



HIT Policy Committee Interoperability and HIE Workgroup Final Transcript April 24, 2015

Presentation

Operator

All lines are now bridged.

Michelle Consolazio, MPA – Federal Advisory Committee 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 Interoperability and HIE Workgroup. This is a public call and there will be time for public comment at the end of the call. Actually for those that participate online through the webinar, in the past people typically will write some comments and we usually only make those a part of the transcript. But today we're going to try and share those through the public comments at the end of the meeting; so, we'll see how that goes, this is our trial run for today. For those participants on the phone today, if you could please state your name before speaking as this meeting is being transcribed and recorded. And I will now take roll. Micky Tripathi?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

This is Micky, here.

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

Hi, Micky. Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Good morning, Michelle.

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

Hi, Chris. Beth Morrow?

Beth Morrow, JD – Director, Health IT Initiatives – The Children's Partnership

Hello.

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

Hi, Beth. Brian Ahier?

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

I know Brian is here.

Brian Ahier – Director of Standards and Government Affairs – Medicity

I'm here. Yup.

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

Carl Dvorak?

Carl Dvorak – President – EPIC Systems Corporation

Yes, here as well.

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

Hi, Carl. Dave Whittlinger? Hal Baker? Jitin Asnaani? John Blair?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Here.

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

Kate...hi, John.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Hi.

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

Kate Kiefer? Kitt Winter?

Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration

Here.

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

Hi, Kitt. Landen Bain? Larry Garber? Margaret Donohue? Melissa Goldstein? Nancy Orvis? Shelly Spiro?

Shelly Spiro – Executive Director – Pharmacy e-Health Information Technology Collaborative

I'm here.

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

Hi, Shelly. Tony told me he was not available. Troy Seagondollar?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

I'm here, Michelle.

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

Hi, Troy. And Wes Rishel?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Hey.

Wes Rishel – Independent Consultant

Here.

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

Hi, Wes. And from ONC, do we have Kory Mertz?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

I'm here.

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

Hi, Kory. Anyone else from ONC on the line? Okay, with that I'll turn it over to you Chris and Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Great, thanks. Hi, this is Micky and welcome everyone and thanks for joining. Sorry I couldn't make the last meeting and I want to especially thank Chris for covering the meeting last time. I did have the opportunity to listen to the recording; all of you will be happy to know that you all sounded brilliant and it sounds like a lot of great conversation and great progress was made. So, look forward to the conversation today.

So, why don't we jump ahead and Chris, jump in...any part of...as always, jump in at any point along the way, but certainly because I wasn't on the call last time, so I would welcome any sort of correction or additional comments that you have throughout the call today.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Go right ahead Micky and I'll jump in if there's anything that I want to add.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, sounds great. So just looking at slide 3 for a second, we'll dive right in, but just to get us sort of oriented to where we are in the timeline. We've got...last time we covered some of the send I think and we're going to finish up...let me just see here, let's see, so, so yeah, we finished up...we covered some of the...we're going to finish the review of the send and the capture and then start the review of the governance question. And we had, our call last week, we've got today and then we have one more call on April 30, so it looks like Thursday of next week, in terms of the live calls that we have to get through the send, capture and the governance questions. And then it looks like we have something like 7-10 days between that last call and the Policy Committee; so we may have some opportunity for some offline refinement afterward, but we do need to make a lot of headway today, as well as the next call to get through the bulk of what we've got to cover here. So, just want to make sure everyone has a good sense of the timeline.

So why don't we just dive right in, Kory has done a great job, I think, at summarizing where the conversations left off, left off along a number of different threads from last time. And so at the beginning here, I suggest that we just go over the summary that Kory created of where we left off; let's make sure that that is an accurate reflection in everyone's mind of what we discussed and also there are still some open questions with respect to particular refinements, are there some specific recommendations that we want to make based on issues that were raised last time that perhaps didn't come to full closure and let's tackle those as well. And then we can sort of cover the new territory after we get through that, if that makes sense.

So jumping to slide 5, we had, you know, the first question on the send with the question being will the ecosystem across the country be ready to support a 50% threshold and there were a couple of different issues here. One, this first issue on slide 5 is really not a recommendation, per se, I think it's found in some of the discussion and from the synthesis like, this is really just a comment from various, you know, from the workgroup...various members of the workgroup about perhaps unintended consequences or just considerations when thinking about it, but didn't lead to a specific recommendation.

In particular it sounded like there were two...starkly different opinions of two types of concerns raised; one being that the current threshold, by raising the threshold from 10% to 50%, it affect referral patterns to the extent that at that higher level, organizations are driven toward those who can receive in an electronic manner sufficient to their being able to use those transactions for their meaningful use attestation.

And there are sort of two sides to that coin; one, the concern that wow, is meaningful use going to now drive referral patterns in a way that's...that could create some non-competitive kinds of aspects in the market. On the other hand, there's the alternative view that, no, this actually can be a lever for creating greater use and penetration of electronic systems because it basically says essentially that we're raising sort of the expectation of what exchange means among trading partners and particularly for those who are not covered directly by meaningful use, this could be a driver for them to feel like they need to have the means to electronically trade with those who are specifically driven by meaningful use to do that.

So, there seem to be two sides to that issue there; I don't know if there's anything more to say about that, because it's not a specific recommendation, but...

Wes Rishel – Independent Consultant

Micky...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

...it seems like there was discussion about it. Yup, go ahead.

Wes Rishel – Independent Consultant

This is Wes Rishel, I always have something to say. The words you said right now in describing the main bullet were a lot better than the words on the screen. The way I read the words on the slide, it never answers the question, will the ecosystem be ready? It says that the high threshold will be important to drive, but it really doesn't answer the question. It doesn't make the statement that a high threshold will drive changes in the ecosystem to support a 50% threshold. And I think the underlying question associated with this thought is that...is to address that issue.

So as of this point, I would suggest that if we are ready to take a stand and say that the ecosystem me...and by that I mean the structure of the capability of interoperability in eligible and non-eligible providers, like LTPACs, will respond to this imperative in a timely fashion then we should state it. If we think that that's a significant issue, we should question the 50% threshold. So, I just would like to put a mark in the conversation somewhere, let's not duck this question.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah. No, I think that's a great point Wes and I know some others are probably going to have a comment on that, which is great. I would just point to the next slide for a second, just to bring some data to that question. And so Kory has pulled out some of the data from the Stage 2 attestations, which if, I'm not looking at the screen, but if we could flip to slide 6 for a second, which shows a segmentation by size of hospital and by type of hospital what the average percent of electronic...electronically reported hospital transitions was for those.

And you can see the overall mean of, you know, in an ideal world, we wouldn't be...assuming that these are well-behaved distributions around these means, right, I mean it would be nice to know what is the average percent of hospitals that was able to do 30% or whatever the mean is. But this shows just the average for each of those segments. Assuming they're relatively well-behaved distributions, it kind of looks like, you know, there are a lot of hospitals or a significant critical mass of hospitals who are coming close to 35-40%, suggesting that the 50% might be a good stretch, but achievable goal. But that's just some data to help inform that question.

So going back to ques...really what's this question, which I think makes a lot of sense, do we as a group have a view on that question of, is raising the 50% threshold going to be something that is a positive...overall a net positive driver for all of the other sort of healthcare providers both eligible and non-eligible?

