

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
March 15, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning, everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call, and there is time for public comment built into the end of the agenda, and the call is also being transcribed and recorded, so please make sure you identify yourself when speaking. I'll now take roll. Paul Tang?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Christine. Neil Calman?

Neil Calman – The Institute for Family Health

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Neil. Art Davidson?

Art Davidson – Denver Public Health Department

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Art. Marty Fattig? Leslie Kelly Hall? David Lansky? Deven McGraw? Marc Overhage? Charlene Underwood?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Amy Zimmerman? Tim Cromwell? Joe Francis?

Joe Francis – Veterans Health Administration

Joe is here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Joe. Yael Harris? Greg Pace? Robert Tagalicod? And any ONC staff members that are on the line?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay. With that, I'll turn the agenda back over to you, Paul.

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

Great. Thanks, MacKenzie. And I know Deven is going to join about an hour into it. Thank you all for participating in this call, and also for the subgroup calls that have been going on in both the consolidation and the deeming work subgroup. I think this is really an exciting time. I think we're making a transition, and I believe both this consolidation and the deeming efforts are finding it – are making progress and finding it to be sensible and logical, so I look forward to the report outs.

We're breaking this call into two parts. One, we'll have an hour, approximately an hour, to dedicated to going over what the consolidation subgroup has come up with in terms of collapsing or subsuming some of the objectives under others, and then we'll report on the deeming subgroup, looking at use of CQMs, clinical quality measures, and performance on those as a way of deeming your fulfillment, really, of use of the EHR meaningfully.

We'll break for lunch, at least for the East Coasters, and then come back and continue, either pick up some unfinished business or go on into the deeming. So the consolidation subgroup has had a couple of meetings, and I think they're completed with their recommendations, and we'll tweak that as we discuss it. And the deeming subgroup, if you like the work we're doing, we'll continue into some of the details, like what quality measures goes in which package, to get you deemed for what functionality. And we'll conclude with public comment.

And the goal of this – the output of our discussion today goes to the full Policy Committee on April the 3rd, where we'll present this really new approach to the meaningful use Stage 3, and see if they agree with us. And if they do, then we'll finish our detailed work and come back to them after putting in all of the criteria, the proposed criteria that we put out in our RFP, taking into account the responses we got, and then fit them into the new schema. So that's the plan.

As you all know, Marilyn Tavenner said there would be no more rules issued in 2013, so that we would – we would start understanding how Stage 2 is playing out. And so that gives us another two to three months from our original timetable – we were originally going to present our final recommendations from the HIT Policy Committee to ONC and CMS in May, and so we'll delay that until about August, possibly September. So that'll give us enough time to do a thoughtful job at both this new approach, as well as folding in all of the previous work into it. Any questions or comments about that? Good. So why don't I turn it over – George, anything?

George Hripcsak – Columbia University

No, that's good, Paul. Thanks.

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

Okay. Let me turn it over to Christine, who led the consolidation subgroup, and to present their thoughts on that.

Christine Bechtel – National Partnership for Women & Families

Great. So actually, do you want to – well, we've already gone through the agenda here, so I'm just clicking through. Okay. So first, let me say an enormous thank you to those of you who participated in these discussions. They were very intensive and sapping of brain energy, shall we say? And also to Steve Waldren, who we leaned on as an external resource and help. So thank you guys very, very much.

So I'm going to just start with some background on the approach that we used to this work. So as you know, Stage 3 had 39 measures proposed, and Paul did a good job of sort of framing the fact that Stage 3 is a little bit different. So we're four years into meaningful use, so people have been using a lot of these capabilities for at least four years. This also for many will be the final incentive payment year, for those early adopters, so we want to continue, you know, to make sure people are in the program. And because of those factors, there are probably some basic tasks that really should be advanced. So pretty much anything that's a recording objective, we need to figure how to get the data in use so that we don't ask people to just sort of continue checking the recording box, if you will. So, you know, the – looking at more advanced uses, like decision support or sharing data, would be good on that.

So we made a couple of assumptions here. One is that the full workgroup will consider public comments on the RFC and make changes to those criteria at a later date, but that was not part of our scope. We did come up with some items and things that we thought the group should consider. We've collected those in a separate parking lot, if you will. But – and we'll bring those later. But for the most part, we did not – we have – you know, we weren't looking at public comments as we went through this, so the criteria are exactly the same as those that the Policy Committee put out in the RFC.

So the second assumption we made is that all of the criteria would continue to be part of certification, so that anything that we might say, okay, we could retire that, we assume that the electronic health records will continue to be able to do those things or collect those data in a standardized way regardless. And so we really wanted to focus on what is it that needs to be used as opposed to what is it that just moves into certification only, but providers are not asked to attest and demonstrate against them. So that was what got us to the sort of certification only versus certification and use.

So at the end of the, duh duh duh, we were able to suggest that 13 objectives get advanced, bringing the total from 39 down to 26. There were probably at one point 15 or 16 that we'd identified, but there were some challenges in some of them, where we felt like, okay, we'd better keep those separate. And we will talk about a number of those today.

So what I'm going to do on the next couple of slides is give you guys a look, with some detail, but not a ton, at some of those areas where we're suggesting things either move to certification only, or they move into another category where the data would get used there, and therefore, you don't need to have a separate requirement. Then we'll switch to the spreadsheet that you all received in your email, and you should use the email from this morning. And then we'll go more specifically into those changes. So that way, it won't be the first time you're hearing it when you look at the spreadsheet. It'll be the second time.

All right. So in the first bucket of quality, safety, efficiency, and reducing health disparities, as you know, there were 17 objectives that were proposed in the RFC. So we have suggested that two of those, vitals and smoking status, move to certification only, and that smoking status is covered by CQMs, for example, but also that CPOE, advanced directives, and family health history could move into a couple of places. One would be the care summary, the transition of care summary. That's provider to provider. And then also CPOE, at least with respect to labs, etcetera, it could go into view/download/transmit, ePrescribing, things like that. It's required in other places, so it doesn't need to be required here. So our proposal is to consolidate these items into 11 objectives.

So in the second bucket of engaging patients and family, there were eight objectives proposed in the RFC. We're suggesting that two of them, communication preferences and clinical trials, actually move to certification only. Communication preferences would be built into a couple of the other areas, like – that are patient-facing communication, like patient education materials or the visit summary. So they'll be used, and therefore you don't have to collect them – you need to collect them, but not as an independent objective. Okay?

So the – in improving care coordination, you can see that seven objectives were proposed in the RFC, and we're suggesting that two of them, interdisciplinary problem list and the ability to retrieve med history, really get consolidated into a broader reconciliation area. So right now in care coordination, that's – that reconciliation is actually med – specific to medication reconciliation. But if the criteria were broadened a little bit further to, you know, more of a chart reconciliation, then you could put the problem list, interdisciplinary problem list, into the reconciliation category.

For population and public health, it's more of a consolidation, particularly of the registry requirements. So the registry one and two would obviously get moved – you know, grouped together, as would electronic lab reporting and syndromic surveillance. The only thing that I think we're suggesting that's perhaps really notable is that the CDS – the clinical decision support for immunization gets actually merged with the CDS criteria.

So at the end of the day, this is essentially what it would look like. We can thank Michelle Nelson for her brilliance in putting this lovely chart together. So we will I think now go ahead – I'm happy to take some – there we go – general questions, but otherwise, we can flip into the spreadsheet itself. And I would imagine that the Altarum folks – Michelle, are you going to navigate us through that? Instead of like me sharing my –

Michelle Consolazio Nelson – Office of the National Coordinator

I'm hoping Altarum can do it.

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

So just to – as we look at this colorful diagram, to help decode the color, so let's say under improving care coordination, the red transfer of care summary now has the implicit functionality of those blue things inside of it. Is that what it's saying?

Christine Bechtel – National Partnership for Women & Families

Yes. Yeah. Right, Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes. So the blue things were originally in the quality, safety, reducing health disparities category, and those are all – will be encompassed within the transition of care.

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

Okay. Now I see the color coding. Okay.

George Hripcsak – Columbia University

Wait a minute. Where is –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

George, it's hard to hear you.

George Hripcsak – Columbia University

Sorry. Where is imaging? I'm looking for it.

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

It's under the care coordination.

George Hripcsak – Columbia University

Ah, okay.

[Crosstalk]

Michelle Consolazio Nelson – Office of the National Coordinator

And that is an item that we're going to talk about in a little bit more detail.

George Hripcsak – Columbia University

Because really, CPOE rad went into imaging, and then imaging went into transfer of care. I see what happened.

Michelle Consolazio Nelson – Office of the National Coordinator

Possibly. We're going to – that's one a – more of a discussion item for today.

George Hripcsak – Columbia University

And then –

Christine Bechtel – National Partnership for Women & Families

Yeah. So there are, as Michelle is alluding to, there are about five specific things that we want to highlight, where we have questions, or the group was unsure, and we want to talk about those. And so we could definitely be making some different decisions on those, and that's going to be advanced directives, imaging, electronic notes, closing the referral loop, and then some of the public health items.

And then I think we have some work to do post – after today's discussion to look at the – look at the care summary overall and make sure that it's not getting too overloaded, and/or if it is, asking the question about how we might make it customizable at the care level, so that clinicians have the ability to really show the data that's most important. So we – that's another discussion item.

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

So are you going to be going through each of these –

Christine Bechtel – National Partnership for Women & Families

Yep.

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

– one by one? At least the ones that you're consolidating?

Christine Bechtel – National Partnership for Women & Families

Yes.

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

Okay.

George Hripcsak – Columbia University

Great. Let's do it.

Christine Bechtel – National Partnership for Women & Families

Okay. So somebody at Altarum can share the spreadsheet online. Otherwise, everybody on the workgroup, you guys have it in your email, and you can – you can open it up, that would be great. Okay. So in the first – so first of all, what you're looking at in terms of the spreadsheet is kind of a shortened version of it, all right? So what we did to be able to navigate it was we used the ID number, we created a short name so that, you know, we didn't have to read a bunch of text to figure out what it was. We also have in the third column for your convenience what the difference was between Stage 2 and Stage 3, because that would tell us a lot about how long and in what ways providers had been using this particular criteria. So that's column C.

And then what you'll see in the remaining two are what we're suggesting in terms of here are the options for advancement, and then some of the rationale as to why, okay? So that's the basic navigation here.

So the first one, CPOE, meds, labs, and radiology, the suggestion of the subgroup was to integrate it for medications into ePrescribing, but also to consolidate radiology in light of the subgroup 118 and 122 for labs. And then we can also require that the care plan for transitions of care include structured orders for meds, labs, and radiology.

So what I'll do is just sort of pause and, you know, make – ask if there's any comments, and then we'll only hit on the ones where we're proposing some sort of change like this. So any comments on that?

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

Yeah. This is Paul. I think I understand the logic of where you're going. So if you're going to be transmitting a prescription electronically, well, gosh, it's in structured form and it got there because of CPOE, as an example.

Christine Bechtel – National Partnership for Women & Families

Yep.

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

And that makes sense on the one hand of – with that logic. The – I wonder if turning it around is a bit – and so here's where I'm going. We said really the EHR does a number of major things, like one is get it all into readable format, some of which is in structured form, so that we can influence the ordering choices as they are being made. And so that is through CPOE with the support of clinical decision support.

So in some sense, I'm a little – so I feel a little regret that we use CPO – you know, the major thrust of EHRs. So I'm trying to think, is there a way to do the opposite? So if you kept CPOE, because – just because it is such a standout in the way that it affects decisions, then eRx, you would almost say, once you – by the way, we should have made the – reminded ourselves of what we saw yesterday, which was once people touch a functionality, they blow way past the threshold, even in 2013, as it turns out. So they don't stop at 10 percent, they don't stop at 30, they don't even stop at 50. They're up there in the 80s and 90 percent.

So once they do eRx, which requires an interface, it's not likely that they'll turn the thing off. So you might almost – do you see where I'm going?

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

If that becomes one of those things that are – they're just not going to turn off, and we allow CPOE to stay front and center, that allows the importance to be visible.

Christine Bechtel – National Partnership for Women & Families

So I guess, Paul, and, you know, the clinicians on the group should chime in here, but our assumption was that we were not going to keep doing things just for visibility, since they've been done for four years. So what – the data we looked at, and you can see it in the rationale column, is that in Stage 1 already 70 percent of EPs are entering more than 70 percent of permissible orders.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

So do you really need to keep making people measure and attest to it in – by Stage 3, when it's already continued in Stage 2? And then for ePrescribing, because, remember, you have the ePrescribing program separate, and been happening longer than meaningful use. I mean, it's off the charts in terms of performance on these. So, you know, we really stayed – we really took a pretty hard line on things like this, where we felt like, well, if they've been doing it for years, and if you – if you have the care plan include the structured order for meds, labs, and radiology, then you've got to enter it. So do you really – you know, you've got to use CPOE. It's going to continue in certification. Do you really need to require them to prove that they're doing it?

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

Mm-hmm. Yeah.

[Crosstalk]

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

We're actually folding into eRx, though?

Christine Bechtel – National Partnership for Women & Families

Well, that's part of it, and George can help me here as well. But it's kind of coming into multiple places, and I think the assumption was that when you're doing ePrescribing and formulary checking, you would have to have the order in in order to do the ePrescribing and formulary checking. But again, I'm not a clinician, so George, you should speak up if I'm mischaracterizing the discussion.

George Hripcsak – Columbia University

There's two forms of folding in. One is that it's implicit. The other is we just create a merger of the two objectives, right? You know, we can look at this consolidation – sometimes you don't need the other objective anymore. You just assume it must be happening. It's almost like a form of mini-deeming.

And the other is we just start – create an objective which is bigger. So in this case, what we would be doing is splitting CPOE according to the three data types, and maybe eRx can handle the whole thing and you don't need to put CPOE into the eRx, just assume it's happening.

Neil Calman – The Institute for Family Health

This is Neil. There's also like another spillover, I think, which makes this the right move, and that is that once you're at this level, sort of advanced functionality generally, it's hard to imagine that you're going to be – even if you didn't have anything, it's hard to imagine that you would be doing all of these other functions and not doing CPOE. You know, it's just like such a core function.

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

Okay. So you would end up with eRx and care plan?

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

So this gets folded into that. Yeah.

Christine Bechtel – National Partnership for Women & Families

Well, but also 122 and 118, so 118 is image results and 122 is test follow-up. So if there's – if 122 is there, test follow-up, then, you know, right, that would – that's the more implicit, you know, type of consolidation that George just described, I think. And same with image results.

George Hripcsak – Columbia University

Like – so now image results, now I see image results is now in VDT, so I'm not sure about that. But originally, my idea was we could make image results that actually say you have to link it back to the order, which implies you have to have order entry. So that's how I took care of radiology. And then for lab it's the same thing. If we're going to link it to structured results, then we must have orders.

Christine Bechtel – National Partnership for Women & Families

And I'm not sure it's the right answer to put image results – to – if – I think what you referenced about putting it in VDT, I think that's something we should talk about, but I'm not sure it's the right answer to then eliminate image results as a standalone. That's one of the things on our list.

George Hripcsak – Columbia University

Okay.

Christine Bechtel – National Partnership for Women & Families

So we should – you know, we could decide that no, we want to leave that as a standalone, and we want to put it in VDT, but I'm not sure that putting it only in VDT is what we want.

Art Davidson – Denver Public Health Department

Christine, this is Art. Is it in VDT or in transition of care?

Christine Bechtel – National Partnership for Women & Families

Image results?

George Hripcsak – Columbia University

I'm sorry. Transition of care. I said it wrong.

[Crosstalk]

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

No, it's actually – it was – in the picture it was wrong. It's – you are right. It's VDT.

George Hripcsak – Columbia University

It is VDT. That's what I –

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

Yes.

George Hripcsak – Columbia University

Okay. That makes –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

But if somebody sees another way to consolidate – part of what we do want to do here is like if you've got a good idea for consolidating with something else, we can do that. You know, that's what we want to talk about.

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

So even though, you know, we have structured lab and image results, it doesn't mean it couldn't – the order couldn't have come on paper. But I think – I think the way I'm – the reason I'm using to help justify this is if you got through Stage 1 and 2, you already got this stuff going in.

Christine Bechtel – National Partnership for Women & Families

Yep.

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

And that's the main thing. So we're not saying you cannot do the thing that subsumes – we're not saying that if you have image results, that means you had CPOE for imaging, but because you had it in Stage 2, that means you have CPOE for imaging. More like that.

Christine Bechtel – National Partnership for Women & Families

Right. And – that's right, and because it'll continue to be a certification criteria.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

So the system is going to be capable of doing it, and you've been doing it for four years –

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

– and you've been doing it for 70 percent of your orders.

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

Right. Right.

Christine Bechtel – National Partnership for Women & Families

We're going to assume that's going to keep going.

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

Okay. So that's sort of the major thrust of this. Okay.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

Other comments, questions about this one?

Art Davidson – Denver Public Health Department

So in image results, are we talking about the – an image, or the report?

Christine Bechtel – National Partnership for Women & Families

Well, we can – why don't we wait until we get to image results?

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

Yeah. Because that – I'm a little concerned about that one, too.

Christine Bechtel – National Partnership for Women & Families

Yeah. And that's –

[Crosstalk]

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

It's not linked to an order because of all the fragmentation and all that.

Christine Bechtel – National Partnership for Women & Families

Yeah. And that is one where – that's on the high priority list to talk about today, where there's – you could go a couple of different ways, and we want to have a discussion as a group. So any more on that? Okay. So the next one is CPOE referrals.

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

Right.

