful Use Workgroup itself had disagreement on whether this was something that had to be in or shouldn't be in, this was one where we had a bi-modal distribution. That was presented to the HIT Policy Committee and they did approve it with that caveat in there, so so far we're leaving the caveat in there.

I know Paul had said we can't include the vote, but this was actually in the thing that was voted on by the Policy Committee. So so far, Paul and I are leaving that last sentence in there, registries are important to population management, the one side. But there are concerns the objective will be difficult to implement. The only thing is that now that we've taken out C-CDA, a lot of the people objecting to how hard this is might back off about how hard it is, since we already have two registries in Stage 2. But this is the thing that was more or less voted on, other than the correction – not correction, but the change to get rid of C-CDA. So the option is leave it exactly as is, or I guess we can decide to get rid of the second sentence, but I don't know, I don't know, that might not be right – the right thing to do.

Paul Egerman – Businessman/Software Entrepreneur

Well, the last part of the sentence says “this objective will be difficult to implement,” our concern is that this – I mean, that is the concern that I am expressing, and so I would like –

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

And you still – so Paul, you still have it, even without C-CDA, that's my question.

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

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

Okay, good, so then why don't we leave it, because we presented it to the Policy Committee, they approved it, so let's just leave it as is, other than getting rid of C-CDA.

Paul Egerman – Businessman/Software Entrepreneur

I'm not sure I understand what you just said. In other words is the discussion part going to be there or is it not going to be there.

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

We'll leave it in there – this last part will stay in. Because what you're saying is – I was going to put the Meaningful Use Workgroup's no longer split on it, even though the Policy Committee voted to put it in, it's kind of funny to put in if we don't disagree anymore. But since we still disagree, I say we leave it as is and leave it in, just as written. In other words –

Paul Egerman – Businessman/Software Entrepreneur

Yeah, that's fine with me.

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

– go in, is that good?

Paul Egerman – Businessman/Software Entrepreneur

Because I think that captures the thing correctly for giving it to ONC.

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

Okay.

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

Okay. Good.

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

Any other comments on this?

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

Yeah Paul, this is Art. I wanted to understand a little bit better. I see at the bottom there development is high, and I agree with that. But once it's developed, what does it mean, provider use effort is high?

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

I don't – Art, I was – my interpretation, although I'm not the one who wrote down high, was that configuring your EHR – it's not like you just go and use order entry in your system. You now have to link to an outside registry, negotiate, try to be a – you have to decide which fields, which C-CDA document – within C-CDA, which document you're going to be sending, potentially which fields to include, what terminology to use. You're negotiating a whole interface with a registry and that would be a high provider use – because you're – the provider's the one that's got to make the link to the registry, not the vendor.

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

No, I hear that, but that's where I thought all those things, to me, sound more like development and once it's installed, the provider actually has little burden.

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

No, but that's not – no, the providers got to do that – that's not the vendor task, but the providers have. The provider has to find – maybe they can – someone to do it for a lot of money, but that's provider work.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, the provider sets up the template for each registry once and then it becomes a matter of ease. This isn't something that's configured for every single time.

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

But – this is Amy, I think what Art is saying is, the registries aren't going to start to negotiate with every different provider what fields they want. If it's a registry, they've got a standard set of data they need, they're going to want to accept it in a standard way and it's going to be incumbent upon the vendors to know those range of specifications to create the template. That's how I'm thinking about it.

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

No, that's not a vendor job because there could be 10,000 registries, you can't expect the vendors to know what every possible registry is going to do about each possible – this is something the provider is going to have to figure out.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Once for each registry.

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

Okay –

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

Once for each registry.

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

– you know folks, this is – I mean, we're not arguing about the red text here, so let's – I think we're – we're not re-discussing the thing that's been approved.

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

I think the question though is, does it – in the development section, is that just the vendor development piece or is it to imply that the development includes what the provider needs to do. And it –

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

Development was supposed to be just the vendor.

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

Just the vendor, okay. Well then, yeah.