Wes Rishel – Independent Consultant

Can we just review the bidding on what exactly was reported here versus what exactly is required? I don't mean the number, I mean does the new requirement just in order to achieve it, does it imply actual transfer of information in a structured format to more targets than the same percentage number meant in the compliance reported on slide 6?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

So, I'll jump in here and just make a couple of notes. I think two things to think about here; one, for...in Stage 2 the requirements around transmission are tied to using certified technology. And as we talked about last time in the Stage 3 proposal, it is open to any way to send electronically. I think the other thing to consider here, you guys are, at least based on the last discussion, recommending to remove the ability to count referrals within an organization; so that might impact how you think about these thresholds as well. Because that was, you know, those did count in Stage 2, so those would be represented in these percentages.

Wes Rishel – Independent Consultant

Okay, but the denominators don't change in terms of the targets of referrals; referrals to LTPAC counted in the denominators in all of...in slide 6 as well as they count in the denominators for the next round, is that right?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Ah yeah.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

But, self-referrals would be taken out of the numerator and the denominator, right?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right, and I think Kory's pointing out that, well, that would affect the...our view of the 50% because when the 50% was created, that assumed that those would be counted. But also important is that the data we're looking at on slide 6 includes those self-referrals, both in the numerator and the denominator. So, if we ended up taking those out the apples to apples comparison might suggest that that mean is actually, it could be substantially lower than 36%, we just...we don't know.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Yeah, so based on that, it seems logical to float a suggestion that that 50, if we take the self-referral out that the 50% be adjusted downward.

Wes Rishel – Independent Consultant

Well I would say that certainly my understanding of the way it was measured for Stage 2, self-referrals weren't created by a hospital and therefore weren't counted. It was when a hospital created a summary of care on discharge that was...and perhaps providers referring in, but this mechanism for handling self-referrals is so different I doubt if it was counted in a measure.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I'm not sure I understand what you're getting at, Wes, because I think it did, I mean, I think that those did count in...

Wes Rishel – Independent Consultant

How does one...now, today, if we're out there under the Stage 2 rules and somebody self-refers; I mean first of all, emergency department is a form of self-referral that's common, but so suppose someone self-refers to a specialist, the specialist wants to get information from someplace the patient has been before. That could happen one of two ways; it could happen by look up through an HIE or it could happen by a telephone call to the medical records department and then the medical records department could conceivably respond through a network. But, that particular action of sending information ad hoc out of the medical records department doesn't seem like it was a countable thing in a denominator to me.

It wasn't a discharge action by the hospital at the time of when counting occurs, it was a response to a request for information. I just don't...I just...and perhaps Carl or one of the other vendors can advise me that oh yeah, we saw that and we counted that. It just doesn't seem likely to me, that's all.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Wes, this is John Blair. So I think what they're ta...so if you take a hospital that is on one vendor system in the acute care setting and then a different system in the ambulatory, those discharges from the one system to the other counts. If it's the same system between the two settings it does not.

Wes Rishel – Independent Consultant

Currently it does.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I believe...just point of clarification, I think under the earlier counting rules, the one that we're suggesting doing away with, it did even if you were on the same system, if you sent them via...you sent them a CCD transitions of care via a direct compliant mechanism, it counted, even if they were on the same EHR because there were different NPIs and different care setting.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

But you can't send from one to the other if it's the same system; it's the same database. You can't send it via Direct on the same system.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Well, I think that was the nature of the selfies, so, I don't know, Kory or Carl, if you're able to join, I know you're...

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

So yes, to clarify Micky, you're right, that was the policy. So if you were on the same system and you had access to the information, if you sent a care summary record, it could count, even though the other provider had access to the information and was on the same system. And that is what you guys in the last call were recommending to not allow any more, and that was what I was just trying to point out to consider; you might want to consider...

Wes Rishel – Independent Consultant

Yeah.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

...in the threshold.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. So back to the point if they're on the same EHR or a different EHR but they're a part of the same integrated delivery network, they're a part of the same corporate umbrella. Back to your point, Wes, I think that that did happen fairly often and it was, you know, obviously varied a lot by institution, varied a lot by market but it's not as if it was a trivial sort of a factor as we look at this data.

Wes Rishel – Independent Consultant

But I need to make clear which of my points we're referring to. The very last point had to do with self-referrals that Chris brought up. Self-referral is a situation where in effect someone makes an appointment or walks into a provider facility without any supporting referral from a prior facility. And there is language in the Stage 3 material to count that and I'm just saying, I don't think it was ever either in the numerator or the denominator.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I see, right, right, right. Yeah, I think that's a different issue, yeah.

Wes Rishel – Independent Consultant

Yeah, I agree.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Just to go, I mean, for our experience on our network, which is now about 4000 provider organizations, we're in the 30-40% range and that does not have those self-referrals that you're talking about in that number.

Wes Rishel – Independent Consultant

And I would suggest that communities with well established, longtime built HIEs are potentially in much better position to reach a 50% goal than communities that don't.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Wes Rishel – Independent Consultant

I would further suggest that, it's unfortunate, but there are more communities that don't than do and we, you know, it would be great to think of this as the motivation that finally clicked over and caused the roll out of effective HIEs on a much broader scale, but that would not...that couldn't be...couldn't happen in the timeframe necessary for regulatory compliance.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

So the number that I just gave, Wes, is a national number; it's not the communities that are more advanced, it's a lot higher there.

Wes Rishel – Independent Consultant

I'm sorry...

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Can I make a point...

Wes Rishel – Independent Consultant

Who is we, John? When you said we, I thought you were referring to your HIE.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

No, I'm talking about our national network, not the regional efforts.

Wes Rishel – Independent Consultant

Who is our? I'm sorry, I'm really just getting conf...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

The MedAllies Network.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

So, may I make a point of clarification; this is Chris. So there is a co-mingling of two different things; there is the self-referral where there is language actually in the Notice of Proposed Rulemaking and then there is the selfie situation, which is a referral to a...where the patient is referred within the same organization to somebody else. What we had discussed last week were to take out of the counting was those self-referrals, where...so the selfies, where the patient gets...stays within the system. And we had discussed that there needs to be this definition that there's at least a different NPI or a different CMS notification number in order for it to be counted. That's what I was referring to earlier.

Wes Rishel – Independent Consultant

Well I think we've identified three points here and it's just restating what Chris said. We generated...we've identified the number of times a referral, that is, something that originates from the discharging or sending organization is supported with an electronic document. The second one is the number of times a referral is supported by both sides having the same system, and that's, I think, Chris is calling that the selfie. And then the third is a walk-in where it's necessary to request the information, because there was no act to accompany the original sending of the information.

I would propose that we focus on the first question, recognize that it is a substantially higher challenge than the challenge for Meaningful Use Stage 2, but as Carl said when he proposed it, it really moves the needle forward on actual interoperability because some systems don't get the ability to get it for free without any additional effort. And I have to say, I think that that would be a good thing, but I think the 50% number would be beyond challenging.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, so let me just...

Wes Rishel – Independent Consultant

And my rooster does, too.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Let me just recap where I think we are and Wes, it's unfair to have your rooster chiming in as well. First off, I think on the third one that you mentioned, which is the self-refer, the patient self-referral, later in this we recommend removing that entirely. Because we say that's an edge case, doesn't happen that often in this context as I recall; so I think we're saying let's get rid of that, but that's a different topic than we're talking about here. So...