Christine Bechtel – National Partnership for Women & Families

And that was new or is new in Stage 3. And the group's thought was to consolidate that by requiring it in the transition of care summary. So if you'll recall, one of the things you want to keep in mind that we did during the – as you're thinking about this is that, you know, is the thresholds, for example. So if – I think the idea here was, look, if we're talking about referrals, then, you know, putting it in the transition of care summary means that you wouldn't have to independently measure it, but you're still going to have to do it. So this is more of a merger, where you're still – where we expect that if they're doing care summaries for 50 percent of their transitions, or 65, I forget what the threshold is, and 10 percent or whatever it is is electronic, then referrals would get covered. So thoughts on that?

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

This is Charlene. So the use case was in this one that you could request a referral, and by doing that, treating it like an order, you would – and again, this could be implicit, so I can get the argument. Then you could track whether you had an outstanding referral, because we were trying from care coordination to do three functions: communicate, track, and reconcile.

So we would know the order had gone out, and then based on to whom we went the referral to, there can be specific information we have to send in that order to be able to complete the referral. And then closing the loop, and we understand that, you know, we kind of closed the loop in when we got the report back. So it was having that kind of infrastructure in place, knowing that about 25 percent of the referrals never happen, right?

So I just want to – I mean, because we can assume that to get it – to get it onto the transition of care summary, there had to be that request for the order that happened, and they can track – is that kind of what the thought process is?

Christine Bechtel – National Partnership for Women & Families

I think that's right, because the care summary would be provided for 65 percent of transitions of care and referrals. I just looked it up, and it's 30 percent get transmitted electronically. So –

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

Right. Right.

Christine Bechtel – National Partnership for Women & Families

– if you're doing it for 65 percent of all of your transition of care and referrals, and if we've learned anything about thresholds, it's that people far exceed them –

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

Right.

Christine Bechtel – National Partnership for Women & Families

– so that was the idea, that at least the referral order would still be – the integrity of that would still be maintained if it was in transition of care. George, correct me if I'm wrong.

George Hripcsak – Columbia University

Yeah. We thought we could move it over but still do it.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle. I'd also – Christine and I had another conversation, which we'll get to later, but for 305, which is kind of working towards closing the referral loop, you'd have to have the order to close the loop. So in some ways, you could say that it's getting integrated into both transitions of care and the closing of the referral loop, which is 305, because those are a little bit – taking it to the next level, if you will.

Christine Bechtel – National Partnership for Women & Families

Yep. And I – right. And I think that one probably needs to stay as a standalone, but we'll get to that. So everybody okay with that, or want to suggest something different, or want to say no, don't do it?

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

So CPOE for referrals is new in Stage 3, right?

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

Right.

Christine Bechtel – National Partnership for Women & Families

Yep. Right.

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

So if it's going to be subsumed – you're just thinking you have to have ordered it – you have to have – in order to track it, you have to have ordered it electronically.

Christine Bechtel – National Partnership for Women & Families

That's what we describe. Yes.

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

Okay. Okay.

Christine Bechtel – National Partnership for Women & Families

Would you agree?

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

Yeah. Only our – you said we only had to do 30 percent of those electronically, right?

Christine Bechtel – National Partnership for Women & Families

The transmission of the summary is – yes, but you have to –

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

Enter all of – yeah. Sixty-five –

Christine Bechtel – National Partnership for Women & Families

Yeah, it's 65 – you have to still send the summary somehow for 65 percent. It's just you might be faxing.

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

So when you do this kind of subsumption, how do you – what do you do to the thresholds? Or do they – yeah, how do you handle –

Christine Bechtel – National Partnership for Women & Families

Well, yeah, that's a really good question. So the threshold – the rule that we used was that the threshold of the criteria that is kind of taking it over would be then the governing threshold, because otherwise, if you just say – and we'll get to this in advanced directives. If you say, well, you know, we want to put this here, but we want to have a separate threshold, then the provider still has to track two different things, and still has to essentially attest to two different things. So that's really not consolidation. That's moving stuff around on a table.

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

Right. Right.

Christine Bechtel – National Partnership for Women & Families

So we really – but there are a couple of areas where we struggled with that, and you'll see those. But for the most part, if you – the rule was if you move it, the threshold of the place you're moving it to becomes the de facto threshold for the objective you're talking about.

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

So then you have to either track or close the loop on 30 – at least 30 percent?

Christine Bechtel – National Partnership for Women & Families

Yeah. Well –

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

Because that was the minimum number of electronically transmitted?

Christine Bechtel – National Partnership for Women & Families

Well, let's not do the loop thing yet, because I think we have to get there. But this is – for referrals, you've got to do – you would have to do CPOE on referrals for basically 65 percent of your referrals or transitions, because that's what the threshold is of the care summary.

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

Okay.

Art Davidson – Denver Public Health Department

So Christine, I'm looking at the 303 –

Christine Bechtel – National Partnership for Women & Families

Yep.

Art Davidson – Denver Public Health Department

– column D, options for advancement. The bottom line there, it says care summary should always contain an up to date medication problem list, etcetera. Are the pending referrals included in this wording?

Christine Bechtel – National Partnership for Women & Families

Are you on one of the tabs, Art, or are you down in the same simplification tab?

Art Davidson – Denver Public Health Department

I'm in the simplification one.

Christine Bechtel – National Partnership for Women & Families

Okay.

Art Davidson – Denver Public Health Department

I'm sorry. I can't read it well on your – the screen's too small here for me to – I have to open up that –

Christine Bechtel – National Partnership for Women & Families

Yeah.

Art Davidson – Denver Public Health Department

So I think it's line 35D.

Christine Bechtel – National Partnership for Women & Families

Yep. And in column D?

Art Davidson – Denver Public Health Department

D.

Christine Bechtel – National Partnership for Women & Families

Okay. So what's your –

Art Davidson – Denver Public Health Department

And the question is, because we're now lumping pending CPOE referrals into the transition of care document. Is that what we're saying?

Christine Bechtel – National Partnership for Women & Families

So I'm going to ask George to help me out on –

George Hripcsak – Columbia University

Say that again. Can you say that – repeat that question?

Art Davidson – Denver Public Health Department

Yeah. George, I'm just – if you can open up to line 35D, the bottom of that cell, on options for advancement, it just describes the care summary should always contain, and it describes a bunch of things. And I'm just wondering if we should make reference to here, the fact that now it will contain pending referrals as well.

Christine Bechtel – National Partnership for Women & Families

Well, that's what that –

[Crosstalk]

Michelle Consolazio Nelson – Office of the National Coordinator

So it actually does say that. It says additional items that will be added here, and I think that's part of another discussion, but the first line is enter the referral using CPOE.

Neil Calman – The Institute for Family Health

Right. But I have a question. If you're missing one of the elements of the care summary, are you not going to get credit for it at all? In other words, are we going to have people actually do every single item on the care summary in order to get credit for saying that they've developed a care summary?

Christine Bechtel – National Partnership for Women & Families

So that's one of the – that's one of the questions I flagged in the beginning, which is it is a – it's a challenging one in the sense that in a way, I think – so let's start with this. What happens today – I don't know if Michelle can speak to this – but, you know, today the care summary already requires ... procedures and counter-diagnosis, patient name, blah blah blah. What happens today if the care summary doesn't include one of the required items? Or is that just the wrong question because it's automatically generated?

George Hripcsak – Columbia University

Well, in theory, I think you wouldn't get credit.

Michelle Consolazio Nelson – Office of the National Coordinator

No. So in – so this is from Stage 2.

Christine Bechtel – National Partnership for Women & Families

Yep.

Michelle Consolazio Nelson – Office of the National Coordinator

In circumstances where there is no information available to populate one or more of the fields listed previously, the EP or hospital may leave the field blank and still meet the objective and its associated measure.

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

No, what I mean is so if they did not program it so that their care – clinical summary, as an example, didn't have that field in the report, then they actually wouldn't qualify for having that report, the clinical summary, or the transfer of care? The field may be blank, but not having a report with all the required fields –

Christine Bechtel – National Partnership for Women & Families

Right.

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

– wouldn't suffice. So was the question from Neil whether the field is blank or whether they didn't have –

Neil Calman – The Institute for Family Health

Well, if the field was blank, or if the field was blank and they just didn't do that piece of the care summary, like they just didn't connect that part of the care summary, so would you fail the whole criteria? And also, how does that get determined? I mean, they're going to – this is all – people are just attesting that their care summaries are complete with all elements all the time? I mean, how are we – do you understand my question?

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

So I think as an auditor you walk in and you say, okay, I'm picking track number 345. Show me the care summary. And when you press the button and it doesn't have problems even in the report, that would fail.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, because – so what is required is the problem list, the med list, and the med allergy list. So those three fields must be there. Those are required. The rest of the elements that are included aren't required and can be left blank.

Christine Bechtel – National Partnership for Women & Families

Oh, meaning what? Meaning care plan field, care team members, discharge instructions, reason for referral, all those things?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. Yeah.

Christine Bechtel – National Partnership for Women & Families

Okay. So that's kind of an issue.

Neil Calman – The Institute for Family Health

That's a problem. That's a real problem. I mean, if we're building everything into this, we're going to have to have a way to make sure that every piece of it is linked. And on auditing, I mean, people are going to have to audit enough records to make sure that they hit on every one of those factors to make sure that it's not just totally missing in terms of the linkage, but it's just missing in that record because there was no referral, or there was no, you know, order.

Christine Bechtel – National Partnership for Women & Families

And that's true for Stage 1 and 2 as well. So, you know, perhaps a way to do this is that for anything that we're saying goes into the care summary because of this consolidation, it is a must include field.

George Hripcsak – Columbia University

So here's the thing. If we – but then you have to get into, well, how many – what's the denominator? So if we start creating objectives, like –

Christine Bechtel – National Partnership for Women & Families

Well, no –

George Hripcsak – Columbia University

Well, if we want – like we don't want to say that there has to be a referral in every transition – well, let me think. I'm trying to find a good example, like a clinical summary doesn't need to have a referral in every clinical summary. We want to say if there's been a referral, but not if there hasn't, because there may not have been a referral.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Unless you have – this is Amy. Unless you have it as a field and have to enter not applicable or something.

George Hripcsak – Columbia University

Well, that's kind of how the problem list works now. That if –

Neil Calman – The Institute for Family Health

But aren't we also transmitting the summary with every referral?

George Hripcsak – Columbia University

No, I don't want to get too – I'm just saying we don't want to create – my point is simple. We don't want to create mega objectives that are really just meaningful use programs internally where we have separate denominators and –

Christine Bechtel – National Partnership for Women & Families

Right.

George Hripcsak – Columbia University

– so we don't want to get that complicated. So we have to avoid that. So the question is, one way is if the field is there, then we know – we could – the certification will take care of it. And what you're asking is, well, what about someone who never does a referral because it's not a required field in a transmission – transition of care document or transition of care action. So I have to think about that.

Christine Bechtel – National Partnership for Women & Families

Yeah. I mean, I think there's two issues. So one is with respect to this particular objective, because it's new for Stage 3, can we have confidence or is there some way to, you know, make it be implicit to the transition of care summary? That's the first question.

But there will be other things, like CPOE med labs and rads, where, you know, they're not – they're not – you know, the field doesn't have to be filled in or present, you know, according to what Michelle's told us. And I think that's a different – that's a different issue, right? And then you have to really think about, well, have they been doing it for four years? Are the performance thresholds high? So that can take us to a different path, and I think that's probably okay, for CPOE, for meds, labs, and radiology.

But for referrals, where it's new, if there isn't a way to require it be part of the care summary, where the threshold, you know, still makes sense, then I think we would want to keep it as an independent objective.

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

Why wouldn't you just make it a required field, a field in the report, but it doesn't have to have any date in it?

Christine Bechtel – National Partnership for Women & Families

Right, right, right. Which is really about the certification. So – which is what we're saying. This is the, you know, essentially certification only, and – but I think on this one, we did suggest that the actual summary show the referral order. Is that what this means, Michelle? And I'm not sure if I recall that correctly, either.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, Christine. Can you say that again? I just want to make sure –

Christine Bechtel – National Partnership for Women & Families

Would the care summary show the referral order, and does it make sense clinically, for the docs on the phone, to do that? Because if it doesn't, then it could be – then I think it's more of an implicit than a merger.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. I think we meant more of an implicit, like so if you're entering a referral using CPOE –

Christine Bechtel – National Partnership for Women & Families

Which don't you have to enter the referral using CPOE in order to count – so the 65 percent threshold –

Michelle Consolazio Nelson – Office of the National Coordinator

Probably – it has to be entered somewhere in order for it to count for the threshold.

Christine Bechtel – National Partnership for Women & Families

That – so that's the question, I guess, which that would take us out of this whole debate about, you know, what shows on the summary or not. But does that – I mean, right, you guys? You have to – in order to count whether you're even meeting the 65 percent threshold for care summary on transitions or referrals, then you need to have CPOE to enter the order for referral in order to calculate that measure.

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

That's right. That's right.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

But because it's new, you'd have to translate that 65 and 30 over to your new thing, which almost doesn't make sense. So – because the 65 and 30 describes the input. You're saying the input's going to be implicit because you have output. So there is no threshold for output. I think that's what George meant by the denominator problem. You basically have to include the present – which doesn't say what – how many you'd have to go input. So this is sort of tough.

Christine Bechtel – National Partnership for Women & Families

Wait, Paul. Wait. Let me back up. For the transition of care summary denominator, and I don't know how it's being calculated in Stage 2, but wouldn't you have to enter both your transitions and your referrals somehow, so that you could count them? Because it's 65 percent of transitions and referrals, not 65 percent of referrals and 65 percent of transitions. So –

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

But you're –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

– how does the system count them?

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

So I think – well, it's the problem with the paper. So for all of your referrals, 65 percent of them –

[Crosstalk]

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

– entered in, 30 percent of them have to be transmitted electronically.

Christine Bechtel – National Partnership for Women & Families

Well, no. You have to transmit 65 percent, because –

[Background voices]

Christine Bechtel – National Partnership for Women & Families

Sorry. We've got background noise. But it says provide a summary of care record for 65 percent of transitions, and at least 30 percent are electronic. So the provision is 65 percent.

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

Yeah. No, you're right.

Christine Bechtel – National Partnership for Women & Families

So if you have to do it for 65 percent, how – then you have to I would imagine enter a referral order and something else that – so you can count transitions, so you can even get to the denominator. So if you make the – I don't – if it's attestation in Stage 2, then, you know, this would allow us to move away from that and have the count be automated so people don't have to manually do it.

Neil Calman – The Institute for Family Health

In Stage 2, how do we know the total number of transitions? We recognized that problem, and we said we almost have to say – have a flag that says I'm about to make a transition. How was that handled in Stage 2?

Michelle Consolazio Nelson – Office of the National Coordinator

So yeah. This is Michelle. The conversation was essentially it has to be a checkbox that says –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

– remember, we talked about that. You didn't want another mechanism to measure it. Another collection, data collection.

[Crosstalk]

Neil Calman – The Institute for Family Health

But it is a checkbox?

Christine Bechtel – National Partnership for Women & Families

And even the vendors felt like we needed a denominator.

MacKenzie Robertson – Office of the National Coordinator

Sorry. This is MacKenzie. Can I just remind everyone again, we're getting a lot of background noise, please mute your phones if you're not currently speaking.

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

So how is this handled in Stage 2?

Christine Bechtel – National Partnership for Women & Families

I don't think we got around to checkbox.

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

Yeah. So it is a checkbox, right?

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Checkbox, Paul, meaning as a provider, you just have to say yes, I did it?

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

Yeah. No. The checkbox unfortunately is I'm about to have a transition, which is – it's a bit funky.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So you would electronically check a box, and that's how the ... is done in Stage 2?

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

Yeah. That's essentially how the denominator – so this is another one where it's a bit silly, because you basically want an on or off, either have all these things and you give all the – all of the folks a summary of care document or not.

George Hripcsak – Columbia University

See – this is George, to me, this objective, this is an example where a union of two objectives makes sense. If we're moving CP – the rest of CPOE out of the, you know, way, then for this – for 130, we simply want to say that the transition has to be recorded as an order in this objective. And we're really just merging two objectives into one, and then do the transition of care for – of information. So it's you enter the order ... doing the transmission, because we had a checkbox before ... order now, and then you do – you transfer the document also.

So normally, I don't want to just merge two things. I want to really consolidate in a more meaningful way. But in this one I think it makes sense, especially because 130 is new for Stage 3, so it would make sense that it doesn't just disappear somewhere else, versus say medication order entry, we've been doing it for four years.

Christine Bechtel – National Partnership for Women & Families

So George, you're saying leave it as it was, as a standalone?

George Hripcsak – Columbia University

No.

Christine Bechtel – National Partnership for Women & Families

No?

George Hripcsak – Columbia University

I'm saying phrase it as it was as a standalone and stick it in 303.

Christine Bechtel – National Partnership for Women & Families

So the other thing also is – and we're going to talk about this, with this 305, but we might as well mention it now, which is closing the referral loop. I think we had as a subgroup thought, and maybe we got a little overzealous with our consolidation, but I think we had originally thought about integrating it with the care summary, but the – it needs to stay separate because – and that's why we revised the spreadsheet, because there's not just a send, which is what the summary is, but also a receipt.

So if that stays separate, the referral loop piece, that's another way that would I think argue for consolidating CPOE referrals, 130, because the measure is that for patients referred during an ... reporting period, referral results generated from the EHR, 50 percent are returned to the requester, and 10 percent of those are returned electronically. So if that stays on its own, it's going to be pretty hard to hit the 50 percent market without doing it with an order, right? Doctors? EHR users?

George Hripcsak – Columbia University

I have to think, because it's whose order and who's returning. So this one, 305 is getting the receipt or sending the receipt?

Christine Bechtel – National Partnership for Women & Families

This is –

Michelle Consolazio Nelson – Office of the National Coordinator

Getting the receipt.