Paul Egerman – Businessman/Software Entrepreneur

It's one of the reasons, Neil that the work implement is sort of like the right word, it's difficult to implement. I mean there are reasons why I think provider use effort is high, but it's also difficult to implement and this is a challenge. But I think we've talked this one into –

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

We've talked this one through, since population health is one of the four emphasis areas and that's why we accepted the fact that there is effort to put this in, but it's something that we need to do. Okay. Can we move to the next slide, please?

Okay so the next topic is the listening session, which we're trying to schedule for April. And this does not – obviously doesn't affect the recommendations we're putting in. It is to continue to gather feedback from the public. We're having some question about how do we structure this listening session; it's generally scheduled for 2 hours. One thing would be – one style would be to just leave it like our public comment and have anybody tee up and make their comments. Another way to do it is to try to organize it into categories and have people pre-register so one, we can manage – I don't know whether we'd have more comments than the time allotted.

And another way, and maybe this – I sort of almost like this when I thought about it again, is to have questions that we prepare for let's say each one of these categories. And so I think we might be getting more directed, and still people can comment on maybe there's an open session. But, try to either tease out some of the key questions that we have, we want to hear about or we leave it just categorized in categories. So the three options are just like public comment, whatever people want to say in any order. Or structure it somewhat by categories. Or try to have some questions that we'd like to hear answers about.

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

So Paul, this is Neil. So in the listening session, is there discussion or these are just one-way?

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

That's a good question. My – well, Michelle, do you have an answer to that question from other listening sessions?

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

I think we can do what you want. I mean, we could have it – in the past we've had hearings, so it could be no different than a hearing if there were particular people that we wanted to hear from. But I guess I was thinking that this would really be more of a public comment and not necessarily a Q&A type session or – I guess if we had follow up questions we could certainly ask it, but typically we just let them comment and move on to the next person. But it's really up to the group how we want to run it.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul. I mean I participated in the Information Exchange listening sessions on Stage 2.

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

Will say, that we called those listening sessions, but those are basically mini-panel sessions –

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

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

– or mini-virtual hearings. So, I just want to clarify, we had already put out there it was a listening session, but we – it wasn't a listening session, if you will.

Paul Egerman – Businessman/Software Entrepreneur

What I would say though is I thought they were very good, they were informative and one of the things that made it good was that not only were there questions, but there was a time for the panelists, if that's the right word, they would sort of like comment on each other's areas. And I found it really very interesting. And so I'd – because otherwise, if you don't – there ought to be some questions, there ought to be some interaction, otherwise you get stuck with a situation where people just read the prepared material for three minutes, and that parts always boring. It's the discussion that I find interesting.

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

So this is Mike –

Paul Egerman – Businessman/Software Entrepreneur

And especially if you can get – learn something when two different people approach something a little bit differently or –

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

I mean, if there is no discussion, we might as well just ask for comments in writing.

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

I agree.

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

So this is Mike. I would say there is a value to having people's com – to me the definition of listening is to hear what somebody says and to be able to reflect back to them both the content to make sure you heard them right, because spoken word is a fraction of the total communication. And perhaps the significance, I won't exactly say the emotional impact, but the better sense of how important or urgent or impactful the comment is, with regard to the presenter. So for me a listening session, I'm watching, listening, clarifying, make sure I've got it. I'm not sure I'm responding if it's a listening session, because that's the other half of solving the concern. But that's at least the way I would see a listening session having value above and beyond written comments.

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

Paul, its Christine if I can get in the queue.

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

Yes, go ahead Christine.

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

I agree with folks, I think the general sentiment here. I think when you limit something to 3 minutes, it's very difficult to be thoughtful, it's very difficult to be comprehensive. But because we hold these sessions in Washington, and you only have 3 minutes, it really tends to mean that you only get hear from the trade associations and not really get any depth around what's going on in the field. I also heard at the Policy Committee a lot of people saying, we really need to understand how Stage 2 is playing out, and I agree with that and I think it would be very informative for Stage 3.

So while I totally get the need to have feedback for the NPRM later this year, I'm wondering if maybe we'd shift approach and think about asking for public comments in writing, where they can be more thoughtful and you can hear from a wider array on the Stage 3 piece. But really do a listening session or a hearing on Stage 2 and how it's going with a Stage 3 lens on it, where we can ask some key questions, see how it's happening really in the field and be more thoughtful, but still give people an opportunity to comment in writing on the Stage 3 components.