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

That's correct. That's correct, that's the consensus we reached last week.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. Okay. So and then...so on the question of this one, which is the 50%, the question here I think is do we think that 50% is too high? Wes, what I hear you saying is that you do believe that this would be a market motivator; however, given where the market is in general, 50% is probably too high.

Wes Rishel – Independent Consultant

Yeah, I'm saying particularly in the context of a proposed change of the criteria to exclude null transfers.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Selfies. Yeah, so if you take out the selfies, then the data that we just saw is probably lower, suggesting...going back to Chris' point, which suggests that the 50% probably would be appro...ought to be appropriately lowered as well. So do we have a, I don't know, we're sort of operating without a lot of data at this point. We're at 10% now, the suggestion here is 50%; is there any basis for us to say, well 40% is more reasonable or 30% is more reasonable.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Hey, well Micky are you sure that everybody feels that 50% is too high?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

No, no; I'm sorry, yeah. Let's have that discussion definitely John.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, because...I mean, this is John.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yup.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

I don't think it's too high.

Wes Rishel – Independent Consultant

In that case I have to ask John more about his cited data from MedAllies.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

So, I'm just saying that across our network nationally, which is at about 40,000 provider org...I mean 4000 provider organizations now and about 60,000 providers, we're above 30% on the average. I mean, I think Wes you were thinking I was talking about the Hudson Valley, where we have a much more tenuous effort.

Wes Rishel – Independent Consultant

No, what I was referring to John is comparing areas that are served by an effective HIE versus catchment areas that don't have one of those.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Right and...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Wes, I think, John, you're just talking about the HISP, right?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Right.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

...so this isn't a full-blown HIE right, it's just...that we talked about.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah. Yeah, I'm strictly just talking about the HISP, Wes; I'm not talking about the Hudson Valley work. I mean, the Hudson Valley is a lot higher than that, but I'm just saying nationally the HISP.

Wes Rishel – Independent Consultant

So to...if you say it's a HISP, you're talking about Direct and you're saying that you're hitting 40% levels in the HISP area, which is much larger than the catchment area for Hudson Valley. So that Direct, in effect, and I'm implying or I'm inferring from that that most of that number that you're turning to is Direct. So you're suggesting that a target...that Direct provides a means to get to 50% that is just a reasonable level of stretch. And I, when it's put in that context, I would...it certainly sounds good enough for me to defer to those who actually have data.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, now it's a whole other thing when you get to med reconciliation via Direct and usage, when it gets to the other side, but I'm just talking about transactions that were received on the other side and acknowledged that they're received.

Brian Ahier – Director of Standards and Government Affairs – Medicity

All right. So this is Brian, I'd agree. I think for this measure, remember we're talking about three measures, there's the sending, there's the retrieving and then there's incorporation of the data. For this measure specifically on sending, 50%, you know, we're talking about a few years from now where I think that that will be achievable and is probably a reasonable expectation.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. Okay, why don't...I have a suggestion, why don't we...so we'll take those as two data points and maybe between now and the next call we can reach out to, I know Carl is only able to join sporadically here; maybe we can reach out to him and get a little bit of other data from some other places with the vendors and then just confirm what Brian and John are suggesting which is that a couple of years from now this ought to be achievable, even though we're going to not allow the so called selfies to be counted.

Carl Dvorak – President – EPIC Systems Corporation

Yeah, and this is Carl...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

I want to qualify one thing, my numbers I was giving is more for hospital, I don't know, I'm not...I don't know where it really is fully on the ambulatory side.

Carl Dvorak – President – EPIC Systems Corporation

Yeah, this is Carl dropping in for a second, the...been listening, so sorry for not being equal participant but I think we see the same phenomenon that we saw with early Meaningful Use items like ePrescribing. You know, they set a low threshold but truth is, once somebody turns it on, it's just on and use it for pretty much everything. So I think the phenomenon of those who are connected making good use of the connection follows that model, I just think we have to be very thoughtful about the places that aren't connected yet and there are so many places out there that are taking the hardship exemption with some of the vendors and there are so many places that patients end up going to that are outside the scope of Meaningful Use in the first place, I think we should really study that carefully before we set a 50%. I'd rather set a correct target that's achievable and will create the ePrescribing effect rather than set an artificially false one that dissuades people from trying or we end up in the circus of going from 5% to 1 patient in a year or something like that.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. So two questions Carl; one is how do we get at...what kind of data could we get between now and we'll say the next call to better inform what an appropriate number might be if we think it's not 50%? And then the other question for you is, based on your experience, you know, just off the top of your head, did selfies account for a lot of the attestations, from your perspective, for those who attested who are on EPIC.

Carl Dvorak – President – EPIC Systems Corporation

Not from our perspective; we tried to dissuade people from it in the first place. We saw it as a very, very high risk maneuver that would be questioned on audit, so we really talked as many people out of it as brought it up. I think there were one or two sites that decided yeah, good enough and then unfortunately CMS and ONC clarified, yeah, that's what we meant. So I think there might have been a few at the very end, but for the most part no, that wasn't in our numbers.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay. And given that actually EPIC is a very large fraction of Meaningful Use Stage 2 data, so it could be that these numbers that we're looking at aren't so far off, the ones on slide 6.

Carl Dvorak – President – EPIC Systems Corporation

Yeah if everyone's ready to connect then it's easy; I just...I worry about future hardship exemptions and such being granted and those who would have been ready get...fail the measure because we've allowed so many people to not be ready.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. Okay. So back to the first question then, Brian and John were suggesting that based on the data and what they're seeing on the ground that 50% might actually be a good target nevertheless, given that it's a couple of years from now and from what they're seeing among the people they work with.

Carl Dvorak – President – EPIC Systems Corporation

It may, but again I caution let's remember about the ePrescribing effect, right? For those who are connected, they'll like make use of it 100% pretty quickly. It's factoring in those who have yet to connect that we have to understand how that impacts the remaining.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Right. Yeah, I think Carl...this is John again. I think Carl brings up a good point and it is those that get connected and have trading partners that are connected, it's probably more a factor of who you can send...or if there are enough to send to versus if you are star...so if you're connected, you're using it fully. But the real question is, as he pointed out, how many out there can receive?

Wes Rishel – Independent Consultant

I think...

Brian Ahier – Director of Standards and Government Affairs – Medicity

He was right.

Carl Dvorak – President – EPIC Systems Corporation

Yeah and if you were connected to an HIE I think you got credit, even if the document never made it to the receiver, right, you still got credit?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

No, you have to pull it down.

Carl Dvorak – President – EPIC Systems Corporation

Well, does...

Brian Ahier – Director of Standards and Government Affairs – Medicity

No, I think...this is Brian; I think you're right Carl in that if you send it, you know, so just focusing on the measures in front of us, on the send piece yeah, if you send it, regardless of what happens on the other end, you're not responsible for what the other practice does. And to your point on, and maybe the threshold if we want to really keep an eye out for the little guy, needs to come down to 40 or so or something more...you know, not such a big jump.

But I think that regardless of what threshold this lands on in the final rule, we should keep in mind that this is...as you said with sort of the ePrescribing example, if this is to spur the use of the systems that hopefully would be widely deployed and available as Stage 3 takes place. And also I think looking at this through the lens of the new merit incentive payment system, this being the final rule of Meaningful Use, and Meaningful Use being folded into MIPS and this type of measure, I think, is really driving towards greater interoperability. So just keeping that mind as we sort of debate here what the appropriate threshold might be.