George Hripcsak – Columbia University

Getting the receipt. Well, if it's getting the receipt, then it could be merged with 130. It's just a question of whether you merge it also with 303.

Christine Bechtel – National Partnership for Women & Families

No, get – as in receiving from another provider the receipt?

George Hripcsak – Columbia University

Yes. That's my question.

Christine Bechtel – National Partnership for Women & Families

Michelle, is that –

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

No, no, because we actually at this end, because we tried to keep it simple, was to count that it was send – it would be a countable for the person that actually received the referral. That's who we were counting it from.

George Hripcsak – Columbia University

So received the referral. So sending the receipt is what it's –

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

Yeah.

George Hripcsak – Columbia University

So that's a different provider than the one who writes the order.

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

So doing ... return –

[Crosstalk]

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

– to be accountable for closing the loop. That was your accountability. That was where we put the measure.

George Hripcsak – Columbia University

Right. So it's a different person. So that's why those two objectives have to be separate.

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

Okay. Yeah.

George Hripcsak – Columbia University

So 305 could be separate, because it's on a different person than 130 and 303, who are on the same person.

Christine Bechtel – National Partnership for Women & Families

Now there's just one more argument on this one, and we'll touch on it I think when we get to deeming. There's a measure that is the same thing, that specialists are accountable for closing the loop. So there's actually a clinical quality measure for care coordination in this space.

George Hripcsak – Columbia University

Well, that would be in with 305, which is fine, since we're keeping it –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

And that would deem, right?

George Hripcsak – Columbia University

Yeah. That would deem 305, and then it –

Christine Bechtel – National Partnership for Women & Families

Yes. Just – that's just another variation here. So – okay. We can just table that. I mean, we'll have to harmonize all that as we go down the –

[Crosstalk]

Neil Calman – The Institute for Family Health

Yeah. I think this is really complicated, because in a sense, we really want the person who's getting it and the person who's receiving it to have the same responsibility, right? It's a conversation.

Christine Bechtel – National Partnership for Women & Families

Yes.

Neil Calman – The Institute for Family Health

So I appreciate what you're saying about separating the two pieces, but it's actually – it's two parts of a conversation that's going back and forth. So in a sense, the same thing has got to be – you know, it really is one requirement.

George Hripcsak – Columbia University

So it's kind of one requirement, but you just have to – you're doing the – you don't want the – you don't want the subspecialist to have to count how many times the generalist asks him. You want him to count or her to count how often she or he answers.

Neil Calman – The Institute for Family Health

Right. So that's why –

[Crosstalk]

George Hripcsak – Columbia University

They have a different role. So that's why it was separate.

Neil Calman – The Institute for Family Health

But it's not an answer. What – I guess what I'm saying is it's not an answer. It's really – it's the return of a – it's the return of a summary in the other direction, right? Because they're going to have all kinds of information in there –

Christine Bechtel – National Partnership for Women & Families

Yep.

Neil Calman – The Institute for Family Health

We're not expecting them to write the kind of consultation note necessarily in this process that they would normally have written in the old days, right? We're saying that you're going to create a new document that's going to include a lot of the things that would have been in that referral note as part of this electronic conversation that we're – that we're calling out.

George Hripcsak – Columbia University

So you would broaden 303 to say this counts whether you're getting a – making a referral or responding to a referral.

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

Yeah, because –

[Crosstalk]

George Hripcsak – Columbia University

... 303.

Neil Calman – The Institute for Family Health

– the sender – one minute the sender is the sender, but the next minute, they're the receiver. And whether you're a specialist or a primary care person, you know, you're going to be in both of those roles all the time. So I think if we try to keep those things separate, we're going to confuse the hell out of everybody.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Well, this is Amy. I have a question, because if you're the primary care and you send it, when you receive it, you may – you may or may not have more action after the specialist sends it back to you. So I don't – I want to make sure we don't get into this forever loop. Right?

Neil Calman – The Institute for Family Health

But – yeah. I mean, the number of – there are cases where you just send something out and get an answer back. But, you know, I think in terms of the what we're trying to call out in this future sort of mode of operation is that we're, you know, coordinating care. So to me, that's going to change sort of the dynamic of a lot of these send and receive things, maybe not when I send somebody to a neurosurgeon for a single consultation, but in a lot of the conversations where we're going to be using this kind of stuff, it's going to be ongoing collaboration between providers so that we can avoid duplication and give better care to people.

So I think, you know, that this – that if we separate these two functions, people, wait a minute, am I – am I the receiver of this? Am I the person who's supposed to be, you know, generating this information? You know, I just think it's – we're trying to create a single mode of communication, but – you know, maybe I have this wrong. I don't know.

Art Davidson – Denver Public Health Department

Yeah. I'm sort of getting – I'm struggling now with sort of the definition of referral. Transition of care and – I mean, so a referral is I'm – you know, and I'm not a physician, so help me out here, but I'm sending someone to somebody else to, you know, look at, and, you know, follow up with this patient on a particular area. They're sending me back something. I may or may not have anything to do with it. So when they go to – I'm just losing in the sending and receiving, if we count them all as the same, how you look at a denominator, especially over a time period.

[Crosstalk]

Art Davidson – Denver Public Health Department

Like for the ongoing part, like so let's say I'm a primary care and you're a cardiologist, and we have – we share a patient, right? So I may – you know, you may see them four times a year, and yes, I should send them – but I'm not always actively referring them, because they're under your care. So every time they go back and forth, is that a transition of care? Is that a referral? And do we expect something to be sent or not?

Neil Calman – The Institute for Family Health

Well, ideally, you would want something to be sent, because if they're just seeing somebody and nothing happens, which sometimes happens, that's okay, but, you know, I think we're trying to create that ongoing communication so that things that might not have been communicated before, because somebody didn't want to, you know, dictate a letter and send a separate thing just because of the change of a single medication, but now that kind of stuff is going to get communicated. So I think we're trying to make – you know, use the electronics to facilitate that.

But the cardiologist may say, you know, while the patient was here, they also started complaining of joint pain, so, you know, you might want to look into that the next time you see them. In that case, they're sort of referring them back to me for something.

Art Davidson – Denver Public Health Department

Yeah. So I'm not disagreeing with the concept that you want to keep the information going back and forth. I'm trying to actually think about the logistics of how it counts.

Christine Bechtel – National Partnership for Women & Families

Right. But I'm assuming – this is Christine, and my normal caveats apply, not a doctor, don't use an EHR. But I'm assuming that if it's – if it's like – it's sort of a vague referral. You know, it's not really a referral. You're saying like, oh, you know, you need to go have your, you know, feet checked on something, which was kind of a one-time thing. It's not really impacting, you know, the care I'm providing for you. I'd go see that guy. This is – they're just not going to code it as a referral in the system, so it's not going to get counted. Right?

George Hripcsak – Columbia University

So –

Christine Bechtel – National Partnership for Women & Families

So there's some clinical judgment, is what I'm saying.

George Hripcsak – Columbia University

So I think we have to keep this general, because of the – so I don't – I'm actually going with Neil. So Michelle and Paul, I'm thinking we keep it simple. And so now what I'm thinking is that 303, instead of talking about checkbox, and I forget if it actually says checkbox. I guess that's just implicit of how you'd have to implement this to get the denominator. We actually explicitly say in order for a referral – in 303, number one. Number two, when we introduce 303, we talk about this is for sending data to referrals and sending the answer back from referrals. And I'm thinking that 305, as per the comments right there, is no longer – you know, becomes part of HIE or something and is not a separate objective. So that's where I am, based on this conversation.

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

I'm trying to take a step back and figure out what's the problem to solve, and then what's the simplest way to try to approach that. I almost think this is – we're force-fitting it into a functional requirement, when maybe it's really just a quality measure, and this – an example of deeming. So the quality measures, we have this – the closed loop, and so the way it affects the EHR is through certification, but not try to make it a use measure. And yes, people can skirt around the system by not doing electronic referrals, but they could have done that by not checking the checkbox anyway.

So in a sense, it was all – it didn't – we want to make it in their best interests for both the specialists and the primary care and – on behalf of the patient, to have this conversation take place. And the way we would measure it is through a quality measure. The way we would enable it is through a certification requirement, but not try to get into this quagmire of measuring the use of it through a meaningful use objective.

Christine Bechtel – National Partnership for Women & Families

But Paul, it's Christine. I see where you're going. My only worry, though, is that it's a quality measure. It's very, very option. They've got 10,000 to choose from, depending on the path they go. I mean, that's an overstatement, but – I mean, unless you're talking about requiring that everybody, you know, be accountable for that quality measure, sort of like we did in Stage 1, where there were three core measures, I'm not sure how to get the measure actually used.

Neil Calman – The Institute for Family Health

So we have so few quality measures for specialists, this could be one of the core quality measures for specialists, and it is something they and the primary care providers told us about. So it is one of the very few cross-cutting measures we have for specialists.

Christine Bechtel – National Partnership for Women & Families

Which I think is great, if it – if we're talking about making it a core requirement.

Neil Calman – The Institute for Family Health

Yeah. I think that this is – I mean, if you think about what – where we're headed, this really is the most fundamental – you know, in the top three most sort of fundamental things that we're trying to –

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

Yeah.

Neil Calman – The Institute for Family Health

And that – where electronic communication really puts us into a totally different realm than we've been in before.

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

Yeah. It's the closest thing we have to care coordination. It's the closest thing we have to relevant cross-cutting specialty measures. So I think we could defend it as a core quality measure, and we still will have the denominator, and I guess my first – my first straw man would say use the electronic denominator. In other words, the denominator is all electronically transmitted referrals. And yes, they could skirt around us, but they always could, because they could always not check the checkbox. So it just makes the measurement –

Christine Bechtel – National Partnership for Women & Families

... electronically transmitted referrals. Why not all referrals ...?

[Crosstalk]

Neil Calman – The Institute for Family Health

Because you never can catch the –

Christine Bechtel – National Partnership for Women & Families

No.

Neil Calman – The Institute for Family Health

No, you're right. You're right.

[Crosstalk]

George Hripcsak – Columbia University

We're having the same conversation now. We had kept 305 separate. We were saying –

Christine Bechtel – National Partnership for Women & Families

Right.

George Hripcsak – Columbia University

– we could get rid of the objective, we could deem it, whatever, but that's not what we're – so I agree with your position, Paul, and that we should deem 305 a quality measure, but, you know, Christine, I can understand your position. But we've got to decide what to do with 130 and 303, which is a different side of the argument. Do we have to force an order or not?

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

We don't – well, we are – it is in the best interest of all parties to have this electronically tracked order from start to return.

George Hripcsak – Columbia University

So then would it be good enough just to state 303 in terms of the order for the referral?

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

Yes.

George Hripcsak – Columbia University

And you'd do it that way, instead of having a separate objective called 130?

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

Yes. So 130 – so 130 just makes the referral – the presence of a referral order and its status in the transition of care document. That's all.

George Hripcsak – Columbia University

I'm sorry. Are you agreeing that the order should just be mentioned in 303 and we can get rid of 130?

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

Get – well, the way it appears in – and I don't remember 130 – I think 130's your summary of care document?

Christine Bechtel – National Partnership for Women & Families

No, 130 is the CPOE ...

[Crosstalk]

Neil Calman – The Institute for Family Health

The original order for referrals.

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

Yeah. So yes, get rid of the original order – get rid of forcing things through the objectives. Measure it on the quality measure side, and include its status in the transition – the summary of care document.

George Hripcsak – Columbia University

So I think we're agreeing.

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

Yeah.

George Hripcsak – Columbia University

Okay.

Christine Bechtel – National Partnership for Women & Families

So let me just – so that – so that was the original suggestion of the subgroup.

George Hripcsak – Columbia University

Right.

Christine Bechtel – National Partnership for Women & Families

The – with the addition of including it in a quality measure. So we would have to maybe note that we're suggesting it be a core quality measure for all providers. But if you do that, be aware that this is not – you are not measuring performance. So they can perform incredibly poorly and still be successful.

Neil Calman – The Institute for Family Health

No, they won't it get deemed then. So –

Christine Bechtel – National Partnership for Women & Families

Well, if you're assuming the deeming happens as – and we haven't talked about whether – does –

Neil Calman – The Institute for Family Health

I get it. No, I get it.

Christine Bechtel – National Partnership for Women & Families

– Stage 3 go to deeming or not.

Neil Calman – The Institute for Family Health

Yeah. I get it.

George Hripcsak – Columbia University

That's the deeming discussion on whether you keep 305, which is not our topic right now. We said no changes to recommendations in terms of consolidation, so I think we're in agreement.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

So the only thing that – I think one of the things we – you had to discuss that I'm introducing is simplifying the denominator problem.

George Hripcsak – Columbia University

Denominator where? In which ...?

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

Wherever you measure the close the loop.

George Hripcsak – Columbia University

Close the loop is 305. We recommend no changes to that objective. So now the deeming group can say we can deem it, but we're not putting anything forward for that.

Christine Bechtel – National Partnership for Women & Families

Right.

George Hripcsak – Columbia University

We do mention on the side, and maybe this is a transport, but we don't have to do that. I mean, our actual recommendation is talk to the deeming group.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

Well, hope – yes, but I guess I assumed that as we went through this, I did not rule out the possibility that the – that a new structure could be two different pathways that people self-select. Either they go deeming, or if they're not comfortable because deeming has a performance associated with it, they can go, you know, with a consolidated path if we want, but they've got to check a bunch of boxes, or they've got – you know, there's some disincentive – I just didn't assume that we had figured out that we might go all the way to deeming.

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

So maybe – yeah, deeming, one of the things to remember, so consolidation is it applies to everybody.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

Deeming is an alternative pathway.

Christine Bechtel – National Partnership for Women & Families

Right.

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

And I think what George was saying is right. Deeming – if we want this to be a deeming thing, then you'd leave in 130, mainly because it's a new requirement. So as Neil was saying, this is probably one of the single biggest things in both specialty care and care coordination. That's why we originally put it in. Possibly it actually stays in and doesn't actually get consolidated, because then it would – you know, it would no longer be there. But we have an –

[Crosstalk]

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

– alternative pathway. If you are returning, then you don't have to –

Christine Bechtel – National Partnership for Women & Families

Right. If you're doing deeming, you may not – but – so I guess – but I'm – I want to make sure we're talking about the same thing, Paul. The word – we should just be doing the consolidation and make no assumptions about deeming right now.

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

That's correct.

Christine Bechtel – National Partnership for Women & Families

Because then we can merge deeming and consolidation in the deeming discussion, and that can be a different pathway. But for C – 130 is CPOE for referrals.

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

Right.

Christine Bechtel – National Partnership for Women & Families

It's not closing the loop. We're going to leave closing the loop separately. And the subgroup's recommendation was it's pretty integral to the transition of care, so if you show its status in the care summary, you don't need to require it separately.

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

Christine Bechtel – National Partnership for Women & Families
But if we think that that can be gamed or whatever, then we should require it separately.

Paul Tang – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer
Well, I – so the one thing you do need is certification requirements.

Christine Bechtel – National Partnership for Women & Families
Yep.

Paul Tang – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer
The requirements.

Christine Bechtel – National Partnership for Women & Families
All of those apply.

Paul Tang – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer
Okay. So that's certification requirements, and then you either are going to catch it in the summary of care – that would be pathway one – or in deeming, pathway two. In any case, you're going to have to both – you're going to have to have it in your EHR and you'll have to use it, in either case.

Christine Bechtel – National Partnership for Women & Families
Right.

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

Christine Bechtel – National Partnership for Women & Families
Okay.

Art Davidson – Denver Public Health Department
So this is art. I want to go back to the question I asked. This has been a really fascinating discussion. Back on that cell 35D –

Christine Bechtel – National Partnership for Women & Families
Yep.

Art Davidson – Denver Public Health Department
– so if we – assuming you've done the CPOE entry of a referral, the care summary should always contain an up to date medication problem, allergy list, pending referrals, or recent referrals? This conversation that Neil described, how much of it needs to be in this? Is it just the pending incomplete ones, the ones that haven't got a closed loop? Or do we keep pieces of the closed loop there? Or three months' worth of closed loop conversations? What is the definition of up to date?

Christine Bechtel – National Partnership for Women & Families
Well, I guess – so let me make – ask one clarifying question, Art. I'm only – I think we're talk – we're not talking necessarily about the loop closing yet, but more the CPOE. So what Paul I think or somebody said earlier was that the care summary would show the status of referrals.

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

Christine Bechtel – National Partnership for Women & Families

What – I don't know what that means, or if there's a better way to say it.

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

So if I have – so I'm referring somebody. Then in the transfer of care, in the summary of care document, there will be a – the note that there's a referral pending to cardiology.

Art Davidson – Denver Public Health Department

That's great. That's great. Yeah.

[Crosstalk]

Art Davidson – Denver Public Health Department

Okay. If it's just pending referrals, that makes sense to me.

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

Yeah.

Art Davidson – Denver Public Health Department

Yeah.

Christine Bechtel – National Partnership for Women & Families

Okay. So instead of – Michelle, I think instead of saying in that first bullet enter it using blah blah blah, it would say status of pending referrals, which would require you enter the referral order with CPOE.

Art Davidson – Denver Public Health Department

Right.

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

Yeah.

Art Davidson – Denver Public Health Department

Thank you.

Christine Bechtel – National Partnership for Women & Families

And that's like a mandatory thing. Okay? All right. All right. I think we have an agreement. Should we get to our third item on the list?

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

Yeah. And let me just do a process check. It's obvious that we actually haven't finished this.

Christine Bechtel – National Partnership for Women & Families

Yes.

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

It sounds like what we're going to do is try to spend the first two hours on consolidation and the second two hours on the deeming.