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

Christine, this is Mike –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, I like what Christine just said and it's like the comments I was making about transition of care document were based on what I heard about what people are saying in Stage 2. And I think that that information would be helpful to this workgroup, especially if what we're going to be doing is somehow commenting on what ONC eventually puts, and CMS eventually puts in the NPRM.

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

Mike, did you have a comment?

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

Yeah, so I hear what Christine's saying and that may well be a great thing to do, I'm just trying to clarify if we want a listening session per se on Stage 3. Because that was a proposal for Stage 2 with a lens to Stage 3, and I think that's helpful, but it seems like it's a second activity with some good potential. But do we actually want to have a discussion – I don't know if it's a discussion even, it's that notion of, are we hearing clearly from people about how they're feeling about Stage 3, based on what they know so far and do we have enough information just from the written comments to inform us.

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

Paul, this is Amy, what's our ti – maybe we should work back timeframe wise. I like the suggestion that Christine gave as well, but I'm trying to think about like at what point, like can we just review the timeline working backwards, because maybe there's a way to do a little bit of both.

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

What do you mean timeline working backwards? Timeline on the rulemaking?

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

Well, yeah, I mean so we wanted this listening session, it says, in April. We wanted that for a reason in that time, because can we work back from when they're going to issue the NPRM?

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

The NPRM, according to their public statements is in the fall of this year. So, you don't know when in the fall, but they're in theory, from the time they get our transmittal letter, this month, they generally take about 6 months to produce the NPRM.

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

Okay, so the transmittal letter that we're going to send isn't going to be impacted by what – by public comment –

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

No...

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

– and public comment will be available on the NPRM, correct?

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

That's correct. That's – we're doing a lot of things in parallel, but just because it isn't in one of these milestones doesn't mean they aren't listening.

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

No, no, no, I understand. So I'm trying to think about just how to order and what is most helpful in what order.

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

Along – this is George – along those lines, I guess Michelle, if we do this listening session, having us hear what people hear of Stage 3 is not very useful, since we're done talking about it until a year from now. But if CMS and ONC are going to look at the results of the listening session, and incorporate into their thoughts about how to craft Stage 3, then we could do that. If not, then we should just listen about Stage 2 at this point.

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

You know –

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

Paul, its Christine. I think what I'm suggesting is April is pretty quick even for like Stage 2. And so if we had in April a public comment period where people could submit more detailed thoughts in writing and reaction to it and then that gets sort of summarized back to us and to ONC by June. I think that would be probably helpful for them, if that's what they'd like. But again, if they're not interested, then it doesn't make sense to do, but I think they are. And then really doing a listening session around Stage 2, with kind of a Stage 3 lens, but doing that a little later in the summer, when the field has had more time for implementation.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul. Why are we waiting until summer, we're six months into Stage 2 already?

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

Yeah, but not everybody started at the same point implementing Stage 2, they have much more flexibility in timelines, not everybody started on day 1 of Stage 1, which would get them into Stage 2. And I think EPs have only been doing this since January, and they did not have to necessarily implement in January. So, I think there is more time also for workflow change and to really see the impact on outcomes, I think that's going to take a little bit more time than 3 months.

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

I would agree with Christine because I think we'll get a better sense of where the real challenges and difficulties are if we wait a little bit more, especially on the EP side. I would absolutely agree with that.

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

So I will – this is where Amy's work backward. I will say that the earlier we are in this rulemaking process, the more potential impact it may have on the NPRM. On the other hand, I see what you're saying in terms of well, let's start this listening session about how the experience, I like what you said about the – with a lens towards Stage 3. We can have more information that informs our direct response to the NPRM. So it's almost, there's a little bit of a gating to say, do we want to mostly inform our response to the NRPM or do we want to still have input into the writing of the NPRM? And I think that would affect the timing.

So, one way to look at is, well, we just finished our transmittal letter, maybe we wait and let's get more the benefit of the Stage 2 experience, with a lens towards Stage 3. And that would speak towards early summer or something.

Paul Egerman – Businessman/Software Entrepreneur

Relative to Stage 2, I assume people know, vendors are dropping out, providers are dropping out, there are significant problems, there are some significant levels of dissatisfaction. It's one of the reasons why they announced the hardship – loosened up hardship rules. There are some very significant issues there.