I think the bottom line for me, Micky, is that we've...we seem to all agree that the objective and the measure is appropriate and we're quibbling a little bit over what the threshold may be. We want to see the threshold increase from the current requirements, but potentially not as we need a little more data maybe to determine do we go as high as 50%.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, I think that was well said, Brian.

Wes Rishel – Independent Consultant

This is Wes again.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yup, go ahead Wes.

Wes Rishel – Independent Consultant

I really don't know any numbers with regards to the hardship exceptions but the thrust of the level of concern I hear, I hear arguments for being less aggressive about the threshold that comprise...that fall into two categories. One, there is this pattern that once you get a channel open, people begin to use it that argues against the need to be aggressive at the high end of the threshold. Second is that when we rely on Direct transfer rather than selfies or rather than an HIE where there's a guaranteed receiver, then the struggle becomes finding a trading partner who will...who is the appropriate referral target, who will receive and many of these trading partners are not themselves Meaningful Use incented organizations; they're non-eligible providers in the sort of the current vernacular. And again, I don't have any numbers there, but I can just say I live in a catchment area where there are no nursing homes or LTPACs at all that have any ability to do anything electronically.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. So I think Wes to that point, I think we can actually move to the next measure because that's...because the next measure actually tries to take into account this question of...that both you and Carl and John just raised of, how many of the trading partners I want to...that I actually have patients going to actually have the electronic means to allow me to send something electronically to them to meet this requirement and perhaps having some way of providers being able to get some kind of exclusion or some kind of waiver based on that.

So, I suggest that we jump to slide 7 to talk about that specifically, because we did have some discussion about that last time and there are sort of beginnings of a recommendation here for that. Going back just for a second then to close out the previous one; I think Brian you did...I thought that was a very nice summary of where we are on that which is that if we all agree with the objective and the measure, we all agree that it would be good to have a higher measure because that would have a net positive impact and we're really just about, you know, sort of just trying to figure out where, is it like 40% or 50% that is more appropriate. So maybe between now and the next meeting we can get a little bit more data perhaps to help inform that specific question.

But this one on slide 7, which is two of three; measure one, send, two and three is not unrelated to the previous one because this is where we discuss this very question; providers who are willing and able to send care summaries to meet the measure shouldn't be penalized if there aren't enough recipients ready to catch care summaries. And it sounds like, just from the previous discussion here, we all agree with that in principle, the question is, how do we operationalize it?

So I know just listening to the recording, there were a number of different ideas that were batted around and Kory has, I think, tried to capture as much as we could, sort of one concrete or as much of a concrete sort of view towards this as he could. So let's just walk through this for a second.

So an EP or EH should be able to exclude a referral if the organization they're intending to send to does not have the capability to receive it electronically. The sender would attest to the accuracy of the inability of the other organization to receive it electronically. The sender could maintain documentation from the receiving, sorry from receive, demonstrating that they lack the capability to receive electronically. Somewhere along the way if we agree in general that this is an issue, if we agree that providers who are able to send shouldn't be penalized for the fact that they're in an ecosystem where a lot of the people who their patients are going to are unable to receive electronically, then how would we operationalize it?

It seems like it raises a number of different of, first off, how would this work from a workflow in just a documentation perspective? Is this unreasonable to expect that the senders could document this? Are there ways of perversely gaming the system; one could imagine many ways of doing that, which we have to have time limits as a dynamic situation. It seems like if we were going to say that, there would have to be some way of saying, well, if that intended recipient, who is a genuine recipient, I can attest that a number of patients from my system actually are going there, and they weren't able to electronically capture by half way through my attestation year or something, it seems like we would have to set some kind of time limit on it as well if we're going to try to operationalize this. Those are some immediate thoughts. What are people's thoughts on this?

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy e-Health Information Technology Collaborative

Yeah, this is Shelly Spiro and coming from representing providers who are mostly non-meaningful users or receiving the incentives for Meaningful Use, both pharmacists and pharmacies and the LTPAC HIT setting, part of the LTPAC HIT Collaborative. I'm going to have to say that number one, meaningful users are going to have to send the information. I'm still very concerned about a process measure to say, well I just sent it so I'm off the hook, and I don't have to do anything else. And because those who are not receiving the incentives or as Wes had said, he's in an area, especially a rural area that isn't able to make those connections that we all have a responsibility to find ways to make it work and to be interoperable.

And so one of the aspects is, I think we're so focused on meeting a threshold so that we can meet a process measure that we sent a transition of care document or ePrescribed or whatever and I think we're missing the point of the outcome of what that means to the patient and the care of our patient. And so I don't mind lowering a measure or a process measure...I mean, lowering a measure of expectation, as long as we focus on maybe clinical quality measures or outcome measures that are going to eventually help meet our patients' needs. Now I'm not sure I have a solution for that, but I think that that's a more important issue.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

This is John; can I make a comment Micky, to that?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes, please.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, okay, so I mean I agree with looking at outcome measures ultimately, or even concurrently, but when you start something new like this, I believe you really need to have process measures out of the gate to help move that along. And I would point out in the MU3 there is also a process measure on receipt and review, which is not there in MU2, and then I think there's also something in there about reconciliation. So it does expand that process...set of pro...it creates a set of process measures that go further. Anyway, that's my point.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, no, John, I would...I'm glad you raised that because I was going to mention that as well. But I do, I mean I agree, Shelly, that again that we do want to get to outcomes, we're just in a stage where it's hard to specify what those outcome measures would be, as you pointed out. But to John's point, there now with Meaningful Use Stage 3, there are other pieces so we shouldn't look at this in isolation. The fact that now you're going to have to be able to receive and you're going to have to do some information reconciliation as well; now it's not a 1:1 correspondence, it's not saying that every sender has to reconcile that what I sent is something that is received and reconciled for every single transaction. But I think if we sort of think about the thresholds here and the fact that it's attacking the problem from a different dimension, it seems like it significantly moves the ball forward towards something with more meanin...more, you know, look more like outcome measures.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy e-Health Information Technology Collaborative

Well then if you're going...yeah, this is Shelly. Then if you're going to promote or agree with process measures, then make them high. If you're not, and you want to get to more outcomes measures, which was the original intent of Meaningful Use Stage 3, then we need to start to outcomes measures to drive interoperability and use by those who are not receiving the incentives for Meaningful Use.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah Shelly, I think that...I agree with you, you need outcome measures in there and so I would not say process at the exclusion of outcomes, I'm just saying early days, when you bring something new in, process is helpful.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy e-Health Information Technology Collaborative

Then make that percentage high enough where it's going to drive it.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay. So I think on the previous one where we're actually talking about the percentage, you know, we're really, as we said, left with just saying either 50 or 40 or something like that or something in between, which is a significant jump from 10, which is where we are today. So on this point then, back to this one slide 7; Shelly I don't know if your comments related to this as well, which is, should there be some ability to allow providers to get some kind of relief from penalties if they're in an ecosystem where they just can't find enough electronic receivers to meet their now what's going to be 40% or 50%.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy e-Health Information Technology Collaborative

No, because that's the only thing that's going to drive the process are the penalties. If the penalties are in place, then they're going to find a solution to make it work. If they're not, and it's not high enough on a process measure, that's what I'm saying; if you're going to be stuck on these process measures and try to relieve the industry from the responsibility of patient care, then take away the process measure or make the process measures whatever you want but then put in a low outcomes measure to drive it is what I'm saying. By relieving the capability, you're not helping the adoption of those who are not receiving incentives.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, so...