Christine Bechtel – National Partnership for Women & Families

Yep.

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

Just to set people's expectations, or reset them.

George Hripcsak – Columbia University

Yep.

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

And it does get faster as we go. The first probably five or ten are the hardest.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

And then it does get a little easier. But those first couple are really the hardest, I think.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

All right. So the next one is ePrescribing and formulary checking, and essentially, the suggestion of the group was have this really be about formulary checking, and not about the transmission anymore, because then we will have done it for four years, we'll have done it under the ePrescribing incentive program, and we're already seen, you know, about 60 percent of providers sending more than 70 percent of the permissible prescriptions. So that's the – that's the recommendation. Okay? And we've talked about the link between CPOE as well already. So if you have to check formulary and generic substitutions, that would still trigger it.

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

Okay. And Christine, are there any qualifiers around formulary? Because this was the issue with, again, the patient's – you might have to go through the PBM or, you know, some mechanism to find the relevant health plan's formulary. Is there any thoughts on that? Or was it –

Christine Bechtel – National Partnership for Women & Families

I think, Charlene, that that's a larger issue that we have to go through when we like go back through the criteria in response to the RFC, right? I don't think that – did that relate to the consolidation, or was that kind of –

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

It's just – it was just in the EP world in terms of what form – you know, it's like it gets trickier. Like in a hospital it's pretty straightforward, but –

Christine Bechtel – National Partnership for Women & Families

Right. But I don't think that's – I think that's an issue that existed with this criteria all along. I don't think it's a problem created by consolidation, right?

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

So that's one of the ones –

[Crosstalk]

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

We need to get back to that, then. All right.

Christine Bechtel – National Partnership for Women & Families

We need to come back to that –

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

We'll come back to that when we deal with the RFC. Yeah.

Christine Bechtel – National Partnership for Women & Families

Exactly.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

So Michelle is creating a parking lot of those items already, because we found a couple, too, so that we'll have Michelle to put that in the parking lot. Okay. Any issues with this – you know, again, certification only for transmission, but maintaining the formulary/generic substitution piece? Okay.

So the next one is demographics. So similarly, we were suggesting that you retire the existing demographics that have been part of Stage 1 and Stage 2 and keep them in certification only, because you have quality measures and decision support and other things that use those data, as well as view/download and care summary. But that you probably need to keep the – you know, we need to keep the criteria for SOGI and disability status and occupation, so – you know, when we go back through the RFC, I think the – so let me ask the subgroup, though, because I thought that the – I guess the question that we talked about was could you have the certification – let's take – let's assume there are standards for disability status and occupation codes and SOGI. Could you only have certification criteria for those instead of requiring them as a recording objective?

Michelle Consolazio Nelson – Office of the National Coordinator

Hey, Christine, this is Michelle. So I do want to clarify, in the RFC –

Christine Bechtel – National Partnership for Women & Families

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

– it was recommended that everything be certification only, even the new items. So they would be – the new items would be added to the certification criteria, but there was no use case.

Christine Bechtel – National Partnership for Women & Families

Right. Okay, I –

Michelle Consolazio Nelson – Office of the National Coordinator

But I think what the subgroup talked about was that they would want those new data types to be required for a use case, but I think –

Christine Bechtel – National Partnership for Women & Families

Yeah, so I –

Michelle Consolazio Nelson – Office of the National Coordinator

– that's something that we probably need to go back to the full workgroup on when we reconcile comments.

Christine Bechtel – National Partnership for Women & Families

Yeah. I thought that's what we agreed, Michelle. That's why I was confused by the – because what it says is here, except for new data types. But I thought the workgroup agreed, the subgroup agreed, that those even could be certification only, because as long as that level of detail is required in care summary and all those other ways, and it's used in CDS or decision support, blah blah blah, then you wouldn't need to have it be a recording objective, standalone. I thought that's what we agreed on. Does anybody have a different memory? Okay. So I think there's an error in the spreadsheet in that.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. I'll fix the language, then.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. So does that make sense, people? What we're saying is that actually all the recording of demographics goes to certification only, but that they're used in the transition of care summary, in view/download, in, you know, the quality measures, in CDS, etcetera. Any comment on that?

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

I think it's consistent with – our major focus is exchange, care coordination, and patient engagement.

Christine Bechtel – National Partnership for Women & Families

Yeah. Exactly.

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

So what you said, basically.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. So that's also the same approach the group recommended for the next several objectives, so 105 through 109, because we already had in the RFC proposed retiring the measure for Stage 3. So those would go to certification only, and they're covered elsewhere. So if we want, we can take those as a lump sum. Anybody have comments on any of those, or concerns?

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

I think you're going to handle it later, but we did introduce this whole up to date and accurate. So we didn't retire – so problem list, we – these are certification requirements. That's right. So those are caught somewhere?

Christine Bechtel – National Partnership for Women & Families

Up to date and accurate?

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

Yeah. So to have the functionality in the EHR, and many of them already do now, but this is calling out for those who don't, to be able to program some rules that would ... so you don't not have diabetes on the problem list, yet the A1C is high. You do not have hypertension on the problem list, yet the last three blood pressures were high. That kind of support to help people maintain more accurate and up to date problem lists and meds, problems, meds, and allergies.

Christine Bechtel – National Partnership for Women & Families

So how did we cover those in the RFC?

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

In certification requirements.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

They were just advanced requirements of – further than what was currently there.

Christine Bechtel – National Partnership for Women & Families

Yeah. Okay. So in those –

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

So just don't want to lose that.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Neil Calman – The Institute for Family Health

I'm not clear on that. Are you saying that the certification requirements are that these things are going to be built into certification, that they automatically – that the capability of programming it so it automatically flags you if something's missing from the problem list? Or what part of it is certification?

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

Yes, that you have support for being able to – in our world, Neil, it's writing a BPA, for example, that says the BP – the blood pressure has been high for the past three times, yet I don't see hypertension on the problem list. Do you want to add it? It doesn't do anything automatically, but it helps find things. Another example could be gosh, this person's been on antibiotics and – a non-acne antibiotic for three years. Are you sure – you know, do you want to discontinue that? Things that help prompt the clinician to make sure that these important lists are up to date.

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

Yeah. And – hold on a second.

[Crosstalk]

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

Paul – oh, this is Charlene. Would that come under CDS, clinical decision support, then?

Neil Calman – The Institute for Family Health

Yeah.

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

It sure could. Yeah.

Christine Bechtel – National Partnership for Women & Families

So yeah, so that – the certification criteria in Stage 3, as proposed in the RFC, says things like use of problem and lab test results to support clinicians' maintenance of up to date, accurate med list, provide decision support about additions, edits, deletions for clinicians' review.

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

Right.

Christine Bechtel – National Partnership for Women & Families

So that would stay.

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

Right.

Christine Bechtel – National Partnership for Women & Families

That would stay. So we just kind of as a shorthand here – you know, we're a victim of shorthand.

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

Or do we just do what I guess Neil and others said, is just move that same language over to CDS?

Christine Bechtel – National Partnership for Women & Families

Well, it's not – I don't know that it matters, because it's not – when there is an independent line that's – its, you know, generally indicative of what the docs have to prove they're doing. So either way, it's fine, I think.

Neil Calman – The Institute for Family Health

So what are we – what are we – what would be the proof here?

Christine Bechtel – National Partnership for Women & Families

What would be what?

Neil Calman – The Institute for Family Health

What would be the proof that something's up to date? Or ...?

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

No, no, that's – no, that's the whole point, is –

Neil Calman – The Institute for Family Health

Right. The point is that we can't prove it, and therefore, we're just basically saying that the systems have to have a mechanism to help people along this path.

Christine Bechtel – National Partnership for Women & Families

Yes.

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

Correct. What we're leading up to, of course, is better reports, better CDS.

Christine Bechtel – National Partnership for Women & Families

Right.

Neil Calman – The Institute for Family Health

Okay. Got it. Okay.

Christine Bechtel – National Partnership for Women & Families

Right. I mean, I almost feel like we're a victim of our own formatting, and that we probably at some point, at least for this consolidation thing, have to have the list that is certification criteria, and then the list that is literally meaningful use.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

Where we're not saying you have to prove you're doing all this in certification only. But anyway, okay, so that – but that's a good – you know, good thing to point out, Paul. So are we ready to move on?

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

Yep.

Christine Bechtel – National Partnership for Women & Families

Okay. So smoking status, similarly, certification only because it's covered through quality measures, and it's – I think the performance is very, very high. Any comment on that?

Okay. So the next one is advance directive. This is one that we need to have some discussion about. We went back and forth as a group, and I think where we came down as a subgroup is at the end of the day, we probably need to keep it as its own standalone objective. But let me tell you what we thought about, and, you know, we can go from there.

There are two issues here. One is it's moving to core for eligible hospitals, but it's actually the most popular menu item for eligible hospitals, and their performance on it is very, very high. But it is new for EPs, okay? So that's issue number one. So one way that we talked about treating this would be leave it as a standalone EP objective, and for hospitals, you could build it into the care summary, because it – where the care summary would say presence or absence of an advanced directive.

If you did that, though, in a true consolidation form, it raises two issues. One is that if you built it into the care summary for hospitals, it would change the denominator to all – you know, to everyone, instead of just 65 and older, because I assume that everyone transitions out of the hospital. So the transition of care summary denominator is everyone, not just 65 plus, and it's a larger percentage than was previously done. So because of those, you know, kind of challenges, we really struggled with how to consolidate this into another place. We thought the care summary was probably the most obvious place to do it, but again, it would change the denominator pretty significantly.

So perhaps this one needs to stand alone, but – at least for EPs, but for hospitals, if we feel like this could be integrated elsewhere, that's what we wanted to raise.

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

I think you're right in the sense of the denominator for EPs is really your entire senior population, which isn't captured by only those who have been hospitalized, in addition to saying – you know, people who are hospitalized are – can also be younger. So the fact that it's core and expected for a large percent of hospitalized patients – well, hospitalized senior patients, then that's fine. But I think I'm agreeing with your notion of having something separate for EPs.

Christine Bechtel – National Partnership for Women & Families

Well, that's how it was proposed in the – in the RFC, so the – it's an EP menu objective, proposed as a menu objective, and it's just record whether a patient 65 or older has an advanced directive.

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

Right.

Christine Bechtel – National Partnership for Women & Families

But it goes to EP core.

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

Right.

Christine Bechtel – National Partnership for Women & Families

And the measure would be more than half of all patients 65 plus who are admitted, blah blah blah, or have an office visit, you know, have the advanced directive status recorded. So again, you could kind of consolidate it. Probably most – it would make sense for hospitals. Leave it separate for EPs. But if you consolidated it for hospitals, it does change the denominator. So that's why we're saying probably best to leave it as is, and we have some work to do on the objective anyway, when we get to our public comments.

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

So this is a really important one. We talked – this is Charlene. We talked about this in the care coordination deeming group. But as we thought about it, again, I think there's some work in standards that is starting to flush out the content of what's included in an advanced directive, because it's really part of a care plan.

So we had – we certainly supported indicating that an advanced directive existed in the care summary. You know, and I know it's going to mess your denominator up, but –

Christine Bechtel – National Partnership for Women & Families

So –

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

The other thing we thought was important is we started to really think through, and this will have some impact, but actually including some broader content around what the advanced directive instructions were in the care plan, because it is care. So again – but I think our thought process on both of those is that it would be defined as a part of either a one – either one or those two documents. So we were okay with the direction you were going, exclusive of the denominator, in terms of using the transition of care and/or the – and the care summary or the care plan over time, as a means to be able to communicate this.

Christine Bechtel – National Partnership for Women & Families

Yeah. We – it's actually one of the other things that's on the list to talk about with the full workgroup, is that there are probably some things that if you actually move the care plan from a future stage into Stage 3, and have at least a basic one, that you could consolidate, and advanced directive would potentially be one of them.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

But I didn't bring that up now because it's not an existing thing, but it is on my list of other items that we need to talk about.

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

Yeah. And so, Paul, I think when Leslie – she's not on the call today, but she was talking about there's some work in the –

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

– one of the workgroups that's starting to flush some of this out. So we don't know – I mean, Halamka could come back and say it's not going to be ready, but because we're not putting rules out this year, maybe that's relaxed a little bit. So Christine could be right in that maybe there's some pieces that get flushed out there.

Christine Bechtel – National Partnership for Women & Families

So for now, it sounds like we should leave this as a standalone and as it is, which is how we did it, but flag it in our parking lot for coming back to once we talk about some of these other issues.

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

But you're going to – you're going to leave it as a standalone for hospitals, too, then, right now?

Christine Bechtel – National Partnership for Women & Families

Yeah. I think we –

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

Yeah. Okay.

[Crosstalk]

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

I mean, we're – I think we need to work this one through more, but yeah, I – that's all right, given the other denominator problem.

Christine Bechtel – National Partnership for Women & Families

Yeah. That's the only reason that it's standalone, in my mind, because it would be much better on a transition of care summary and on a care plan, but the denominator is different.

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

So is at least the presence indicated on the care plan now? Or, I mean, on the transition document now?

Christine Bechtel – National Partnership for Women & Families

No.

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

That's a gap. We missed that. So – okay.

Christine Bechtel – National Partnership for Women & Families

But again, that's because – you know, I guess you could have like an N/A. So this is what I'm raising, right? You could have the field – hold on. Let me just double check that. Yeah. You could have the – it's not on there now, but you could have the field on there, but if – it wouldn't be filled in for anybody – it wouldn't be asked to be filled in for under 65-year-olds if you're doing meaningful use.

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

Right.

Neil Calman – The Institute for Family Health

So this is Neil. Can I ask a question about this?

Christine Bechtel – National Partnership for Women & Families

Yes.

Neil Calman – The Institute for Family Health

I remember that we were talking about advance directives as very much a part of future considerations of HIE.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Neil Calman – The Institute for Family Health

Because right now, we have two problems. We have the people that have five of them, and we have the people that have none of them. And so I'm not sure how – you know, if we're thinking about eventually – like what are we – what's the – how are we going to – how are we going to reconcile those things? Like the fact that multiple – multiple advanced directives, you know, are there. We have – you know, we have one in our record. The hospital has one in another record. They're obtained at different times under different circumstances.

Christine Bechtel – National Partnership for Women & Families

Yep.

Neil Calman – The Institute for Family Health

I guess I'm just saying, this is like a very big issue that we – that we're probably going to have to, you know, deal with in a – in a –

Christine Bechtel – National Partnership for Women & Families

Yeah. It –

Neil Calman – The Institute for Family Health

– through what's the future state that we're headed towards, where there's kind of like a repository of kind of the latest advanced directives that everybody can kind of seek out, perhaps through an exchange or something like that.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Neil Calman – The Institute for Family Health

Because right now, it's very confusing.

Christine Bechtel – National Partnership for Women & Families

So Neil, we – actually, we were going to – and I'll ask Michelle and Paul to weigh in here, because there was originally a hearing planned on this. We didn't –

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

Right. There was going to be a listening session, and Michelle, I guess we just didn't follow up, right?

Michelle Consolazio Nelson – Office of the National Coordinator

No. So we prioritized the clinical documentation hearing –

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

– over the advanced directive hearing. And we had talked about assigning it to another workgroup, because the meaningful use workgroup has so many other things on their plate. We can certainly revisit that and see if there is – because things got pushed out, if there is time to do a listening session now. I mean, the thought behind it is still – we still have the outline, and we could certainly work towards it.

Christine Bechtel – National Partnership for Women & Families

The other place that – and I know we're off the topic here, but, you know, that might be interesting would be the new consumer empowerment and consumer technology workgroups doing a joint thing, because they have the standards piece, and, you know, we have the policy piece. So if the meaningful use workgroup can't do it, and – which would make some sense, because I think it's broader than meaningful use. That might be another option.

Neil Calman – The Institute for Family Health

Yeah. So I'm just suggesting that we don't do anything with it right now –

Christine Bechtel – National Partnership for Women & Families

Yeah.

Neil Calman – The Institute for Family Health

– because making a transition of this at a point where we really haven't figured out what the end game is yet doesn't really make sense.

Christine Bechtel – National Partnership for Women & Families

Right. Right. So why don't we move on to the next one because of our time constraints, and we'll flag that we need to follow up on doing some sort of a hearing or listening session or whatever in some workgroup somewhere.

[Crosstalk]

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. I'll follow up with others at ONC to –

Neil Calman – The Institute for Family Health

Yeah. And the only thing I would like to see is that we have this – we have this input in time for our final recommendations. So if the – you know, if the consumer workgroups are up and running and that's the perfect place, fine.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Neil Calman – The Institute for Family Health

But just that we have this done by then, by the time –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

Okay .

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

This is Amy. And I think the other place to think about that, and I don't want to belabor this, is some states may have registries around this. So, you know, when you're thinking about – when we're thinking about registries and stuff, so I think whenever – if there's a listening session or someone takes it on, really investigating if there are existing registries. I think ONC even had challenge grants on that. So I think that needs to get sorted on where and how that fits here as well.

Christine Bechtel – National Partnership for Women & Families

Yep. Very true. Okay. So the next one is clinical decision support. This is row 16, subgroup 113. And we did not suggest any change here, except that we actually want to integration 401b, which is immunization CDS, into it. So this as a piece would standalone, and then I think we should just, given our time, move on to the next one, because when we hit 401b, we can talk about that when we get there.

Okay. So subgroup 114 is structured lab results. So we're suggesting that this gets integrated into the care summary and view/download/transmit, because they're required in those anyway. So maybe it's more of an implicit kind of thing. Also because CQMs use structured labs as well, and they're also on the office visit summary. So since they're on the care summary, the visit summary, and the – and view/download, we felt like it didn't need its independent thing. This is not the hospital labs one, for those of you thinking it might be. So any comments on that? Okay.