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

Paul, how do we know who's dropping out if we don't know – if we haven't – if we're not near the deadline? Are people just saying I'm dropping out? I mean, how do we know that they're dropping?

Paul Egerman – Businessman/Software Entrepreneur

Well one of the things you know, one of the things you know, is how many vendors have completed their certification qualification process. And if the vendor is – if you have a vendor and they haven't gotten certified for Stage 2, then the provider certainly can't do it.

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

And are we thinking that that's necessarily a bad thing that vendors that aren't willing to advance their systems are dropping out? I mean, you keep – I've heard you say this a few times, but are we actually thinking that that's a bad thing? I'm thinking –

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I do. I think it is.

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

– if vendors who are stuck in a place and are not advancing their systems the way we think it's important to do, it's going to narrow the group of vendors who move forward and – but they're moving forward. I mean, we –

Paul Egerman – Businessman/Software Entrepreneur

Well again – again, I would just say, one of the comments that was made in the Policy Committee meeting was from Judy Faulkner who said across her company 50 million dollars and over 300 person/years to do the Stage 2 development and, that's a massive amount of effort.

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

Let me comment on both that and Neil's comment. One, first Neil's comment, I think it's important, and let me remind us that I believe, and Michelle correct me, that something like 80%...so 80%...so of the hundreds, several hundred vendors who got certified. First of all, half of them, no one ever bought the product, so we can't have such a big denominator and say a small percent. It turns out that people who have already attested with a vendor, I think 80-90% of those vendors already have a 2014 edition certified. So the vast majority of folks do have the availability of a certified product. That's one point.

The second about the comment of amount of money spent on developing Stage 2 functionality, compared to what. Should they not develop any of these things that we've – that a lot of people think are important and that's the state of the products, the state the products should be? I don't think so. I think that a lot of people think that this functionality, including everyone in the Policy Committee all said the list was good, should be – is valuable to people trying to deliver good care and achieve higher outcomes.

Paul Egerman – Businessman/Software Entrepreneur

Well, and my response Paul, those are all interesting comments, even as, I don't know how to say it, I view it as defensive. I mean, you're defending where you are and you're saying what you did was really good. But it's not the same as having a listening session where you hear what people have gone through and what their views are and I'm sort of suggesting that there is value in doing that and there's value in doing that soon. There are vendors who have done this and they're angry about some things and it would be helpful to hear what they're angry about and there are both eligible providers and hospitals who have tried to attest or are attesting and they have areas where they have serious issues, and it would be helpful to hear what those are. And I mean one of the issues –

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

It's not about –

Paul Egerman – Businessman/Software Entrepreneur

– was, in fact, the Direct protocol, it's helpful to understand what is going on there.

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

The comment was not about whether to have a listening session –

Neil S. Calman, MD – The Institute for Family Health – President and Co-founder

Right.

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

– the comment was Neil’s question to you about saying what –

Neil S. Calman, MD – The Institute for Family Health – President and Co-founder

What my – specifically was whether or not it was a good thing or a bad thing that vendors who were refusing or didn’t have the ability to advance their products in ways that we all have agreed over time are important, whether we have a concern about that. I have a concern for some of the people who bought their products, but we’re hearing that’s very few and sometimes none. And I think that it’s a natural – it’s a natural thing in the marketplace that as this gets more complex, some of the mom and pop and small vendors that haven’t really had a lot of success aren’t going to find the investment useful and are going to drop out. And I don’t think that’s a bad thing and I don’t think we should keep talking about it as if it’s a bad thing, without looking at the specifics of that.

But also I’m concerned about a listening – I’m concerned about sessions where people who are the most disenfranchised and the most unhappy are the ones who sort of show up, right? It’s the letters that you get as a healthcare provider, we get 30 letters a year from people who feel like they just were horribly treated in our system and 5 letters from people who think they were great, meanwhile 100,000 steady patients who come to us all the time. I think if we’re going to have that kind of hearing session where we’re going to weigh the evidence about whether we proceed or not. I want to make sure that we have plenty of people there who are basically going to come in and talk about all the successes they’ve had with improving quality of care, with improving patient satisfaction and everything else.