Brian Ahier – Director of Standards and Government Affairs – Medicity

So, this is Brian...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

...just because it's a process measure doesn't mean it's not difficult. So in this case, there could be situations where it's just it's out of my control as a provider who is sending to be able to get enough of that ecosystem in this timeline in a position where they can electronically receive. They may not have the resources, right? And I think that's the issue here.

Brian Ahier – Director of Standards and Government Affairs – Medicity

Right, so this is Brian. I think that is the issue and what they're asking for are potential approaches so they give an example of one, which we may or may not support about excluding referrals from the denominator. Ultimately I think it is really the issue that they raise here is solved by focusing on how many are included in the denominator. If I can attest to, here are a bunch of transitions of care that occurred with this facility, I would love to send them information but they aren't capable of receiving it, and I can attest to that as a provider, then I should be able to exclude them from the denominator in calculating whether or not I meet the threshold.

Operationalizing that is, I think, what the issue is here not necessarily is it a good thing or, you know, really it's more how would we go about relieving that problem. And I think that simply just stating that organizations that are unable to receive should be excluded from the denominator.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, yeah, this is John again. Sorry to keep jumping in, but the...I mean, on this one I'm thinking about comments made on both sides. I'm struck by Carl's comment about not having you know, what happened with VDT go from 5 per...the 5% to one a year; so not setting it so high that you have to completely capitulate. So I'm sensitive to the comment about receivers, but then I also think about our experience with post-acute care and there has been, I'd say we've had several thousand post-acute care receiving applications where they're still on paper, but applications that can allow them to receive the C-CDA on discharge, and it was that 10% that the hospitals had to hit early days when they didn't have ambulatory receivers, you know, ambulatory providers that could receive that really pushed this in getting those post-acute care to get it.

So on one hand the idea of pushing this really did bring on many, many long-term care facilities. On the other hand, we don't want to have a full roll-back. So, I'm kind of caught in the middle on these arguments.

Brian Ahier – Director of Standards and Government Affairs – Medicity

Well, you know, the administrative...the burden of administratively excluding referrals and transitions from the denominator is probably about equal to helping those in the community to actually get connected.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So that's a good way to look at it.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

That's right, that's kind of what...just said.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So, just a quick question of clarification, because Kory, this is something that we came up with, right? This was not something that was in the rule...

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

That is correct.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

...sure on this. Right, so Brian this is your point.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, this is you guys proposal.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, so the language here, this came from us, just to be clear. There's nothing in the rule about any kind of exclusion for these. And I wonder though, if there is some way, because I think that there is sort of a both...there are two sides to this clearly and we don't want to undercut the motivation for the kinds of activities that John was talking about, which is...because we've seen that in the market that we're in as well that it did provide a lot of motivation for hospitals and those who are better resourced to be able to provide some type of technology for the receivers to be able to receive.

Is it...I wonder if there's a way of operationalizing this to say that you can...you could claim an exclusion if you can demonstrate that 80% of your market is not able to receive. So you set a different number for that, so you set the bar high for them to show that even if they tried to do that, they, you know, they can't be expected to try to electronically enable 80% of their market. And the denominator would have to be the real transitions that they have, so they'd have to be able to show that no, this is where my patients went and 80% of those settings did not have electronic capability. I'm just throwing a number out there; it's different than the...

Wes Rishel – Independent Consultant

I think that...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

...point...

Wes Rishel – Independent Consultant

This is Wes; it would be hard for...to launch a compliance period without knowing how the numbers were going to come out until the end. I think that you...one possibility is that something that is established on the day...some number that's established on the day the compliance period starts rather than anything else is some kind of exclusion that's established that way. But it's really asking people to take a lot of risk to say, well...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, that's...

Wes Rishel – Independent Consultant

(Indiscernible)

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

...that's the point. It would either have to be a snapshot taken at the beginning of the reporting period or you could set a time within the reporting period to say, if by one-quarter into your reporting period you take a snapshot and a high threshold, 80% whatever it is, are not electronically enabled, then I'm going to need an exclusion on...

Wes Rishel – Independent Consultant

Or you could use your referral pattern from the prior year.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy e-Health Information Technology Collaborative

Yeah, but this is Shelly; I'm going to have to disagree with this. And the reason I...and I'm looking at it from a provider standpoint that this is such an important piece of exchanging information at times of transition that if we can't solve this problem, it's going to have other effects. It's a slippery slope that we're going to have that are going to cause hospital readmissions, where other areas of the hospital are going to be hit, not necessarily in terms of Meaningful Use process, but more into value-based payment processes that they're going to be facing with. I mean, this includes for physicians' offices also.

So I think we have to be really, really careful with this one. This is such an important piece to the care of our patients; these are the critical points where we really need this health IT portion to work. And I'd be very, very careful about putting an excluded referral process in place at this point.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. And Shelly, I...and I agree with you and I guess that's why I'm suggesting a high threshold for that, for you're being able to do an exclusion. Because I guess I would just ask, I mean, there are going to be situations that...where I need to get to 50%, let's say it's 50%, I need to get to 50% and it is absolutely true that in my market 80% are not...80% of settings that would qualify for this are not electronically enabled. What do I do in that circumstance? I can try to do what John just mentioned, you know, try to buy them web portals based on some kind of HISP solution or something like that, but I may not be able to close that 30% gap.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

So of course, this is Chris, the devil's again in the details, right? What defines your market? You know, and that becomes critical in that 80% threshold. So you have to have a good definition for market before you can postulate such a threshold.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, I mean, it's where your patients go, right? So maybe it's Wes' suggestion that you look at the prior year or something like that.

Wes Rishel – Independent Consultant

Well, I want to be...I want to do a couple of things. One, I want to suggest that we really want to avoid a proposal that looks like it influences the choice of referral targets based on their electronic capability. I think we all think that that is a feature that people should take into account, but not in an unbalanced way when compared to, you know, closeness to the patient's family and other factors that are strong predictors of where referrals go. And second, I want to emphasize part of the starting, and this is a response to Shelly really, part of the starting premise of this discussion that we have now two rounds of experience with this program and we recognize that the argument that this particular thing must be done for the good of healthcare is...can lead to decisions that end up in rules that are undercut after they're issued through...at great cost to the credibility of the program.

So I think it's our obligation to find the right way to establish what is a stretch but what is not simply a statement of principle about what's important. But what is only a statement of principle about what's important.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah. Completely agree with you.

Wes Rishel – Independent Consultant

Thanks.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I think one way for us to think about this is we keep a high, like keep the 50% on the prior as a stretch goal and we consider some type of exclusion on this one, but keep the bar high in recognition of Shelly's point that we don't want to do this in a cavalier way. But we do want to give people the ability to have an exclusion in sort of in the cases where it really is extreme.

Wes Rishel – Independent Consultant

A potential friendly amendment, if you see it as friendly, is that we report back to the Policy Committee with two options; one a higher threshold without taking a stand on the issue of selfies...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah.