So 115 is – it was generate patient lists before, and – but it's also really, if you read the text, it's really about a population health dashboard. So what we've suggested is that it stay – it maintains as a standalone, but it's certification only, and here's why. What we're suggesting is that you actually increase the certification criteria around list generation so that you can do lists by problems, meds, procedures, vital signs, demographics, labs, because those are what you need for quality measures and things like that, and you need also for patient reminders.

So if we actually increase the certification criteria to – and really put those in the context of a population health dashboard, knowing all the new models of care that are coming, knowing that you need to be able to report quality measures, which means you're going to want to look at a dashboard, we felt like there wasn't a very meaningful way to have people making sure they're using the dashboard. Like what are you going to do, count views? So we felt like this was okay to really do two things. One is focus it more on the population health dashboard idea, and then increase the capability of that dashboard to be looked at through these different views, which are really lists of problems, meds, etcetera. Any comments on that?

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

I like the rationale.

Christine Bechtel – National Partnership for Women & Families

Okay. Okay. So the next one is patient reminders, and we're not suggesting that the – that the item go away or get integrated, but we are suggesting that we maintain the per patient preference piece in terms of the communication medium, because that's key to being able to go to certification only on the communications preferences piece later. So really, no change here, because reminders were already for patient preference.

We did talk about integrating reminders into view/download, and I think where we ended up was that we do need to make sure that from a certification perspective, view/download and secure messaging can handle the patient-facing information, which includes reminders as well as the visit summary, etcetera, but that if you just sort of dump it into view/download, it changes the threshold pretty dramatically from 20 percent to at least 50 percent. So we just kept this one as a standalone. We also felt like it's the most deferred item in Stage 1, so we need to keep our finger on that one, keep the gas pedal down. Any comments? Okay. So we –

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

This – oh, my ... yeah, one comment. There is – in care coordination, again, there's some preventive – and I think also in – this is where there might be some overlap with deeming. That's all I said. Because when we did the measures, there are some preventative measures, too.

Christine Bechtel – National Partnership for Women & Families

Yeah, there's a lot of overlap with deeming, and that's –

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

Okay. All right. That's all.

Christine Bechtel – National Partnership for Women & Families

– a good thing, I think. Okay. So the next is medication administration tracking. We did not suggest advancing that in any way. Image results, subgroup 118, we did have a lot of discussion about this. It's moving from menu to core. We don't have any performance data on it, because it's new to Stage 2. And so we felt like we probably needed to keep it as it was. There were discussions about, you know, well, you could integrate it into view/download and into the care summary, and, you know, into this and this and to that. But it raised so many questions about diagnostic image quality and what happens if you convert it to a PDF, and duh duh duh.

So I think it raised for us kind of a separate question with respect to view/download, which is do we want to amend view/download to include a copy of the image for patients, but really felt at the end of the day like the image results needed to probably stay as a standalone, separate piece. Commends on that?

George Hripcsak – Columbia University

This is George. I mean, I agree with you. I think it's just such a different thing from the other things they're talking about, that either we do it or we don't. If we're doing it, it probably has to be a separate objective.

Christine Bechtel – National Partnership for Women & Families

Yeah. Agreed.

George Hripcsak – Columbia University

I mean, the quality measures, you know, you try to see that they look at the – you know, it's just too distant.

Christine Bechtel – National Partnership for Women & Families

Yep. Any other comments?

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

Oh, the only other – the comment is in terms of including an image physically, kind of in the document, because then we'll get into – typically, you just view an image. You know, you go and you're able to look –

George Hripcsak – Columbia University

Well, wait – so let's not – so Charlene, I think that that's – remember, it was – we had – we had gone through this, right?

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

Yeah.

George Hripcsak – Columbia University

And I think – I forget how it's phrased, but is it a link, possibly a link to the image? I mean, there needs to be a mechanism. That's it. So we don't want to redefine the objective here. We're just saying we don't want to consolidate it.

Christine Bechtel – National Partnership for Women & Families

Right.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

So Michelle can throw that maybe in the parking lot to make sure that we have the – have the language right later, because remember, you're not actually looking at the language here.

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

Okay. That's fine. I just don't want to – yes.

Christine Bechtel – National Partnership for Women & Families

Yeah. And we – that's where we went to this acceptable. That's what it says in the RFC, and I think that was a carefully chosen word. So I think – I think that's okay, Charlene, but we're not consolidating this one.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

Family history, we did – this is one where there's a couple of options. So we did suggest that this be integrated into two places. One is the care summary and view/download/transmit. It does in fact end up raising the threshold when you do that. The threshold was already going to be at 40 percent for Stage 3. So given the fact that people when you give them a threshold tend to blow it out of the water anyway, and the threshold for care summary – or VDT is 50 percent. It's 65 percent, but I think it's one that's probably likely to be one of those not always required pieces. I think it's okay.

The other piece that we'll talk about later is if we want to move the care plan up, you could actually include this there as well. But I think the big piece, the most important thing, is that if it is a requirement, particular in view/download, then it does – it does put the reporting of the data to use. It also is an opportunity for patient-generated health data. So comments on that?

George Hripcsak – Columbia University

That sounds good.

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

Sounds good.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. So the next one is electronic notes. We had a lot of discussion about this, and what we recognized is that we're not – having just had the clinical documentation hearing, I think there's still work being done to come up with those recommendations. We did discuss including it in view/download/transmit, because if it's there, then you wouldn't have to – this is a reporting objective, right? So for the consolidation approach, anything that's a reporting is like a red flag by Stage 3. But – since they've been doing it Stage 2.

But the issue then becomes the threshold. So if you integrate it into view/download, even if there was agreement, and I think there was, for the most part, coming out of that hearing, that patients should be able to see the notes –

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

Yep.

Christine Bechtel – National Partnership for Women & Families

– assuming there was that agreement, if you integrated it into view/download, it would mean that the notes would have to be recorded on a higher percent of patients potentially. So we struggled with that. I do think this is something – the denominator as 30 percent is as proposed, but I do think this is something that's probably worth revisiting in our parking lot of items after the clinical documentation piece is done, because there may be a way that we could put it – the question becomes can you put it in view/download in a way that doesn't dramatically change the denominator, but also preserves the denominator? Does that make sense?

Neil Calman – The Institute for Family Health

I don't understand that.

Christine Bechtel – National Partnership for Women & Families

So the denominator – so you have to offer patients – 50 percent of patients the ability to go online and view their health information, and it's a – and it's a, you know, there's a list of what they're able to view. If you added notes to that view, good news is you open it up to patients, but, you know, then we struggled with the implications for the denominator, because as proposed for the notes objective, it was only recording notes on 30 percent of your patients.

Now you could argue that people will really exceed that, so if you just put it in view/download, which is, you know, 50 percent of your patients, which means you're going to really have to record all that data on a much larger percentage, then – right? That's where we struggled as a group. We liked the idea, but we were – we were worried about the denominator issue.

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

So I think that, like with the other thresholds, I don't – I think most people – although actually we found out differently with some recent stats, but most people record progress notes in the record. I think the big change, and it is a big change, is the sharing it with the patients. And I – so that's why I think your approach of keeping it separate as we move it to a stage – I think later on it'll just be part of the clinical summary, and so it won't be a problem. But it's such a new idea to share these with the patients that we probably should, you know, focus on it, take the feedback, and go through this transition phase.

Christine Bechtel – National Partnership for Women & Families

Well, so let me ask you this. Should it be part of a transition of care summary, and that way it could be consolidated? Or should it be part of the after visit summary? Again, if the group – I mean, I thought there was some agreement that the patients should be able to view the notes. So –

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

Yeah, but I think we have to ... that.

Christine Bechtel – National Partnership for Women & Families

Okay.

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

So ... transition of care summary, which is provider – a provider, should it be –

[Crosstalk]

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

No, I don't think that the trans – I don't think we're – the transition of care summary – I mean, it's – for the patient's view, you wouldn't want them to just be able to read the last notes. You'd want them to be able to read – go back and read multiple problem notes, which you're not going to put into – I wouldn't think in a transition of care document.

Christine Bechtel – National Partnership for Women & Families

No.

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

So I think that's sort of – I wouldn't mix the two of those up.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

I think it's totally different, different items.

Christine Bechtel – National Partnership for Women & Families

Okay. Great.

George Hripcsak – Columbia University

Yeah. This is George. Based on the hearing, I would keep it separate for now. Like I know Paul argued that order entry was core, so we should keep it in, but we've been doing it for four years, so we argued back against that. This one hasn't been in for four years, and we just had a hearing on it.

Christine Bechtel – National Partnership for Women & Families

Yep.

George Hripcsak – Columbia University

I think there are things we're going to want to do with it, or which – I – my instinct is not to put it into the other ones yet. Maybe if there's a next stage, it would go in that.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

So we – and we'll talk more about that, too, when we do VDT as part of the broader comments. I think we can move on. So this is already required – not being changed, preserved as a separate requirement. That's true also with the next two, which is hospital labs and test results follow-up. Any comments on those? Okay.

So now we're down to – congratulations, you got through the first bucket, so now we're down to patients and families. So view/download, which really we have not – it's obviously a catchment area for some of these other advancements. So we have – that should be images with a question mark, and also should be images. So we have added those – some things that we have talked about previously.

So Michelle, I didn't probably look at this previously, but the new pieces in here are going to be family health history, ability to amend the record, which we'll talk about in a second, and that's it. We had – we should take out the references to patient education and clinical summary and images and notes, because we didn't agree on all of those. The only one I think we should go back to at some point is images.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Christine Bechtel – National Partnership for Women & Families

Thanks. All right. So this basically – you know, a couple of other pieces coming in here, but it's not moving otherwise. Any comments on it? Okay.

So patient-generated health information, no changes here, although I do think that probably we need to make sure view/download has the capability of supporting it, if we want that. But we can get to that later. So the next one –

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

So Christine, you would be view/download/transmit, and amend? Is that what you're doing?

Christine Bechtel – National Partnership for Women & Families

Yeah – well, yeah, but I – let me explain that. So 204D, here was the thing, right? We – I think most people thought – as we created the capability, particularly in the patient and family engagement subgroup, you know, we were worried about everybody kind of downloading all this data and having a way to correct it. And so as you'll recall, the RFC proposed that we make available to patients the ability to offer an amendment to the record in an obvious manner. And what we know is that the RFC comments came back and said, what does that mean?

And so the idea that we came up with was we could actually – we could do two things. One is we could translate it – you know, make it a certification criteria, so they don't have to, you know, demonstrate that it's been offered so much. All we need to do, though, is make sure the functionality is turned on, which can be done in an automated fashion, so they don't have to check a box or anything.

But the second recommendation here is that if ONC were to create a branded icon, like Blue Button – maybe it's another button, or maybe it's a, you know, triangle, I don't know, but some sort of a branded icon that is common across all systems so that patients begin to recognize that the private sector can pick it up, then they'll know they'll have a common user experience, and they will know how to, you know, say, hey, I wanted to let you know, this piece of my record is incorrect, and then of course the normal HIPAA process takes over, right?

So that's the recommendation here, which is really if ONC could help to create a branded feature, then we could make that feature, you know, part of certified systems, part of certification. And we will – all we would require is that in view/download, the capability must be turned on, which the count would be automated. Does that make sense? What do people think?

Deven McGraw – Center for Democracy & Technology

Christine, it's Deven. I – you know, I like this, because it's a way for patients to say, hey, I think something's not right in here, but it's not giving patients the capability to correct the information themselves, which would be problematic on a whole lot of levels.

Christine Bechtel – National Partnership for Women & Families

Right. Exactly right.

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

I mean, I like the idea, too. I'm not sure I would prescribe a branded button.

Christine Bechtel – National Partnership for Women & Families

Why not, Paul?

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

We could do that for so many things. That's all. I mean, it's just –

Christine Bechtel – National Partnership for Women & Families

Well, this is – I guess our logic was this is one of the few consumer-facing elements, and there aren't that many in meaningful use. So we're not suggesting we do that for provider facing things, and – because I would agree with you, there are a million you could do that. But for consumer-facing things, we agreed on the – view/download is Blue Button, and so we agreed on that importance of a common user experience. But this amendment idea, it was – you and I had come up with this, you know, in an obvious manner wording.

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

Right.

Christine Bechtel – National Partnership for Women & Families

And so the common user experience was really designed to address that obvious manner, because I think we're worried that as consumers are beginning to be able to download data from multiple sources across different healthcare providers from the hospital, whatever, they're not going to know what to do necessarily when they see errors that they – or things they think are errors. And we need to have an easy way that they can commonly deal with that. And I don't think the market is there for having the private sector deal with it, so I think a common – or at least have a common user experience. But if ONC were to create just the, you know, the sort of icon that everybody could use, then the private sector would be able to pick it up, and it could be part of view/download certification.

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

But you can imagine other ways of doing this. So you have an immunization section of your record, and it says when it's due next or – and that could be hyperlinked, and basically you would click on that and you're instantly taken to immunization and – for flu vacs, let's say. And it just avoids so much navigation that that actually turns out to be the most convenient way to, quote, update your flu vacc history, versus going to one button that takes you somewhere that you have to create additional navigation. I don't know that it – Blue Button is like a – just an all-encompassing concept. I don't know why would want to – we would need to be prescriptive on something where I can imagine, you know, even more convenience, less hassle, less navigational burden, than having a generic update.

Christine Bechtel – National Partnership for Women & Families

Yeah. I see what you're saying. I'd like to think about it a little bit more, because I really – I am very concerned about this, and – but I didn't know how else, and I think the subgroup didn't come up with an alternative way to make that capability available in an obvious manner.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

And to make it available in a way that doesn't have to be counted as an independent objective. Because without something like that, I wasn't – you know, it's not clear how to consolidate this piece. So perhaps we can, given that we're going to be running short on time, maybe we can put this on our list to come back to.

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

Yeah.

Art Davidson – Denver Public Health Department

This is Art. I like the concept of adding an A to the end of that VDT.

Christine Bechtel – National Partnership for Women & Families

Okay. That might be another –

Art Davidson – Denver Public Health Department

And then specifically – I think I agree with Paul that, you know, exactly how this works out – I think Blue Button is more just a concept than anything else at this point. And we could say that all the certification criteria are concepts that we're just trying to make possible. And I agree with you that there should be a way for people to amend, and hopefully, it'll be very consumer-friendly.

Christine Bechtel – National Partnership for Women & Families

Okay. So why don't we do this? Why don't we agree that this will be VDTA, as Charlene kind of pointed out, and we'll deal with the common user experience thing later, because it – you raised a good point, Paul, that I hadn't thought about, which is you – you know, you may – it may – it looks like – you may want to only – it's not like a ... where you go click here, and –

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

Right.

Christine Bechtel – National Partnership for Women & Families

– you know – although that could be one way they deal with it. So it may be real specific to data sets, and there's easier ways.

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

Right.

George Hripcsak – Columbia University

So – all right. So Michelle, we'll go ahead and make it VDTA, and then we'll have –

Neil Calman – The Institute for Family Health

Wait, wait, wait. We're agreeing to that?

George Hripcsak – Columbia University

Well, I mean, that's what –

[Crosstalk]

George Hripcsak – Columbia University

We're making the objective – like I have to think about – I mean, you know how strongly some people feel about amend and how that works legally, and what –

Christine Bechtel – National Partnership for Women & Families

And George –

George Hripcsak – Columbia University

– you know, do I amend, you know, part of the operation away?

Christine Bechtel – National Partnership for Women & Families

No, no, no, no. So this is what Deven just said and also what our subgroup has agreed to and what we proposed in the RFC. This is offer an amendment. This is point out where there's information incorrect.

Deven McGraw – Center for Democracy & Technology

Right.

Christine Bechtel – National Partnership for Women & Families

This is not go in and change the record.

Deven McGraw – Center for Democracy & Technology

Exactly.

[Crosstalk]

Deven McGraw – Center for Democracy & Technology

It's just – George, it's Deven. It's just a process whereby the patient can alert the provider that they think an amendment is needed. There's no automatic amendment. There's still a process that has to take place on the provider end to sort of figure out whether they agree with the patient, and that's all laid out in HIPAA. All this does is create the pathway to alert the provider that an amendment –

[Crosstalk]

Neil Calman – The Institute for Family Health

Oh, isn't this just a subset of a secure message?

Deven McGraw – Center for Democracy & Technology

Yeah.

[Crosstalk]

Neil Calman – The Institute for Family Health

So why don't we just – why don't we – it really is a secure – the way you've proposed it, it's the same as a secure message from the patient to the provider, saying such and such is wrong in my record, you know, could you fix it or something like that. So maybe there's just – maybe what we – all we really need is a way to flag this particular type of secure message, at this particular point. I'm not saying that that's the end point, because I think Paul – you know, Paul's issue is critical. I think there needs to be ways to amend certain things that we should think through that will help the workflow. But I think for now, you know, we're really talking about a particular type of secure message.

Christine Bechtel – National Partnership for Women & Families

Okay.

George Hripcsak – Columbia University

I mean – this is George. I just – I'm worried about like what is the process. How much time does it take now that we have an – so we'd have to work through – and then what is the legal implication of not –

[Crosstalk]

Deven McGraw – Center for Democracy & Technology

No, like what is your process is your process, George, to notice that it's pending. The law is already clear that you have to have a process, and I presume that every institution has one already to deal with requests that come in from patients, not through some sort of secure message-like function.

George Hripcsak – Columbia University

Okay, but, I mean, if you suddenly ask – well –

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

Well, so we have this process.

George Hripcsak – Columbia University

Okay.

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

There are links, and you click it. It goes to a licensed professional, because of the implications of changing the record. And we get thousands of these. So there's a – but that's good, because it's, you know, updating our records. But it is real. It does have some volume. And it does require a licensed professional, unless you want to put it to the docs. But we do have a way of not burdening the docs.