I really just don’t want to hear about the people who are going to complain about how hard it was to advance this thing forward; I’d like to hear about both – I’d like to hear both sides of it. I’d like to make sure that we hear from both sides of it.

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

Do you have a suggestion how to structure it so that the balance is – a higher chance of achieving that balance?

Neil S. Calman, MD – The Institute for Family Health – President and Co-founder

I actually do. I think we should look at some of the success models because we want to learn from the people who’ve been most successful. Yes, I think it’s really important to hear where people are struggling and I’m not a Pollyanna, believe me, I mean we struggle with this stuff every day. I think it’s important to hear from people who are struggling. But I think it’s also important for all us of to hear from the people who’ve been very successful, who have large percentages of their patients using portals and who’ve been successful in showing real quality improvements and who’ve been successful in connecting with public health and are innovating in that area. I think it’s important that we balance the listening session so that we hear from both groups.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, I don't have any trouble with that and I just think that we do need to listen. I mean I participated in listening to the Information Exchange Workgroup, which all the Meaningful Use Workgroup people were invited to, and we had very good people, we had Group Health Cooperative in Washington, you had University of Missouri, these are good organizations. And they talked about what was working and they talked about where they were having problems and challenges and that's useful information. I don't think you're going to find anybody who says this is 100% perfect and those things are valuable, I mean it might be helpful for the workgroups to read the transcript of that listening session to get a little bit of a sense of what people were talking about. They were struggling with, for example, the transition of care document and they're struggling with it from the standpoint of trying to make it work, and it was – it's useful information to understand what is happening.

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

So this is Mike, could I tell a one minute story about my own situation? So I might not be a meaningful user this year and the reason is that the vendor that we have, which is a major vendor, offers multiple different versions of its EHR. The one we're on, with about 300 providers, was not certified for Meaningful Use Stage 2, it doesn't meet the 2014 criteria, it was on a path to be able to do it by "x" period of time, and it didn't make it. It was deferred, it was put in later. Then there's ICD-10, then our organization had to make a decision about that kind of double or triple jump would be necessary to number one, meet our ICD-10 deadline, which is first priority. And then second, to meet the Meaningful Use Stage 2 certification requirements and maybe have the hardship exemption if we can't, which of course eliminates Meaningful Use, but at least helps defer a penalty.

So I am still not clear whether or not this large organization that I do my own clinical patient care at, will be able to do that. And I'm not sure it will wise enough to know by April 1 that it needs to apply for the exemption. And whether or not if they do so, John Halamka's sense that you can both apply for the exception and if by the way, you can still attest for Meaningful Use as it turns out, at the last quarter, then you'll actually get it. So that's a real live story in a large organization that is trying to struggle with a vendor who certainly has the resources to try to be able to do this, but found it hard and therefore is at risk. So that kind of story is probably important to hear. There are lots of great things that have happened, but it doesn't change the reality that this has been what we've all described and that is kind of a big lift, some bigger for others than for different vendors or different organizations.

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

So, I think I heard a couple of things, well, more than a couple of things. One is, Neil's point about let's try to find a structural way of achieving balance. There is a category at the very end, benefits of MU for the organization or quality of care, but maybe there's a share your stories and best practices, is something we should look at, because it can be a learning for other folks. There was something else that I've forgotten already – this last point that Mike Zaroukian just brought up is, I mean, I think that's an interesting quick story to tell, and it just points – it may be a signal for CMS to say, okay look, how do – first is allowed to both apply for the incentive and the hardship? I think that seems reasonable, but those kinds of quick questions and an example, why does that question come up is useful.

I think we might want to put some kind of restriction – we don't really need to hear – it's been well voiced and has been heard loudly about the timing, because I – so I don't know that we want to spend precious time hearing the same thing. We really want to hear from both people who are doing it, are making progress, but also aren't and why. So Mike's story was a quick example and had a very concrete question that could be answered, let's say, with an FAQ. But that's –

Paul Egerman – Businessman/Software Entrepreneur

And for example also Paul, I understand 9 hospitals have made it through Stage 2 and so we should get one or two of those to –

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

That's right.