Wes Rishel – Independent Consultant

...and one a lower threshold with a recommendation to avoid selfies.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Oh, you want to throw the selfies in the mix, I thought we did away with selfies. I was suggesting a trade-off between, I thought you were going to say a trade-off between a higher threshold with no exclusion for this one that we're talking about here, with no exclusion for your ecosystem of receivers; or a lower threshold...no, a lower threshold with no exclusion or a higher threshold with some type of exclusion but the selfies...

Wes Rishel – Independent Consultant

Well, that wasn't what I was saying; that wasn't what I was saying...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Wes Rishel – Independent Consultant

But, so I'll...I just think these two issues are inter-related, you can't strike a number without considering whether you're going to also make a recommenda...do you...have we decided as a group not to address the selfies issue, is that correct?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I thought that we had a basic consensus that we should not allow the selfies to count, that's why...

Wes Rishel – Independent Consultant

Oh, in that case, if that's established, then I would surely not rec...I would recommend a lower threshold, but much higher than...still higher than what we have now in Stage 2.

Brian Ahier – Director of Standards and Government Affairs – Medicity

So this is Brian, just for a point of clarification, Micky, for those following along at home. Could we maybe define what we mean when we talk about selfies?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah. So the selfies would be that case where you are...where the recipient is a part of the same system. So the example would be hospital discharges a patient, the patient is a patient of a PCP who is actually a part of the same integrated delivery network, they could be on a different EHR, they could be on the same EHR, but the selfie was where I could send a Direct compliant message to them even though they had access to my EMR and that would count, even though I think we would all agree that from a care perspective, it probably didn't add anything and that's no longer...

Brian Ahier – Director of Standards and Government Affairs – Medicity

Right. Yup, thanks. And so that's, I think we're going to talk about that specific definition of referral and transition piece on slide 9.

Wes Rishel – Independent Consultant

Yes, I'm just suggesting that we can't close this topic until we have that discussion.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay.

Brian Ahier – Director of Standards and Government Affairs – Medicity

Right. So you're, Wes, I guess what I'm gaining from this is you're saying that by not...by limiting the selfies then this threshold becomes too high.

Wes Rishel – Independent Consultant

I think current complian...I think if we had any way to get data, we would probably find that selfies constitute a major portion of the compliance, purported compliance percentages. And in fact, I'm not...I don't see any reason from a policy point of view that we should be discouraging referrals to organizations that have the same EHR because I think that's good in a lot of ways.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, no, just to clarify. We're not, I mean, this doesn't discourage those; this just says you shouldn't be able to count those for your Meaningful Use...

Wes Rishel – Independent Consultant

Yeah, if you have to find another place to refer to in order to get into your numerator, then it does discourage.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Well, but you're taking it out of the numerator and the denominator, so...and just from a...

M

(Indiscernible)

Wes Rishel – Independent Consultant

If your selfies are 100%, if your selfies are 100% and your non-selfies are 5% and you take your selfies out of the numerator and the denominator, you're at 5%. I mean, it's...

Brian Ahier – Director of Standards and Government Affairs – Medicity

No, no, no, you don't have 5% anymore because you're taking all those selfies out, so it would only be 5...that 5% is now a smaller universe. So what I'm suggesting is that the universe, we shrink the universe of those that are applied to this threshold, not that I would discourage. And there may actually be a situation where a provider does not refer a single patient outside of...to a separate EHR and then they would have an exclusion.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

That is right, they'd be under a 100 and they'd have the exclusion. So let just, let me just make sure that we're all on the same page with what we've already established. So, with the selfies, the issue that was raised on the last call was that that seems to disproportionately advantage large systems who are able to take advantage of that because small systems couldn't take advantage of that and so excluding that from the numerator and the denominator seemed to make sense.

Then we had the conversation on this call about well, how big are the selfies anyway, because we looked at the data and said, well geez, if selfies are a big part of that, then maybe we need to adjust the threshold. Both from what John Blair and Brian and Carl had suggested, selfies were not a big part of the data; it was not a big part of the attestations. Now Carl has raised the point that that...it still may be that the thresholds too high and we want to be cautious about what the threshold is. But I just want to establish that we have, to the best of our ability on this call, established that selfies are probably not a big part of it, even though they were allowed.

Wes Rishel – Independent Consultant

I...okay, I did not hear that, maybe I just was misinterpreting what I heard. I want to just go back to the mathematics a minute and say that if an organization is referring 75% of its patients to itself and achieved 100% compliance for those 75% and 25% of its patients outside and achieved 2% compliance, that when you take the numbers out of the numerator and denominator, you don't end up with a high proportion on the revised numerator and denominators. It's just...that's just not mathematically correct to say that.

Carl Dvorak – President – EPIC Systems Corporation

I agree with your math, Wes.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yup.

Carl Dvorak – President – EPIC Systems Corporation

And Micky, I think...

Wes Rishel – Independent Consultant

And then the issue about there not being a lot of these, I didn't hear that, in fact, I thought I heard the opposite, but again, I'm subject to...

Carl Dvorak – President – EPIC Systems Corporation

We're uncertain. So many people took a hardship exemption on Stage 2 it's hard to know for sure what would have happened. We didn't see a ton of it, but the places that did it had, you know, it was a hop, skip and a jump; they didn't even worry about it because the volume was so much. And Micky, the classic selfie, if you're within a health system and you have two different EHRs and you do transmit the document, that wouldn't count as a selfie. The classic selfie case is you actually share a single instance of an EHR.

Wes Rishel – Independent Consultant

Yeah and...

Brian Ahier – Director of Standards and Government Affairs – Medicity

Right.

Carl Dvorak – President – EPIC Systems Corporation

And you send it, but no one ever looks at it, instead you just look at the record like you looked at it all the time anyways, because you have this one combined patient record.

Brian Ahier – Director of Standards and Government Affairs – Medicity

And it's not even useful to count those, I don't think, which was the point of it.

Wes Rishel – Independent Consultant

We all agree they should be excluded from the numerator and denominator, the only question is, how challenging does that make the threshold.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, this is John. I...again, what Carl said I think's correct is it's the hardship exemption that makes me wonder, but I can tell you in our experience, the hospitals did not do that when they were on a single system again for fear of having audit problems, even though there was a later clarification so, the numbers I gave before did not include that happening.

Wes Rishel – Independent Consultant

So I think John's data, which is that he's seeing, and please correct me if I misstate it, but through the use of Direct transmission of summaries of care, he's seeing compliance in various...in a collection of communities across the country at the level of 40%. Maybe the closest we have to actual useful data and is worth considering. The fact that that doesn't...that most of the hospitals didn't do what they ended up being allowed to do is news to me, but its positive news.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, and I would say I was over 30, I'm not going to say close to 40 and Brian, I don't know if you have any kind of numbers, but you might be able to make a comment too about that.

Brian Ahier – Director of Standards and Government Affairs – Medicity

Not...no, so just to maybe put a point or a cap on the issues Wes has raised. If we agree that we're going to exclude the selfies from the calculation for this measure, then 50%, and basically I think the numbers you're tracking exactly right, John, I mean we're talking 30-40%. And to Wes' earlier point, if 40% is not really achievable or 50% is not really achievable and then they have to backtrack two years from now, that just continues to undermine the credibility of the program. Maybe we could comfortably land on, and again, this would be perhaps by next week Micky gets more data, but I think comfortably landing on a 30% threshold recommendation would appropriate, as we're also at the same time recommending the removal of selfies.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, I would go higher, but again, I think we need more data.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So why don't we get a little more data. So I think there are two things coming out of this; one is that the selfies...so we need a little bit more data, I would point to the data that Kory has produced here and note that both from what John is reporting as well as from what Carl was generally reporting and knowing the numbers that a lot of these...the Stage 2 attestations are actually EPIC, I mean it's a large fraction, I'm not saying it's all of them but it's a large fraction.