Christine Bechtel – National Partnership for Women & Families

Right. So the whole notion of this, this is not new. This is what we agreed and proposed as the Policy Committee in the RFC. We're just trying to consolidate it. So I'll remind people of scope here. But I think part of – so I think the volume that Paul described is going to get even larger with online access, and we absolutely have a responsibility to figure out how to – how to enable that for consumers. But I think where we're getting hung up is the word amend, because that's right where – we're using that as part of the law, but it's really about offering amendments. So it's almost like view/download/transit and flag, you know?

So let's – I think what we have on – the option on the table right now is can this be somehow integrated with either view/download/transmit or secure message, so that it's not a standalone thing that people have to attest to. That's the issue.

George Hripcsak – Columbia University

Yeah. Right. I see.

Christine Bechtel – National Partnership for Women & Families

Okay? So I think Neil did make a suggestion, which would be, you know, maybe there's a way that you integrate it – and that was sort of why we came up – not why, but one of the benefits of the secure message piece in Stage 2 was because we knew that people were going to need to flag amendments. But we really wanted to make that a little more visible. So I think this is one that would be – let me try this out. Can people agree that this is one that should be consolidated as part of either view/download or secure message? We just need to figure out the process for how and what it looks like? Or do people think nope, we have to leave this as a separate objective? Because that's really the question on the table.

George Hripcsak – Columbia University

Right. Right.

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

Consolidating is good. I think for visibility, it sort of fits in the VDTA bucket. It's probably going to be implemented, as Neil says, to the patient messaging. But we don't want to be prescriptive, and that's another reason not to have a button in one place. So it seems like it's helpful in the empowerment side, and –

George Hripcsak – Columbia University

Right.

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

– it's sort of consistent with I view, I download, well, I got to do something with it. So it fits. But it's independent of how it's implemented.

Christine Bechtel – National Partnership for Women & Families

Right. So –

Neil Calman – The Institute for Family Health

Well, I think the thing that's going to be confusing is like in the download part, you can't really – that doesn't really call out a way to give feedback, if you're downloading. So that's why I sort of thought about the messaging piece, because you really – you have to kind of be in communication with the EHR in order to kind of create this message back. So if you're downloading your record, that doesn't necessarily give you the mechanism to comment on it. And – but as part of the messaging function, it does. But I think either place is fine, you know, if we can work out the details.

George Hripcsak – Columbia University

Yeah, that sounds – this is George. My sense ... is just – it's one thing for what you're legally allowed to do. It's another thing if we create a \$10 billion ad campaign that you should check the spelling of your doctor's notes. You know, people have to understand what we're suggesting and what would be the conditions that it would probably be worth the effort to do the amendment, given what it'll cost everybody, cost the nation's health system to actually amend very frequently. So that's what I was – that's really what I was sensitive to.

Christine Bechtel – National Partnership for Women & Families

Okay. But I don't –

George Hripcsak – Columbia University

But anyway, but I'm fine with consolidate, so good.

Christine Bechtel – National Partnership for Women & Families

Okay. Well, so – and I'm not sure that's the problem we're seeing, since it's an existing legal right. But I think what we can do here is just agree that we're consolidating it. We'll make a note that we're putting it somewhere. We're just not sure where. We'll come back to it when we kind of flush it out. Maybe we can talk to some providers and vendors and kind of figure out if there are best practices around how they've done it in practice.

Art Davidson – Denver Public Health Department

Yeah. I think we heard some testimony about providers and patients in a large – like 20,000 patients somewhere on the East Coast, didn't we? And it was – all the docs were overwhelmingly in favor of having the patients comment. So this seems like something that would real – actually be advantageous.

Christine Bechtel – National Partnership for Women & Families

Yep. Yep. Agreed.

Neil Calman – The Institute for Family Health

Yeah. I mean, from my perspective, I will tell you, I'm more afraid of getting messages saying, could you please fix this, than allowing the patient to fix it, and being able to see that it was a patient-entered piece of information, because if you think about what Paul's just said, if every one of these requires some action on your part to do something, not just to view the correction, but to actually say, could you add this immunization into my record, you know, we're going to be – I prefer to have people enter that information and then, you know, have it so that we can see it, but not have to necessarily take action on it. I think that just doing it in this kind of like can you correct this for me kind of thing is going to be crazy.

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

So Neil, there is a downside in some licensed professional not being directly involved, and that is now you have something there that nobody – that you don't know whether anybody's seen it, and then –

Neil Calman – The Institute for Family Health

Well, that's like the lab results. It's like a lab result. You know, it comes in through your – through your inbox somewhere, and you have to sign off on it.

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

Yeah.

Neil Calman – The Institute for Family Health

But that's different than – that's different than somebody saying, you know, can you please add this medication into my medication list, which requires you to go into the record and open it up and do all the rest of that stuff, so –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

This is Amy, and I think what I'm sort of struggling with as I'm listening to this is sort of the difference between patient – really semantics, again, around patient-generated data versus an amendment. When I think of an amendment, I think of seeing something in my record that may be wrong. The missing part is where I'm struggling with, because if got an immunization at a CVS, a flu shot, you know, and I generated and put it in, is that patient-generated data, or is that an amendment?

But if someone says that I have a condition or a disease that I didn't think I had, or I was HIV positive and I didn't believe I was, to me, that's an amendment or an error. So I don't know how to get around the distinction, but I think the examples that I'm hearing are crossing between the definition of what might be patient-generated data and what might be an amendment. And Deven, I don't know if there's a legal definition or some way to sort that out and help us in this when we come back to this and think about it.

Deven McGraw – Center for Democracy & Technology

Well, yeah. I mean, HIPAA is actually really clear on sort of, you know – again, these are patient-requested amendments, which should suggest that the language should not be offer an amendment, but request a change in the language. And then there's, you know, a process that's sort of defined in terms of the provider making a determination about whether they're going to make the amendment or not make the amendment. They have that discretion, actually, and then if the patient disputes it, then there's sort of more data that ends up having to be appended to the record to reflect the dispute. Is that what you're talking about, Amy, or am I not –

Art Davidson – Denver Public Health Department

Well, no, I was actually talking – so if there's – if I see anything that doesn't look right or feel right, both an omission – so is an amendment both an omission and an – and an error?

Deven McGraw – Center for Democracy & Technology

Yes.

Art Davidson – Denver Public Health Department

So then – so then I'm trying to distinguish in my mind how we're defining patient-generated data versus an amendment, because we have them separated out here.

Christine Bechtel – National Partnership for Women & Families

You know –

Deven McGraw – Center for Democracy & Technology

Oh, to me, they're very different. You know, an amendment – an amendment is sort of a term for a constellation of changes to language the patient sees in the provider's medical record that the patient thinks is not right, or is incomplete, like missing a data point, but reflective of sort of what the provider decides to keep in his or her record.

Patient-generated data, in my view, although I think we don't have clear defined terms for these, I'll admit to that, in my view, patient-generated data is data that is – comes from the patient's device, or is part of the experience of care that ideally the patient and provider decide is going to flow in to the provider's office, and be – and in some cases be incorporated into the record. It's additional data that comes from the patient, as opposed to, you know, the patient looking at what the provider's accounting is of what the care has been to date and saying, there's something that's not right about this, but not – but it's not about – because there's data missing that was never part of the care process to begin with.

Christine Bechtel – National Partnership for Women & Families

Well, so – it's Christine, and I know we have to move on soon, but I'll say I'm not – I'm not completely sure I agree with that, Deven, only because if I think about, you know, situations where there – you have an allergy that is absolutely relevant to care, and they didn't record it. That's the same – I mean, it's very hard to treat that differently than I got a flu shot already and it's not reflected in your record. So –

Deven McGraw – Center for Democracy & Technology

So I guess it would then be helpful to – because I was sort of basing my distinction based on the hearing we had about patient-generated data –

Christine Bechtel – National Partnership for Women & Families

Right.

Deven McGraw – Center for Democracy & Technology

– which in my view focused more about increasing the inputs into the record, data that wouldn't necessarily be introduced as part of an office visit, as opposed to data that should have been recorded and was missing.

Christine Bechtel – National Partnership for Women & Families

Right.

Deven McGraw – Center for Democracy & Technology

But I'm – so just – we just need to define it. That's all.

Christine Bechtel – National Partnership for Women & Families

Yeah. Well, I think –

Art Davidson – Denver Public Health Department

And that was my point, because –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

Right. But here's where I'm going with this, which is we – I think this probably is something that needs some workgroup attention from probably a couple of different workgroups, because in Stage 2, we're giving people the ability to view and download and transmit their health information, so we can't rule out the fact that a consumer is going to want to use some kind of an amendment function, whether it's a button or a message or a flag or whatever, to make the connection between two providers who have disparate information that is totally relevant to them as an individual, whether that's an – offering an amendment or requesting an amendment, or whether that's patient-generated health data, is very semantic, and it's not an – it's not an unimportant difference, but the – I think from the viewpoint of the person sitting in the chair going, um, you need a whole bunch of info, we just made it easier for them to want to upload, you know, information from view/download/transmit from their cardiologist over to their primary care, if they're not communicating.

So I think those are broader issues that are likely to come into play in the environment, where we need to figure out does it matter what we call the data? You know, under what circumstances? You know, how are going to manage this from a workflow perspective for patients as well as for providers? Because I think Neil brings up some good things, which is treat this like labs. You know, you're reviewing and accepting. And that was something that we talked about in – it might have been one of the things we put in for future stages, actually, in the patient and family engagement component. So –

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

So, Christine –

Christine Bechtel – National Partnership for Women & Families

– we've got to come back to this.

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

Yeah. What's your timeframe here in terms of finishing your –

Christine Bechtel – National Partnership for Women & Families

Well, finish – so finishing how much, Paul? Because we've got –

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

Quite a bit?

Christine Bechtel – National Partnership for Women & Families

Yeah. Quite a bit. So I don't know if you want to try to come back at a later meeting and finish it, or if you want to try to crank through it today.

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

Well, we've got to get through some deeming.

Christine Bechtel – National Partnership for Women & Families

Right.

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

I think – so our goal is April 3rd, we need to present a cogent and simple explanation of what we're trying to do, to get buy-in – to get feedback on to proceed in this direction or not. So it sounds like – this certainly has been hard to describe and hard to figure out some of the details. I wonder whether we need another call on this, and we – the same thing may be true on deeming.

Christine Bechtel – National Partnership for Women & Families

Well, let me – yeah. I mean, I don't know how much you need, if you're going line by line, but you also said that on deeming, you don't have yet the specific quality measures associated with the bundles, which is for me at least where the details really hit the road.

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

Right.

Christine Bechtel – National Partnership for Women & Families

So I don't know how much time the deeming stuff needs today. I can tell you that in looking what – at what we have left, I think we could get through the rest of the patient and family engagement stuff in ten minutes or less.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

And then we're going to probably have to have some discussion in the third area, the care coordination area. Some of it we have already had, though, so that's helpful. And then we've had – we need some help in public health. So I think care coordination is probably – I would hope a half hour or less, and I'm just not sure about public health, because Art wasn't on our group, and we want to make sure we didn't do anything funky here.

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

So for the members, and then MacKenzie will have to say about staff, do we plow through – so we have another – we have until –

Christine Bechtel – National Partnership for Women & Families

Two thirty.

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

– until 2:30, so we have 2 hours, 15 minutes, including a break. If we leave an hour 45 – an hour for deeming and a half, that would give you 45 minutes. Did I calculate that right?

Christine Bechtel – National Partnership for Women & Families

Yep.

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

So –

Michelle Consolazio Nelson – Office of the National Coordinator

Paul, this is Michelle. I would suggest – I think we need to get through a lot of this to finish the deeming work.

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

So maybe we just have an hour for the deeming and get through as much of this as possible.

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

Right. That's where I was headed. So I think if we can wrap this up in 45, we may be okay.

Christine Bechtel – National Partnership for Women & Families

I think we – I hope we can. I think we can.

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

Okay. All right. So the harder – the detailed things about definition, let's try to parking lot that. We may need another call with the subgroup. But let's get through some of your major issues. So – to help both you and the deeming, actually.

Christine Bechtel – National Partnership for Women & Families

Okay. You want to keep going now, or are we breaking for lunch, or what – I mean, I –

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

It's up to your stomach.

Christine Bechtel – National Partnership for Women & Families

Oh, I'm fine, but I don't know about everybody else.

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

So maybe some of the pressure can be –

Neil Calman – The Institute for Family Health

I'm fine.

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

Okay. So the pressure is that no stomach gets fed until you – Christine finishes.

Christine Bechtel – National Partnership for Women & Families

Yeah. Some of us are smart and we bring our food _____ –

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

Yeah. We bring our food in.

[Crosstalk]

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

It's different than face to face, to some extent.

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

Right.

George Hripcsak – Columbia University

Paul, I'm going to step away for a second, but you guys go ahead, and I'll be right back.

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

All right. Thanks.

George Hripcsak – Columbia University

Not for lunch. I set something up thinking there was a break now.

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

Great.

Deven McGraw – Center for Democracy & Technology

Yeah. Likewise. This is Deven. But that's – don't worry. I'll catch up.

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

All right. Well, proceed, Christine.

Christine Bechtel – National Partnership for Women & Families

All right. Here we go. Office visit summary. So this is – we did not advance this. We did debate putting it in view/download, but the whole point of the change that we made in Stage 3 is something we need to talk about as a parking lot item when we get to the RFC, because the whole point of keeping this going was because we wanted to have it be specific to what just occurred, specific to an office visit. And the Standards Committee, as you'll recall, told us that the standards aren't tied to temporal points in time. However, we do have lots of people doing this already, so we need to have a separate discussion about that.

So pending that discussion, what we've suggested is maintain this as a separate objective, but add per patient preference, which means that you could gain some efficiencies in making the summary available via the portal or secure message if the patient wanted it that way. And then – but again, it's a certification criteria, and we wanted to explore – we can do this separate – whether or not the criteria could allow the provider to select which data to include and exclude. Is that some kind of a workaround for the timing issue? Things like that. But – in other words, bottom line, this stays as a separate piece. Any comments?

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

Sounds good, for those reasons.

Christine Bechtel – National Partnership for Women & Families

Okay. So record communication preferences is the next one, 208, on line 32. This we have integrated back up already into all of the patient-facing, you know, stuff, which is patient education material, patient reminders, and the office visit summary. So it can be – it can be consolidated. So – and that's that. Any comments on that?

Neil Calman – The Institute for Family Health

So are we thinking that people – I guess I'm just trying to make sure this isn't done by exception, right? Like there's a difference between saying you have to ask people about their preference, or basically saying, oh, by patient preference, oh, well, that's fine, that just means I'm going to do it the way I normally do unless somebody asks me to do it a different way.

Christine Bechtel – National Partnership for Women & Families

Right.

Neil Calman – The Institute for Family Health

And I think those are very different. And I just think – I don't know. I was a little worried about this one.

Christine Bechtel – National Partnership for Women & Families

Yeah. I'm worried about that, too, and there's a couple of places where we want to kind of – it requires an understanding from ONC and CMS about implementation, because that's I think what we need to know here, because we don't want – it's the same thing for care summary. You don't want the template to be defaulted to an answer. You want to actually have to ask the question. You don't want to assume –

Neil Calman – The Institute for Family Health

Right. But the other thing you could do is you could just say, like right now, if you don't ask for patient preference, it's going to get done the way – you know, there's going to be a default in the system. Even if that field doesn't default to being, you know, English, or, you know, cell phone, or whatever, it's still – there's going to be a default in the system somewhere for the miss – for missing data, because there's always missing data. So –

Christine Bechtel – National Partnership for Women & Families

Michelle, in Stage 2, the patient education materials were supposed to be delivered per patient preference. Do we have any sense of how this issue would potentially be playing out in Stage 2? Because that was an example where ONC actually did integrate this, but they only integrated it into one place on a small population.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. I mean, so there was certification criteria added for patient preference, but not the way that you were hoping for it to be added, I think. And – so I think there still is a little bit of clarification that needs to be made, because per patient preference, as was just said, it could be defaulted, and people may not really be asking it. So we just have to be careful and make sure that the true intent of what you're trying to achieve doesn't get lost.

Christine Bechtel – National Partnership for Women & Families

So if we – if we revised the wording of the measure for the patient education materials, the visit summary, etcetera, and we – and we make it so that it is explicit in the objective and the measure, that they are – that patient preferences for communication are collected and honored, you know, to be – at least for these three types of communication preferences, which is VDT, where we put it in here, VDT – I'm sorry. I lost my place.

Art Davidson – Denver Public Health Department

Secure messaging and paper.

Christine Bechtel – National Partnership for Women & Families

Thank you.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

Right. So if we write that into the objective and the measure specifically in those other three areas, will that solve the problem?

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

I have a couple of comments. One, in terms of trying to make it a routinely captured thing, you might move this to demographics, which is probably a convenient place in the workflow to capture this information. The other is there's going to be a significant pull – I mean, we already have that, but then we have a high penetrance of this stuff. It is far more, far more efficient for us to distribute information – it could be a drug recall, it could be a notice about when the flu vacc is available, via the secure patient messaging, than it is to push out letters.

So it is in our best interests to know this and to know how we get information best to patients. So I think there will be a pull once we cross this – cross the tipping point, and of course, this program is pushing people past the tipping point. But the main thing is to help people understand where – what are the things that you're going to run into and that you'd like to know in the future? And you'd put those things in the – in the workflow of gathering information about patients. You gather the insurance, you gather the contact information, and whether you can leave a message or not, and you gather what their communication preferences are. So in some sense –

Christine Bechtel – National Partnership for Women & Families

You know, Paul, that would argue for leaving it as a separate objective, because remember that we've integrated demographics into care summary and VDT. I guess –

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

You could do the same thing, really.