Paul Egerman – Businessman/Software Entrepreneur

– saying, here's – we succeeded, here's how we did it.

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

Right, right.

Paul Egerman – Businessman/Software Entrepreneur

And here's how we view the thing.

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

Right. Oh, the other thing I was going to think of is included, these are just suggestions for public commenters, if you have a specific suggestion, as part of Christine's through the lens of, if you have a specific suggestion on how to like – you could – Mike's comment could have a specific suggestion. Hey look, you may not know on April 1 what your position is, is it okay if we both continue to try and apply for hardship exemption? That's a specific question and that's potentially a suggestion. Things like that are very constructive, it points out the issue it – and it points out a potential solution and I think that goes a long way.

And same thing with Paul Egerman's suggestion, hey look, of the folks who put it in, was – what did they come across, what are the issues that we could make it easier for the next group or that could help us look at transitions from Stage "X" to the "X+1." So, going from Stage 2 to 3, what happens at that transition? What can we learn from that? So I think the best, and this responds to Neil's – we don't want to just hear either complaints or – we need to have the lessons from these things and to the extent possible, options or concrete proposals. Other suggestions about how to structure the listening session; I think these have been helpful.

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

Paul, its Christine. The one small comment that I would make is I think in the past we've had real trouble with, we give people 5 minutes and it's so hard to get your point across. They give you rich testimony, but I don't know how many of us honestly read 30 people's written testimony that's 6 pages. So maybe we can give less people a little bit more time and be more thoughtful that way.

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

It's a fair comment. We do know that our success formula for hearings and panels has been 5 minutes. When you divi – so 5 minutes is a considerable increase in – over 3, and what happens if you – that's a significant decrease in the number of people. So it's always that trade-off. I think 3 minutes – in our public comments, I think we do get enough in that 3 minutes, and like Mike just demonstrated that in probably 90 seconds. And that's the kind of bite-size stuff that I think we need.

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

I guess I don't totally agree with that because I think we really want thoughtful experiences, and there's a lot that's new in Stage 2, so there's more ground to cover, I feel like in Stage 2. And then we're adding in this sort Stage 3 helper on the end, so I would do one less person on the panel and give them an extra minute or two on top of the 5.

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

Do other people want to comment?

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

So this is –

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

This is Amy, I'm trying figure out where we are in the conversation in terms of are we having people pre-register so we have – I'll get back to the 5 or 7 or whatever minutes. But, I think it depends on the volume of what we think people are going to say and how many of these we want to do and how we're going to structure it in terms of is it more that they're – again, getting back to the earlier questions. I'm not clear if we deci – I think we all said it's more helpful to have some discussion so we can validate we heard something correctly and if we have – if it generates questions, we can ask. That comes out more like hearings than listening session so I'm still struggling with where we are between that, because I think how much time we can – how many people we hear from and how much time we give each person, it's sort of we're getting into a little bit of a circle here about how to structure this.

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

That's a good point, so let me just give some calibration. If there's absolutely no time for discussion say, I sense that we don't want to do it that way, but if that were true, if we made it 3 minutes, we'd hear from a maximum of 35 people. If we made it 5 minutes, we'd hear from a maximum of 21. Now you'd have to probably shave off 30% at least from that if we allow every one or two questions or responses back from us. And chances are that's what we want, so that really is limiting it tremendously.

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

So, it's Christine. Doing the math, I see your point, so that's valid. But I think I want to ask sort of the fundamental question, I'm not really in favor of just sort of a litany of comments. I'd much rather – I think we've benefited the most from the hearings like we did in Stage 1 and 2, and Information Exchange hearings that Paul talked about, where we had panels and we'd ask them specific questions to the panels and we were doing – it's more organized by a provider type. We can have one of – a couple of the 9 successful hospitals, etcetera; really participate in more of a hearing format than a public comment format. So I'm not sure where we're at in the discussion, I thought we were leaning towards the hearing format.