So if from EPIC's perspective selfies weren't a big part of that, then it suggests that these numbers are fairly accurate as a national average, which is roughly consistent with what John is reporting. But I do agree that the large number of those who took hardship exemptions are the real fly in the ointment here, right? We don't know the number of people who self-declared themselves not ready to go to even to it. And we know there are a number of different motivations behind that, the fact that they were allowed to do it, you know, doesn't mean that they couldn't have done it, it means that they chose just to take advantage of the exemption. So I think getting a little more...

Brian Ahier – Director of Standards and Government Affairs – Medicity

Yeah and who's...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Sorry?

Brian Ahier – Director of Standards and Government Affairs – Medicity

Well I was going to say, you're right, we don't know what we don't know but I think this whole thing, I just want to say, really highlights for me the process that we're going through and the importance and the value of how the ONC has structured their federal advisory committees. So here we have the people that are actually saying, wait a minute, this would unfairly disadvantage large organizations or actually from the large organiza...or this would advantage large organizations and disadvantage the smaller players. It's just a...I think that this is a great kumbaya moment.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I think...and I it's a good point. I mean, all the things that we're talking about actually go in different directions, so there are some things that we're suggesting perhaps the bar is too high, but in some things we're suggesting, no, you shouldn't be able to take an exclusion for those things because it just seems unfair...to be unfair. So I think you're right on that mark, Brian.

So why don't we...we should come back for more data on this particular question. And the other thing that I think I've gotten from this, I know I've gotten from this is a little bit of what Wes is talking about...a framework that perhaps we should think about the end game here with an eye towards saying, okay, here are the considerations around the threshold number itself; however, there are a couple of dependencies here that could affect your sort of the view of what level of threshold you ought to have. One is whether selfies get included or not, so that would be one dimension of this to say, is it...in the trade-off between the actual numerical threshold and whether selfies count or not and what impact we...have on that.

The second dimension is the question of exclusion, right? And if you think that you ought to be excluding, you ought to allow an exclusion, then that can also be a trade-off with numerical threshold. You could say, no, I'm going to keep the threshold high, but allow exclusions in extreme cases where the ecosystem doesn't support it. Or I can lower the threshold, but the trade-off would be that I don't offer any exclusions.

Carl Dvorak – President – EPIC Systems Corporation

I like the lower threshold because it's attainable and you will actually encourage everyone to get started rather than walk away. Remember, if too many people walk away, then the rest are messed up.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yup. Yup.

Carl Dvorak – President – EPIC Systems Corporation

And the smaller threshold, I think, once somebody does it at all, I think that's the feedback from the HIE folks on the phone, right? If I'm connected, well then of course I do it, I can achieve a high number, I just pump it out. So I think we just need to get people going on it in a way that they feel can be realistic and then we'll see it explode because if I'm connected, why not?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. So are we in agreement then, actually it seems like this might be a magic moment here. Are we in agreement that we think the threshold should be lower than 50, we have...we'll get a little bit more data on the selfies question, but right now we'll say we think the threshold should be lower, selfies should not be allowed to count and we should not allow the exclusion for the ecosystem because we've sort of compensated for that by lowering the threshold.

Brian Ahier – Director of Standards and Government Affairs – Medicity

I'd agree.

M

Yeah, I'm okay with that.

Wes Rishel – Independent Consultant

I'm...I guess I...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Come on work with me here, work with me here.

Wes Rishel – Independent Consultant

Yeah I know, I know, I know, but I'm now representing my local district here. Uh,

Brian Ahier – Director of Standards and Government Affairs – Medicity

Well Wes has a rooster, so...

Wes Rishel – Independent Consultant

I'll pass for now and let you guys agree.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy e-Health Information Technology Collaborative

This is Shelly, I'm...I'll agree for the sake of moving on, but I still want to go on the record as saying, I disagree, I think the threshold should remain high.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I don't want to railroad anyone, so why don't we...we can articulate this and then look at it again next time, I say that with great caution, but at least just to be able to point out that we've considered a number of trade-offs here and some things that actually have lowered the bar in a general cosmic sense...uber sense. And some of the things that would have raised the bar and I think that we've had the discussion about those trade-offs and if that means that overall it means lowering the threshold, with the caveats that we're all noting, maybe that's something we can all sort of get our arms around.

Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University

Hi there, it's Melissa.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yup.

Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University

I have been lurking in the background and I have to say that Wes' rooster is talking to me, I grew up in Alabama and although I don't have any roosters right now, I'm sort of sensitive to that crowd as well.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, this is John again and I'm okay with what you said, Micky and I think maybe the caveat is then, and we'll confirm with some more data on the threshold number, but we probab...we have oh maybe, I don't know somewhere between 50 and 100 hospitals in small areas and they've really used that receiving application in long-term care facilities to hit their numbers. So Wes, that, you know, if you have any post-acute care in your area, the hospitals are doing it that way.

Wes Rishel – Independent Consultant

Yeah and on that...that may very well be and I think Direct is a factor that is...takes more timely data, that is, that you really have to be pretty current to know what's going on there. I will say that right now we know that the non-home discharge targets, we have 0% ability to receive that information and 0% electronic medical records in those facilities. So the...one of the advantages of Direct from our point of view is that you can't just send it off into the Cloud, you have to find a receiver.

Carl Dvorak – President – EPIC Systems Corporation

Um hmm.

Wes Rishel – Independent Consultant

And it would take community work and I would be all for a threshold that was low enough to seem realizable to cause better cooperation across that schism. I am concerned, as Carl has said that a number like 50% would cause us just to throw up our hands and our breakfast as well.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Carl Dvorak – President – EPIC Systems Corporation

Question for Kory, maybe; my impression of reading the material so far on Meaningful Use and certification is that even though this is put forward as Meaningful Use Stage final, they did reserve the right to increase the threshold percentages in coming years? So if we pick a lower number now, that number could actually be increased without a Meaningful Use Stage 4, but it could be increased by CMS over some time? Is that correct?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

So yes, this was in the follow up email that went out on Tuesday. So from the NPRM they do state that they would consider increasing the thresholds in the future.

Brian Ahier – Director of Standards and Government Affairs – Medicity

And I think that's such an important point...this is Brian; because what we, you know, the thresholds are important for what Stage 3 is as a floor, but what's really important in my mind is that we get the measure right and that...because the threshold may get raised over time, but we want to have a very useful metric that that threshold is measuring.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yup. Okay. All right, so why don't we try to cap...I think we can capture this, there's actually, I think, the...we're very close, I think, to a point of agreement on what all the various trade-offs are here, how that might affect the thresholds and what we might say about sort of an actual threshold within a certain range. So maybe we can just document that and we can talk about it again next time to make sure that we've captured all people's concerns as well as sort of the idea of these trade-offs being important.