Neil Calman – The Institute for Family Health

I thought you were arguing – I thought you were arguing in the other direction, that basically there's going to be such a compelling reason to capture it that you don't really need it to be separate. Is that – is that what you were trying to say, Paul?

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

Yeah. There is – no, there isn't – there isn't a – there isn't a reason to force people to do something, because I think it's going to be in their best interest and most efficient, but –

[Crosstalk]

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

– you've got to make sure that the EHR has that field, and then you've got to build it into your work flow. So to have the field is the certification requirement. The in your workflow, my suggestion is that it's part of demographics, and if you choose to make demographics part of the summary of care document, that's fine. But that's where you lump this stuff.

Christine Bechtel – National Partnership for Women & Families

So I agree – I mean, I – in some ways, I like the idea that when the next – I mean, the idea here was what's the best way to communicate with the patient, which might be helpful on a – on a care summary, but as far as meaningful use, the scope is really best way to communicate the patient-facing pieces of after visit summary, you know, yada yada, education materials and what not. So, I mean, I get what you're saying, and I like – I like it. I think I have one concern, is when we did demographics, the reason we got it into the workflow was because we started it as a recording objective, which this has not been ever done as a recording objective. It's new. So the – I have a worry about that.

The other concern that I have is when I hear you describe it, it feels like the incentive is really for the provider to communicate in the way that is most efficient for them, even though I may, because it's a secure message, I may never check the portal, or I may never –

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

Right, but that's why – see, we have a requirement to get the information to them, let's say a drug recall, so we will do whatever makes sense for them, but we need to know that, which is why we came to – we already do this before, of course, meaningful use. It's just because we need to find the best way to get to them. And the only way is to ask them, which is like –

Christine Bechtel – National Partnership for Women & Families

With drug recall, that makes total sense, but what about patient education materials and the after visit summary, where you're just handing out paper – we hear story after story where you're handing out paper and they don't want it on paper and they end up in the parking lot.

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

But I – that's why we would want this field to apply to – so I guess I'm endorsing what you said, which is add per patient preference to, for example, educational material.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

And certainly the clinical summary. And that will help this problem of the parking lot problem.

Christine Bechtel – National Partnership for Women & Families

Okay. Okay.

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

But the educational piece and the piece where – okay, so the certification requirement is that they have a field, and the field is used in these different communication functions. The education is to help people consider, this is part of demographics, which you gather on every patient. And then the payback will come as these things start popping up.

Christine Bechtel – National Partnership for Women & Families

Okay. So I think what we need to figure out – so do we also want to put it in demographics so that it goes in care summary and VDT? Is that what you're saying in addition?

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

Yeah. Yeah. So that's the educational pieces. This is one of those things you collect on everybody, and it'll pay you back over and over.

Christine Bechtel – National Partnership for Women & Families

Okay. And then so Michelle, I guess I'm back to my original question. We'll write the language into the objective and the measure, of course, for the other three areas where we just agreed to do the integration. Will that help address the – that'll help address the problem, and then the rest of it, what Paul's saying is it'll be market forces and convenience that'll deal with the rest.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Christine Bechtel – National Partnership for Women & Families

Is that right, Paul?

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. Any – everybody okay with that? Any other comments? Okay. The next is query research enrollment. That was already certification only, so that can go on our separate certification list, basically. The – so now we're into the care coordination section on reconciliation. So this one is, again, one we suggest be preserved as a standalone, because we're actually suggesting that it is expanded. So we talked about 125, the interdisciplinary problem list and med history being put here as well. And then adding immunizations here, but not removing that objective. So I think that's what we just agreed to, right? Yeah. On the immunization? Is that what we meant here, Michelle? I'm confused a little bit by the language.

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

Could you scroll up a bit, please.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yeah. Can you scroll up, please?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes. So – sorry, not to be confusing, but Christine, I think you skipped 206 and 207.

Christine Bechtel – National Partnership for Women & Families

Really? Hold on.

Michelle Consolazio Nelson – Office of the National Coordinator

They really – we've kind of discussed them anyway, but I just want to point that out. I don't think you actually walked through them.

Christine Bechtel – National Partnership for Women & Families

Oh, thanks. No. I sure didn't. My bad. I must – I think that I – I was having to do my own spreadsheet, because I can't read the Altarum one. So – okay. So yeah, 206, sorry, was patient specific education material, and again, we agreed to just preserve that but add per preference. 207 is secure messaging, which we did not make any changes to. So pending no comment, we'll do the reconciliation. This is the one where we're basically changing it from med – you know, I think this was med, right? Kind of? Hold on a minute. Let me get to it.

Michelle Consolazio Nelson – Office of the National Coordinator

It was med reconciliation, but –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

We're on 302 now?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

Yeah, 302. So it was – so the original objective was reconciliation for meds, med allergies, and problems. That was the proposal. So we're saying preserve this, but add immunizations as well. And I think allergies. So that way, interdisciplinary problems can come here and be integrated. It also drives the – what we talked about earlier is the problem med lists and allergy lists. We did agree to that earlier, but just double checking.

Art Davidson – Denver Public Health Department

So earlier we discussed the beginning, all that related to e-referrals through CPOE. When does reconciliation for a referral occur?

Christine Bechtel – National Partnership for Women & Families

I can't speak to that. I don't think we ever proposed an objective like that.

Michelle Consolazio Nelson – Office of the National Coordinator

No. The closest I think is 305, getting the receipt from who you referred them to.

Christine Bechtel – National Partnership for Women & Families

So if you want to raise that, Art, we can put it in our parking lot list for –

Art Davidson – Denver Public Health Department

Yeah. Maybe for later.

Christine Bechtel – National Partnership for Women & Families

Okay. Okay.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Well, and I'm assuming this reconciliation is a provider-provider reconciliation and does not get back into our conversation about –

Christine Bechtel – National Partnership for Women & Families

The patients.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

– patient reconciliation, but this is where I think, you know, again, if there's – I mean, I think Art's point is a good one. If there's not sufficient exchange between providers and the patient notices it and wants to somehow figure out how to reconcile, amend, generate, whatever, I mean, I think they all kind of get related in some way. We might – we need to tackle them individually, but I just put it out there as –

Christine Bechtel – National Partnership for Women & Families

Okay.

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

So two things. In terms – this is Charlene. In terms of the referral, again, we got a lot of pushback in terms of the readiness of the standards. Now I know there's a lot of work going on in ONC to solidify the standards, so again, that was kind of the respond to the referral question. So we just, kind of like Paul said, just tried to get it off the ground and starting to make a call for the infrastructure that we needed. So

–

Christine Bechtel – National Partnership for Women & Families

Right. So what we're going to –

[Crosstalk]

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

... Stage 3 approach, and then the other one, in terms of reconciliation of immunizations, they're pretty complex, so are we sure that the standards are there, before we plop them in there? Because we're even concerned – problems reconciliation is not going to be trivial, even though they expect the standards to be there.

Christine Bechtel – National Partnership for Women & Families

Yeah. I'm trying to look up – okay. The immunizations reference, because it's not quite specific enough for us.

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

I know we had thought about pulling them in so that we could reference them and see if the immunization had been done, but I wasn't sure that we were going to actually integrate it into the record and –

Christine Bechtel – National Partnership for Women & Families

So Michelle, which immunizations are we talking about there? Because I'm not sure if that's right or not. I mean, we have immunization registry _____ –

Michelle Consolazio Nelson – Office of the National Coordinator

So that was added by Steve. That wasn't – most of the conversation was about merging 125 and 127, which are objectives ... But then there was also the discussion of adding – I think it's 401A into the reconciliation piece.

Christine Bechtel – National Partnership for Women & Families

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Because you're getting the ongoing submission of the immunization data. But to Charlene's point, that could be a lot harder than the initial intention of this reconciliation item.

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

Right. Yeah.

Christine Bechtel – National Partnership for Women & Families

Yeah. I think that –

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

Reconciliation really meant robust reconciliation, when we thought about this, you know, but viewing is great. We thought that was great. And again, I don't preclude us from doing immunizations, but we just didn't ever get any feedback on doing it. That's all.

Christine Bechtel – National Partnership for Women & Families

Okay. Just – I think hold on one second, because I need to flag a couple of things for folks. So probably – I think what Charlene is saying is we're maybe not ready for the immunizations piece. 127, the interdisciplinary problem list, is actually proposed for a future stage. So I think what we meant there was eventually when we get ready for the interdisciplinary problem list, it could live there, but it wouldn't live there now. And same with 125, because that's med rec PDM, and that's future stage only, too. So I think we can – we got a little confused here. Hold on.

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

I have a – when you say the standards are not there for problem reconciliation, as an example, what are the standards you're – what needs to be ...? I mean, we have SNOMED for problems, so what is the standard for reconciliation?

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

This is Charlene. It was just the data that we need – like we've got the SNOMED codes now in place for problems. We've got the allergy piece now starting ... sorted out, so we could start to, you know, integrate the data there. So immunizations, are they – the content of those standardized such that from a systems perspective we can pull that data in and understand what it means, as well as – and we just never looked at that part in terms of, you know –

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

But I think – I guess I was asking about the problem – I thought you said the problem reconciliation there, the standards weren't ready, but what does that mean?

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

No.

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

Oh, okay.

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

No. No. I didn't say –

[Crosstalk]

Michelle Consolazio Nelson – Office of the National Coordinator

Can I make a suggestion? This is Michelle. So it sounds like we need to review it at the workgroup level when we review the comments and the feedback from the Standards Committee regarding where the standards are at. I mean, some of the Stage 4 things, I mean, I think the hope would be that if possible, we'd get it into Stage 3. So if, for example, it does get into Stage 3, then it could possibly be moved into this reconciliation item, but it's definitely a future conversation once we look at the RFC comments.

Christine Bechtel – National Partnership for Women & Families

Yeah. So I think the bottom line after I've gone through this in a little more detail is that this – tell me if I'm right, Michelle. What we are actually saying here is that the reconciliation objective stays how it is, and that in – if we do add in the future interdisciplinary problem list or med history reconciliation from PBMs, which are proposed – were proposed for future stages, but if we – when and if we do, those could come here, but other than – and I think, you know, since we're not – we're keeping immunizations as a separate objective anyway, I think this stays the same.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

Okay. So we need to just clarify that.

Michelle Consolazio Nelson – Office of the National Coordinator

Yep.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. So sorry about that, guys. All right. So any comments on the new information that this actually does stay the same? All right.

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

Thank you.

Christine Bechtel – National Partnership for Women & Families

Uh-huh. Okay. So 303 is the transition of care summary, so obviously, this stays. We've already made some edits, like status of pending referrals. We would, based on our earlier discussion, we would remove, Michelle, the reference to advanced directive status, I think, or – no.

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

We at least wanted – oh, am I on?

Christine Bechtel – National Partnership for Women & Families

Yes.

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

This is Charlene. We think that's a good get to include the – at least indication there.

Christine Bechtel – National Partnership for Women & Families

Okay. Yeah. Okay. And it does –

Neil Calman – The Institute for Family Health

Does the status mean anything if we don't know where it is or what it is? Like what if it says yes? I mean, what does that mean?

Christine Bechtel – National Partnership for Women & Families

Well, that's – Neil, that's the problem we've had since the beginning, which is –

Neil Calman – The Institute for Family Health

I know, but it just says – it's like meaningless. I mean, it's – in fact, it's probably more dangerous than anything, because then people don't ask, and meanwhile, nobody has any idea where it really is, where it exists, how old it is.

Christine Bechtel – National Partnership for Women & Families

Okay. I'm going to cut you off because we –

[Crosstalk]

Neil Calman – The Institute for Family Health

Okay. That's fine. Cut me off.

Christine Bechtel – National Partnership for Women & Families

– had the hearing on it, or the listening session.

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

Yeah. Okay.

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

So – all right. So we will come back, and we don't – I don't think it makes sense to do it now time-wise, but we should come back and talk about the care summary after today to make – you know, to take a fresh look at what we've put in there, and any issues that we may need to address. But I think we agree it maintains itself as a separate objective.

Neil Calman – The Institute for Family Health

Yes.

Christine Bechtel – National Partnership for Women & Families

Okay. We have the transition of care plan, which again is something we need to talk about, because there were lots of things we could put here, but it was suggested for future stages only. So in terms of consolidation, there are some things, and we can do the work after the call as well, if needed, or come back to it today if we have time, of really rethinking the idea of care plan, that it – perhaps it shouldn't be – perhaps there should be some basic functionality that we could, you know, eliminate three or four objectives if we put them here. So I think we can come back to that when we're done. Does that make sense to folks, or anybody want to suggest a different idea? Okay.

So Michelle, maybe you could put that on our short list here of the immediate follow-up, along with care summary content.

All right. So the next is interdis – or, sorry, is referral receipt. So we're not – we did not suggest changes to this. We had a lot of discussion about it earlier, but we did not suggest any consolidation here. So I don't think it's worth talking about, because we can revisit the content in the RFC discussion ... I mean.

The next two were future stage only, and we just talked about them, so we're going to skip right into healthcare event notification, which we made no changes to as well. That takes us into public health, which is great. So Art, we're going to need you here. And Michelle, you – we're probably going to need your help, because I know you've done a lot of good thinking on this. So on immunization registry, we're saying maintain it. I think we just – we just decided that we probably shouldn't include it as part of chart reconciliation, so we will revise that. Feed – Michelle –

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, Christine. This is Michelle. I accidentally hung up. I just got back in.

Christine Bechtel – National Partnership for Women & Families

Oh.

Michelle Consolazio Nelson – Office of the National Coordinator

Which one – sorry.

Christine Bechtel – National Partnership for Women & Families

Great. So we're on 401A, row 41, and there's an actual – glad you're back, because there's – I was just saying, Michelle, I need some help here. There's a star that says feed from immunization measure is still needed; therefore, it would not be discontinued. Oh, okay. So that's the rationale for it, right?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

Okay. So maintain it.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

All right. So keep going. We're going to keep going on anything that says maintain unless somebody stops and says no, you can put it somewhere else.

Michelle Consolazio Nelson – Office of the National Coordinator

Christine, sorry. On that one, we had said to include it as part of the reconciliation item, but I'm going to remove that now.

Christine Bechtel – National Partnership for Women & Families

Yep. Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Christine Bechtel – National Partnership for Women & Families

I just said that. You just missed it when –

Michelle Consolazio Nelson – Office of the National Coordinator

All right. Sorry.

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

No, that's okay. Glad you're back. Okay. So Immunization CDS. This was one that we talked about integrating into 113, so we'll give you a second, and I'll tell you that 113 is the decision support measure. So it's not standalone. It becomes part of the decision support. That's our suggestion. Anybody have thoughts on that?

Art Davidson – Denver Public Health Department

That sounds fine to me. This is Art.

Christine Bechtel – National Partnership for Women & Families

Great.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

This is Amy, and I do have a question. So under – just remind me. Under the decision support, you have to do one clinical decision support from each one of those four categories?

Christine Bechtel – National Partnership for Women & Families

So –

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

– that's a good – that's a good question. So it's – in Stage 3, the proposal is implement 15 decision support interventions or guidance related to five or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 interventions should include one or more interventions in each of the following areas. So the four areas listed are preventive care – and it says including immunizations there, chronic disease management, including hypertension, appropriate list of labs and radiology orders, advanced medication-related decision support.

So I guess the question is, there's a bullet that says preventive care, including immunizations. If we integrate this above, are we trying to make sure that immunizations is one of the decision support rules they use, and if so, it probably needs to be listed in a separate bullet under 113. But if it's one of some of them under prevention, if we're okay with it being one of, you know, other preventive ones that they could choose, then the measure – 113 as its written seems to me to be fine.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

And I guess that's what I was trying to clarify. Does – so this means you could pick it or you could choose another prevention one and not do it.

Christine Bechtel – National Partnership for Women & Families

Correct.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

As I read this.

Christine Bechtel – National Partnership for Women & Families

I think that's right. So that's the question. Is it so important that it must be one of the decision support rules, because obviously, as a separate objective, that would – that would have been the effect.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So Art, I don't know how you feel about – I mean, I would – I would say that he – you know, the public health community would – since it's been associated with registries, and registries themselves often have the clinical decision support, which is something else that we've talked about, whether giving this up completely, or whether saying this is one of them under that category is –

Art Davidson – Denver Public Health Department

To me, it seems like one of them under that category is valuable. And the other thing that I think is that we should be trying to consolidate knowledge. We're – you know, each of these EHRs need to be receiving this knowledge somewhere. And I think, you know, the clinical decision support is also going to be providing us with types of knowledge that can be consumed by an EHR to run a CDS rule, rather than every EHR having to write its rule –

Christine Bechtel – National Partnership for Women & Families

Yeah.

Art Davidson – Denver Public Health Department

– and then tweak it over time. It just seems like we should be not creating separate systems for maintaining this knowledge of importance to so many EHRs across the country.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Well, that's what – that's what I'm struggling with, because – and I know you and I have talked about this before, I – where the decision support sits for immunizations, whether it's built into an EHR or into individual registries at the state level, or both, and how that gets reconciled –

Art Davidson – Denver Public Health Department

They – I think the EHRs are going to have to figure out smart ways to maintain that and do that.

Christine Bechtel – National Partnership for Women & Families

Right. And the – correct me if I'm wrong, but the fact that the EHR would have to be capable – I mean, we could – what we can do I think to make sure the base is covered is say that this becomes certification only. It's not that it goes away. It's that this – it's that 401B becomes certification only, so you know that this is one of the many rules that an EHR is capable of doing.

Art Davidson – Denver Public Health Department

Right.