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

So I have a que – this is Neil. I have a maybe a suggestion which is, then it might deal with the balance issue and it also might deal with the ho – why do we need 35 different people commenting. What if we ask people to apply to be part of this and actually submit the context of their comments, which they don't have to read, but that would enable somebody to go through them, create a balance so that, we don't have 6 people all saying exactly the same thing. And would also create a balance of people who are demonstrating best practices and people who are struggling with different areas, etcetera and would also give us the ability to organize the comments in some sort of a framework. So have people apply by submitting their comments, and then they would be invited and that would give us more time to have them there to discuss with us, to summarize their comments in 3 minutes, but give us more time to discuss it. And we could have fewer overall comments.

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

Well –

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

Its Christine, what I like about that idea is that I think one of the benefits of it is, we're really hearing about what the field wants to talk about as opposed to us picking the questions ahead of time based on what we think they should talk about. We can then pick the themes from really what's bubbling up out from providers and hopefully patients and families in the field.

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

And so this is Mike. I was actually thinking along the same line, so I appreciate the suggestion. I was also thinking it might help us with what, at least for me is still unclear about how much might we want to get in terms of feedback on Stage 2 with a lens to Stage 3 and how much might we want to pick something that's explicitly a question/comment about Stage 3. And then would it then meet the dual-goals of people on the call and what ONC and CMS might want to hear.

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

Well, let me try to summarize what seems to be a consensus forming, and it sounds like its closer to a hearing than just an outright public comment listening session. And one of the benefits, from what I heard, is that it's – you're submit – we're accepting submissions instead of inviting, so it's self-nominated. And the strength of your nomination is, what's the new – what's the way you're articulating the issue or the success you have. And what we'd use to judge who might be the most – we'd appreciate hearing the most from, is people who have something we can learn from and particularly when they come across with a good idea, a suggestion, constructive options for Stage 3 and beyond. Did I summarize the correctly? That's sort of a combination of Neil and Christine and Mike.

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

I liked it, it's Christine.

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

Yup, Mike, me too.

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

Okay. So it's approximately the same as what's on the screen, actually. So they're essentially registering – proposing to be part of this, and because of the limited number, we're going to have to decide how much. They can say, hey, I'd like to come talk about "X" and it's probably in one of those kinds of categories, and here's the thrust of my comment and here's the idea I'd like to propose, or whatever. And we'll try to establish some kind of balance. My guess is we're only going to have time for about 15-20 of these, and as long – if they're very meaty, then it could be very rich.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, it seems like think 15-20 seems like a lot, I mean, it strikes me, I made a couple of observations. It's not like this is only one shot, we could do more than one of these.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

I'm just wondering if you did something that – if we could get more information if we had fewer people. If you had like say 3 hospitals and you had 3 providers, you had 3 vendors, and that would be very interesting. You could possibly have a very interesting discussion and you try to find the 3 possibly there are only 2 that have succeeded at Stage 2 and then 1 that is, for whatever reason, having difficulty. And the same is true with the providers and same is true of the vendors and I just think that you could possibly then get very good discussion. I think you get 15 or 20 people, we're going to have trouble finding the needle in the haystack, we'll have trouble understanding what are the common views.

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

Yeah, this is Amy and I think the fact that people have to submit will let us organize and see how many people want to comment and on what and then if we really feel we need to, add a second one in. So I agree, 15 to 20 sounds like too much, 10 sounds like more reasonable if we want a little bit of discussion in two hours. But remember, we'll have the benefit of having what people have sent in to understand the range and the depth of what's on people's minds.

The other thing I was going to ask is how were we planning to notify people that we want people to submit for this? So I think we have to go broad on that as well. If we get inundated, then that tells us something right then and there.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

But see, there's a problem with people submitting, it goes back to Neil's thing. It's that people who are going to volunteer to submit are probably the people who are either very unhappy or very happy. It's the people like in the middle that you also want to hear about, and so I think some of those people need to be invited.

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

So this is Mike –

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

What I thought we were – I thought where we came down, unless I misunderstood was, we were going to have people submit like a mini-proposal and we were going to put some criteria to it like, you need to be constructive. What lessons have you learned? What areas are you struggling with? What suggestions do you have? And then we were going to organize those to make sure we had people across the different areas, and then pick those that we thought would be most helpful.