So I know we're going to be running very short on time here in a second, so maybe one thing we should do is just look at the next slide, which is slide 8, which is measure 1 (3 of 3), because a couple of these I think we can dispose of pretty quickly. On slide 8 there were two points; one was the...let's look at the second one first, because I think that's a pretty easy one and this was a suggestion to remove the exclusion for EPs and EHs that conduct 50% or more of their patient encounters in a county that doesn't have 50% or more housing units. I think that it was Carl who had raised, which I think, you know, which I agree with, that this was an exclusion that was really build originally for the VDT looking at the retail consumer market and it's probably not an appropriate exclusion when we're thinking about the provider side of this. So, does anyone disagree with that?

Brian Ahier – Director of Standards and Government Affairs – Medicity

I agree.

Wes Rishel – Independent Consultant

Yes.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay and Wes, representing the rural community, you agree with that?

Wes Rishel – Independent Consultant

My rooster is silent.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Excellent. Okay, so number two we agree with. Number one, there was a discussion as I recall from the recording about the C-CDA and whether the C-CDA...whether we ought to open up the content requirements on this. And I think that, from what I got from this, this discussion was almost like a general thought of whether to the extent that the rule allows for an API approach, only on the patient side of it; do we want to suggest that that ought to be parallel on the provider side? If there is an API approach, then it ought to be allowed. And maybe that takes care of this first bullet, unless I'm misunderstanding that conversation.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

So how does it, Micky, how does an API work for a send?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, that's a good point. Well there is...I mean you could...

Wes Rishel – Independent Consultant

There's no problem creating APIs for sends...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right...

Wes Rishel – Independent Consultant

...does it a lot. The question is, do we have something that's visible as a regulatory target for an API for a send and I think that the...in general, the thinking right now is let's give enough room in the regulation for ONC to make decisions at the last minute about the viability of something like FHIR or SMART or something like that as opposed to nail them down in...directly in the final rule.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

I guess I don't mean how does an API be on the send, I'm just trying to think of how you deal with all the security issues on the send side.

Wes Rishel – Independent Consultant

Almost the same way you do...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

You know, what do you do...API.

Wes Rishel – Independent Consultant

I mean we've been sending data for a long time, I mean, we have agreements, we have information sharing arrangements, we do all those things. I would say that...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

But not at scale, but not at scale.

Carl Dvorak – President – EPIC Systems Corporation

This is Carl; I just want to comment on this. I've watched this process for gosh, 5-6 years, however long it's been and one of our major problems is we lose focus and we miss the opportunity to do the basic wonderful thing that would make a huge difference if done universally. I'd rather that we maintain focus on this one and put our energy behind this document exchange infrastructure because it holds the promise for a great long-term future. There will be other things and there will be reasons to use APIs, but this isn't the best use of that. I think let's let that go down its own path on a separate channel, but let's force the world to get the healthcare ATM up and running; get a single document that everyone understands and can interpret accurately. And I know it will be clubby for some at first, but boy, it can sure be elegant when done reasonably well; so I suggest we just...

Wes Rishel – Independent Consultant

Carl, do you think vendors would compete based on the quality of the documents they produce? Right now I think competition has been to have a document or not have a document and frankly...

Carl Dvorak – President – EPIC Systems Corporation

Yeah.

Wes Rishel – Independent Consultant

...the competition tends to focus on meeting criteria and thresholds.

Carl Dvorak – President – EPIC Systems Corporation

Well yes and no, I...

Wes Rishel – Independent Consultant

You think there's a chance of natural improvement in the quality of the documents that are coming out?

Carl Dvorak – President – EPIC Systems Corporation

Oh God yes, God yes, God yes. What's happened though is so many things are thrown at so many people so fast and ONC will say it's 2000 hours to do Stage 2 but I've got to tell you, we're 60-70,000 hours into it. These things...I mean, people have ramrodded a bunch of stuff through regulation and vendors have had to scurry like the dickens, I feel bad for smaller vendors who don't have as many R&D programmers. But I do think that some will share and I do think people will compete. I think you're going to see it be the anchor point for ACOs; it's the single universal ATM transaction and my God, could it be powerful and it will grow.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, and I would say they're already starting to compete, already starting to compete on this.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. So far I have suggestions around a more constrained C-CDA, which is already...in the works in a variety of places would answer this. So why don't we on this one, why don't we circle back. I think it was Arien, if I'm not mistaken, who had raised this and I wasn't suggesting...the only reason I was throwing out the API approach was just to sort of say, well someone was talking about having a better way to do more granular data level exchange as a possible substitute. If we think that the Consolidated CDA will meet those needs, then they're not going to just dispose of that whole...

Carl Dvorak – President – EPIC Systems Corporation

Yeah.

Wes Rishel – Independent Consultant

Yeah.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

...consideration.

Carl Dvorak – President – EPIC Systems Corporation

And you know, one day the C-CDA might have some sort of URL reference that can be presented to a clinician to link back with a pre-authorized single sign on and you just pop open the chart, wherever it may be in the universe. But I think you can accommodate that through the C-CDA and rather than wander off after every squirrel that walks by or rooster that crows, I think we just focus on get the health...and operational.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay. I mean, we're going to have to stop here and ask for public comment. So why don't we...so we'll try to...we'll document some of what was just talked about here and I think we're going to have to...we'll have to regroup and we're probably going to have to do a little bit more offline in order to meet our timeline and with the meetings that we have scheduled, but, we'll get back to you on that. So, let me turn this over to Michelle for the public comment.

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

Lonnie, can you please open the lines?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute

Yes, sure. 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. If you are on the telephone and would like to make a public comment, please press *1 at this time.

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

We do have a public comment. As a reminder to our public commenter, public comments are limited to 3 minutes. David Tao, please go ahead.

David Tao, MS, DSc – Technical Advisor – ICSA Labs

Hi, thanks for the opportunity to comment. I just wanted to chime in on the very last subject you were discussing about the API versus the document send and I think that I sort of like where you ended up, but I just wanted to add that I think the problem is not whether it's an API versus a document, I think the problem is let's say it was an API FHIR type push, the question still remains, what would they push? They are supposed to push the common clinical data set and the current challenges are that people are putting too much data in within probably within categories of the common clinical data set; for instance, too many results, too many vital signs, irrele...inactive problems and things like that and that the systems are just auto-generating these things without perhaps the degree of clinical discretion that could be applied to make it more relevant and slimmed down.

There has already been guidance that C-CDA should have that clinical judgment applied, but it hasn't been universally followed and I think some of the constraining C-CDA work that's going on now will try to do that same thing. So unless that work is done, which is really more of content selection type of process which would apply equally to FHIR versus C-CDA, I don't think the API versus document is the issue at all or the technical mechanism for how it's sent. It's more how can you get that selection process in to make whatever the content is relevant without it being burdensome to the clinician to have to spend a lot more time doing it. So, just wanted to add that comment; thank you.

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

Thank you, David.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Thank you David, that was very helpful.

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

And it doesn't look like we have any other public comment, so thank you everyone. As Micky said, we'll be in touch with next steps and good luck Micky at NYU.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Thanks. Thanks everyone.

Carl Dvorak – President – EPIC Systems Corporation

Have fun Micky, bye, bye.

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

Have a nice weekend.

Public Comment Received During the Meeting

1. Wow. Dialed in from the UK after seeing a link in a tweet. I had no idea what an industry Meaningful Use had become. Deja vu! This reminds me of our very top down and centrally driven National Program for IT, which failed. Dr. Joe McDonald (UK)