But I thought we were still going to have people – we were going to solicit – I don't remember if it was Christine or someone else – or actually Neil that recommended that balance in the beginning. I kind of like that idea because it'll give us – it'll take a little bit more time on our end, but it'll give us better breadth and depth, I think if we put some criteria, so it just can't turn out to be a complaint session, then we'll be okay.

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

Right, so this is –

Paul Egerman – Businessman/Software Entrepreneur

All I can say is – it's hard to describe this experience I had running a meeting of about a 100 people a month ago, where for the first hour the people who raised their hands were the people who either – predominantly people who were extremely unhappy and occasionally the people who were extremely happy. But then we came to a vote and you would never have guessed how the vote turned out if you heard what the discussion was, it was because there were a lot of people who thought that the idea was pretty good, but they just weren't so excited that they wanted to raise their hand and talk about it. And so – I'm just trying to say, maybe that influenced me. There may be some people out there who they think it's pretty good, but they would not necessarily volunteer.

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

Right. So this is Mike, I'd like, if I can, to dovetail on the other suggestion about criteria. So I've been writing a few things down as we talked. So – and what I heard was that maybe one way to frame it is either preferences given to or selection criteria for those who will be presenting comments, chosen to give their comments would be: Number one, a thoughtful reflection on their experience with Stage 2 to date, including the strengths or the successes rather, and the challenges. Two, how that experience or the experience in Meaningful Use to date informs their comments about Stage 3, because we would like to hear that explicitly. And three, to Paul's point, do they have a specific, constructive suggestion for Stage 3 in light of all that. And if we made those the criteria that might be one way of making sure we not only get balance but we get – we help ensure each of the commenters really adds value to the process.

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

I think that's good framing. This is Christine.

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

So that works for me and I still – I mean I still like the idea that Neil had said, that we sort of solicit with that criteria. And then we can also organize and make sure we don't have everyone talking about VDT versus not talking about registries or whatever the case may be.

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

I think that's – I mean, that is the basis and then Mike was just proposing some criteria.

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

Yeah, no, I like the criteria.

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

All right, I think we have it. It's pretty much like on the screen, we add the criteria that Mike enumerated and we make it known – and I think one of our avenues is the blog, we – my guess is media will pick up on it as well. So we'll try to make it – the opportunity known. Unfortunately, we only have time for, as we've talked about, about 10 and so it's going to be probably more reply than we have available slots. So we don't want to mismanage the expectations either.

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

When we see the submissions, we may alter how many people we have present, just – we're going to go fewer if it's just a lot of redundant stuff or not many submissions.

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

Right.

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

And we might have more if we see a wide variety and we think it's – I think we still have that flexibility to some extent.

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

(Indiscernible)

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

Right and we'll still learn and benefit from the types of things that are coming in, whether we have those presenters present or not.

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

That's exactly what I was going to say. So the fact that we do have substantive submissions means that that's just like public comment, so that's not – and we can point that out. Well, I think this is a new avenue of getting constructive comments and let's see how it works. And if it works well, we can try this in other domains as well. Any further comments about this, and then we'll try to plan – we'll try to find what date will work for us. I don't know, we might do a Doodle, Michelle, do you think that would work?

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

Um, we could do that. I – we have one meeting scheduled in April that George isn't available for, so we are going to reach out and try and find some new times in April, but we could also do a Doodle Poll.

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

Can we use –

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

So this is Amy, just down to the logistics, Paul. The date in April you were talking about for the actual hearing/listening session. But then are we planning to meet before that to look at the submissions and decide like – I presume at this point, with this process, we're going to need to push out the listening towards the end of April so we have time for people to submit and decide who needs –

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

Yeah, that – .

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

– who we want to invite, I think we just have to keep that in mind.

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

That's a good point. So we'll ask Altarum to find us some potential times and we'll put that out as a poll for two times, one is the prep, and we might use April 16 as that, and then the other is for the actual listening session. We might call it interaction session, so at any rate, well this is very helpful, thank you everyone. Any other business before we open to the public? Well thank you everyone and I look forward to this listening interaction session. Could we open to the public please?

Public Comment

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

Operator, can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

Yes. 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 comment at this time.

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

Saving it for our listening session. Well thank you everyone for participating on this call and we look forward to our planning session and the listening session.

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

Thank you, Paul.

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

Thank you.

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

Thank you everyone.