Christine Bechtel – National Partnership for Women & Families

And then whether or not the rule is selected really comes into play under subgroup 113.

Art Davidson – Denver Public Health Department

Right.

Christine Bechtel – National Partnership for Women & Families

Make sense? Is everybody okay with that approach?

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yep.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. So 402A is merge electronic lab reporting and syndromic surveillance, and I think – yeah, this is – we're now well beyond my area of expertise here.

Neil Calman – The Institute for Family Health

Yes. I don't understand that one.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yeah. They're different things. I'm not sure I follow that, either. I know Art and I were at the same – we were traveling to the same meeting and weren't on when you covered this earlier this week.

Christine Bechtel – National Partnership for Women & Families

So – right. But so the – that's why Michelle's put all the stuff in here for us. So EH core, it was the capability to submit electronic reportable lab results at public health agencies, and then there was a separate one about capability to submit syndromic surveillance data.

Art Davidson – Denver Public Health Department

So syndromic surveillance data goes way beyond just lab data.

Christine Bechtel – National Partnership for Women & Families

Right.

Art Davidson – Denver Public Health Department

And so –

[Crosstalk]

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

Could you scroll it so that we can see the A?

Christine Bechtel – National Partnership for Women & Families

Yeah. Scroll up. Okay. You know what? I might be able to do it. No, other way, I think. Yep. There you go. The one with the red.

[Crosstalk]

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

Thanks.

Christine Bechtel – National Partnership for Women & Families

So I'm not – I think – is George back?

George Hripcsak – Columbia University

George is back.

Christine Bechtel – National Partnership for Women & Families

George, do you remember on this one in the subgroup, was it merged – were the two things merged because it was really like the certification – I'm sorry, the capability to submit, and then it's just really the data sets that are different? I can't recall why –

George Hripcsak – Columbia University

Yes. I was – that was the intent. We have to look whether that really works.

Christine Bechtel – National Partnership for Women & Families

Right.

George Hripcsak – Columbia University

But the idea was if we're doing different forms of submission to the same agency, can we put that into one objective.

[Crosstalk]

Art Davidson – Denver Public Health Department

So it's not necessarily the same agency. That's one thing.

George Hripcsak – Columbia University

So the syndromic and the surveillance are not the same? The reportable lab results –

Art Davidson – Denver Public Health Department

So if syndromic takes off the way that they're trying to do it with BioSense 2, it'll go a different way than to the state, which is what – which is the local – where the reportable laboratory –

[Crosstalk]

George Hripcsak – Columbia University

Yeah, but that's – yeah, but that's not – yeah, but even syndromic might have to go two ways. It might have to go to the state and to BioSense 2.

Christine Bechtel – National Partnership for Women & Families

But if –

George Hripcsak – Columbia University

So the – so I don't think the single – number of agencies – yeah, I don't think number of agencies has to –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So I'm – this is Amy. I'm confused. I'm confused at what they're saying. Is this saying that regardless of – because we know the data elements are not synonymous here. So is this – are you trying to say that you can do one or the other, or you only have to do electronic lab reporting? Because that doesn't cover all the syndromic surveillance information. Or are you –

Michelle Consolazio Nelson – Office of the National Coordinator

No. It really was just merging them into one objective. I mean, you'd still have to do syndromic surveillance and you'd still have to do ELR. All the requirements were the same for both, so the thought was, well, let's just put them into one measure, because they're both, at least according to the objectives, getting reported to the public health agency. So just check one box instead of two. But the work is really the same, Stage 1 or 2.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So – well, when they go to the – when they go to an agency, they may not go to the same part of the agency, but that's – and I think that's what Art was getting at. So if we're just – we're calling it one objective, but you still have to do two things. What happens if you don't meet one half of the objective? You don't meet either of them?

Michelle Consolazio Nelson – Office of the National Coordinator

Correct.

Art Davidson – Denver Public Health Department

That's it.

[Crosstalk]

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So pushing this by saying you do both or you don't get credit at all?

Christine Bechtel – National Partnership for Women & Families

Well, but I think if you – I mean, the way that it's set up now, if you fail one objective, period –

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

Christine Bechtel – National Partnership for Women & Families

– you're out.

Michelle Consolazio Nelson – Office of the National Coordinator

I mean, they're both core for EH anyway.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

And they're both menu for EP.

Christine Bechtel – National Partnership for Women & Families

Right. Which we would – which we did preserve.

George Hripcsak – Columbia University

Well, so then – so the only difference would be for EP, couldn't do one without the other. So that's the only slight change.

Christine Bechtel – National Partnership for Women & Families

Yeah, that's – yep, that is true.

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

But we did go through – I mean, it's like the same technology. It's the same part of your EHR. It's a different field, I realize. And although it might be going to a slightly different agency, it's their job to route it. I mean, it's going to be the same technology on their end. It's kind of like saying, well, should the transfer – should the summary of care be three objectives to cover the three different parts of the summary of care record? Well, no, we put it into one.

Christine Bechtel – National Partnership for Women & Families

So – but I think what we just realized is that at least EP probably does have to be a different objective, which, you know, you haven't – if you have – you still have the same number of objectives, I think, if you do that, right? So if you pull EP out because it's menu, so they're not – I don't want to disincentivize people, because oh, I've got to do two things in one item. You could merge them potentially for care, at least – I mean, for hospitals in theory, but if you have to pull the EPs out, then you have two objectives, that's one VP, one VH, as opposed to one ELR and one syndromic surveillance. So if we have to pull the EPs out, then we should probably just revert back to how it was.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I personally think this is going to confuse the – at least the public health agencies way more, because I agree with you. I think the EPs need to be separate. I mean, I think you need to go back, if they're both menu. And I think this will add more confusion than it's worth. But that's my personal opinion.

Christine Bechtel – National Partnership for Women & Families

Okay. That's helpful, Amy. Other – anybody else, thoughts on this?

Art Davidson – Denver Public Health Department

Has Farzad commented on this?

Michelle Consolazio Nelson – Office of the National Coordinator

No.

Christine Bechtel – National Partnership for Women & Families

No.

Art Davidson – Denver Public Health Department

You might get his opinion.

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

Yeah. And, you know, this is the piece where, Art, you've been kind of over the long – from the vendor perspective, there's two separate, you know, transactions that we have to support, and could vary by multiple states. And the vendors have been saying we need to come to a single set of standards, at least for each of these scenarios, and then, Art, you were advocating for more commonality even among those different standards. We still need to be pushing in that direction. So I don't think it's there yet. So –

Art Davidson – Denver Public Health Department

Yeah.

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

You know, if – and there's kind of two different use cases right now.

Art Davidson – Denver Public Health Department

They are. They're very different.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. So it sounds like we'll revert back to the original recommendation.

Christine Bechtel – National Partnership for Women & Families

Yeah. I think that's probably best, because either way, I mean, unless – does anybody disagree with the fact that you have to pull EP out of this anyway? So given that, it doesn't do anything, and it's potentially confusing. It doesn't gain us any consolidation. So let's just go back to the original.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I think that – again, this is Amy. I think that is the simplest, easiest way to deal with this.

Art Davidson – Denver Public Health Department

Yeah.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. So the next one is access to case reporting. There's no change there. The one after that is the syndromic surveillance, which we just agreed that it's going to be no change to recommendation there as well. So cancer registry, basically, what we – there were some – there were several different registry items, so we're on 404. There was cancer registry, specialized registry, and associated infection registry. There was also the FDA registry, but that's future stage only. But – so the recommendation was rather than having them all listed separately, that we would put them altogether. I think the only question is that we never specified in the RFC for like specialized registry or whatever, whether that's a menu or a core. So we're not really – and same for cancer. So we have to think about are these menu or core, because if they're menu or something – you know, I don't know. But anyway –

Art Davidson – Denver Public Health Department

So is it – in Stage 2, is the specialized registry core?

Christine Bechtel – National Partnership for Women & Families

No, it's menu.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I thought – isn't cancer core in Stage 2?

Art Davidson – Denver Public Health Department

Yeah. I can't remember. Are there core – are there menu items in Stage 2, Paul?

Christine Bechtel – National Partnership for Women & Families

I have –

Michelle Consolazio Nelson – Office of the National Coordinator

I believe they're both menu, but I'm checking.

[Crosstalk]

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

Yeah ... yeah.

[Crosstalk]

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

I think they're menu as well.

Christine Bechtel – National Partnership for Women & Families

Specialized registry is menu. It's EP only, and menu. And cancer registry is also EP only and menu.

Art Davidson – Denver Public Health Department

Okay.

Christine Bechtel – National Partnership for Women & Families

So – okay. So that helps. So – but we never said in Stage 3 if we intended for them to be core or not, so I don't know if that changes anything. But we felt like we could do something like the CDS, you know, format, the one we did for, I think – what is that, 118? Where we say there's a capability to submit electronically to a standardized – you know, a standardized, commonly formatted report, to two registries from certified EHR, to either local, state, public health department, except where prohibited, or, you know, a specialized registry. So you can read the rest of it there, but that was kind of the thought.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So this is Amy. I agree. It sounds like what we're doing is we're taking the cancer registry and sort of putting it in with the rest of the registries and saying, pick some registries.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I mean, just simplifying. Which I actually think makes a lot of sense, because I know a lot of people felt that way even in Stage 2. They didn't know why cancer was separated out from others.

Christine Bechtel – National Partnership for Women & Families

Right. So it could be that one option here would be say, you know – we have to figure out if registry reporting is core, does that apply to everyone, and is that appropriate. If it did, you could say, you got to pick one. Or if you pick this item, you have to pick one. You know, that kind of a thing. And you can pick all these – or you can say one or more. But just to put – and I think we have some work to do with this text, because it's pretty dense and there's some typos. But the whole idea is just give people a list of registries.

Now the only thing to consider is if, you know, somebody – does – I want to make sure that it doesn't provide specialists with even less flexibility in the end. So I think we have to come back in a way to this, because depending on – we didn't – depending on the number of menu items you have to choose, for a specialist, if you lump them all into one, then it becomes they only have one menu item, as opposed to they could be submitting to multiple registries and call that multiple menu items.

But because we never really went through in a unified way in the RFC and said each of these is menu and each of these is core and this is how many you have to choose, we don't know. So we may want to flag this as something to come back and look at structurally once we figure out the rest of what the program looks like. Does that make sense?

Art Davidson – Denver Public Health Department

Yeah. So I think I basically agree with this. And way at the beginning, I was suggesting you could select maybe combining these, so I'm glad that we're kind of returning to this.

Christine Bechtel – National Partnership for Women & Families

Okay.

Art Davidson – Denver Public Health Department

But one of the things is – this one registry, which is now listed here as associated infection registry, is healthcare-acquired infections, and did we have that for EPs and EHS, or just EHS?

Christine Bechtel – National Partnership for Women & Families

It's EH.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

It's EH.

Art Davidson – Denver Public Health Department

Right. And that may be a little bit different than these other types of registries, although we may decide to lump them all together. It has a lot to do with the quality of care in a hospital.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I thought there were – this is – this is –

Michelle Consolazio Nelson – Office of the National Coordinator

I don't think that we could lump them currently, because the other two are EP only, and then the associated infections is hospital.

Art Davidson – Denver Public Health Department

Okay. Okay. I – because I thought I heard earlier Christine make mention of that. But we're going to keep that separate. Right. Okay.

Christine Bechtel – National Partnership for Women & Families

I did actually make mention of it, I did, because it is – see subgroup 404 down below, Michelle. But I think we didn't – we didn't –

Michelle Consolazio Nelson – Office of the National Coordinator

I didn't mark – I should have – I – this is something we really need to talk about as a group, anyway, so –

Art Davidson – Denver Public Health Department

Okay.

Christine Bechtel – National Partnership for Women & Families

Okay. All right. So – but – so I think we'll keep that separate because it's EH.

Art Davidson – Denver Public Health Department

Yeah.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

But I can just go back? Cancer was EH and EP, right?

Christine Bechtel – National Partnership for Women & Families

No.

Michelle Consolazio Nelson – Office of the National Coordinator

No, EP.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Cancer is only EP?

Christine Bechtel – National Partnership for Women & Families

Yep.

Michelle Consolazio Nelson – Office of the National Coordinator

Yep.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Okay.

Christine Bechtel – National Partnership for Women & Families

Okay.

Art Davidson – Denver Public Health Department

So I think, you know, basic concept of lumping is a good idea, and Michelle, I'm sorry I couldn't get back to you earlier this week when you send this to me.

Michelle Consolazio Nelson – Office of the National Coordinator

Oh, that's okay.

Art Davidson – Denver Public Health Department

I'll work on this with you and Christine, and bring something back to the group where we can make work this wording out and address both issues of EP, EH, and numbers, and stuff like that.

Christine Bechtel – National Partnership for Women & Families

Okay. That'd be great.

Art Davidson – Denver Public Health Department

Okay.

Christine Bechtel – National Partnership for Women & Families

So everybody agrees that we're going to kind of lump and combine as much as we can, but there may be some, like the associated infection registry, where we keep it separate because it's EH only.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

And could I just – this is Amy. I'm just clarifying. Based on reading this, immunization registry submission is still a separate one?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Okay.

Christine Bechtel – National Partnership for Women & Families

Unless –

[Crosstalk]

Art Davidson – Denver Public Health Department

That is indeed true, based on, what is it, 401A, right?

Michelle Consolazio Nelson – Office of the National Coordinator

Correct.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yeah. The reason I was looking is because under the wording, it says additional registry, and that puts immunizations back in, but earlier, it said this is in addition to immunizations. So I was confused.

Christine Bechtel – National Partnership for Women & Families

Oh, hang on. Let's –

George Hripcsak – Columbia University

Well, there could be – I mean, there's the public – I think we should take out immunizations so it's not unclear, but actually, it's true, because there's the public health – it's your local health department that handles all your immunizations for your area. And then there may be like a national immunization registry that you could theoretically submit to, which is kind of a different topic. But I think we should just take out the word immunization so we don't confuse people.

Christine Bechtel – National Partnership for Women & Families

So it – I mean, I'm asking an uninformed question, because I don't know, but – which is department of redundancy department. The immunization registry, 401A, could it be combined? I mean, it's EP and EH, so if there's a – does it make sense to combine it? It doesn't – it's not clear whether it's core or menu.

Art Davidson – Denver Public Health Department

In theory, it might be able to, but we added these extra things, like reacting to the information that's in the registry that you're dealing with.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Art Davidson – Denver Public Health Department

And also, the discussion during the subcommittee was about – like it's another one of these this is so important, let's keep this separate.

Christine Bechtel – National Partnership for Women & Families

Okay. So maybe Art, you and George could take a whole look at all of these and see, you know, if there's a way to have like EH menu options and EPs, or, you know, whatever, and think about whether this should be in there or not, or whether some of the reacting to the information types of things should actually be in the other registries, and maybe there is a way to consolidate. But we'll leave it to you guys to advise. Does that work for you?

Art Davidson – Denver Public Health Department

Yes. And I'll ask Amy to help, too.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

That's fine.

Christine Bechtel – National Partnership for Women & Families

Yeah. Sorry, Amy. I'm thinking –

[Crosstalk]

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Oh, I don't take offense. No problem.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

Can I ask a question just in general about these registries? Is the certification requirement that there are a basic set of data elements that would apply to all registries, and the EHR needs to be able to submit those? Or does EHR have to essentially submit a number – specialized data elements to each registry? Do you see what I'm saying?

Art Davidson – Denver Public Health Department

Yeah. I don't think we – I don't know that we know enough yet from the standards and interoperability framework, but there's hope that some sort of C-CDA document would actually help populate registries.

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

So is that already true in Stage 2?

Art Davidson – Denver Public Health Department

Not really.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Is the question – but I took the question a little differently. Is the question – I wasn't looking at it from the standards. I thought you were asking the question, is there a common core data set across all these registries.

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

Correct, because that would make it easier to say, well, it really doesn't matter how many registries you submit to. You're basically using some core standard for which the EHRs are certified to transmit just the basics, and it's up to you to do the things on top of that.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So I don't – so this is a good question, because from a public health perspective and a state perspective, I don't know. Like in Rhode Island, there's a birth defects registry, and I don't know if that is different from others – if there's a national data set that everyone adheres to that comes out of CDC, or whether states do it on their own by law.

Art Davidson – Denver Public Health Department

So indeed, that's why cancer got in, because they had a standard, Paul.

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

Okay. And it is – it includes data elements pertinent to cancer.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yes.

Art Davidson – Denver Public Health Department

Correct.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

Paul, so you're right. If we could do what you're suggest –

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

Yes.

Christine Bechtel – National Partnership for Women & Families

If this is the case, so there's vendors – because of our – who we have to report to and the special ____ –

[Crosstalk]

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

Right.

Christine Bechtel – National Partnership for Women & Families

– we do that for, so if it's there, we can do that. But there's – and we can demonstrate we can do that, but there's not a course – there's not a more standardized approach that exists among these different things. So the scalability would be better if there were.

Art Davidson – Denver Public Health Department

And the Public Health Reporting Initiative that's working with the S&I framework is – and Doug spoke about that yesterday, they're working towards that standard, which would allow us to, you know, say we know what – what are the minimum data elements that need to happen or be sent between an EHR and the different registries.

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

Then isn't as possible as we go to Stage 3 to reduce it to three different kinds, period, instead of so many, I guess?

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

We'd have to try to find the most three commonly – you know, the three large common ones, and, you know, make some decisions about that.

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

Right.

Art Davidson – Denver Public Health Department

Well, we're also trying to address the specialists, who have different types of registries than the public health ones.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Right.

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

Right.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Unless there's a way to sort of address like public health registries and then other registries, and maybe separate it out that way. I don't know.

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

Okay. Sorry. That was a side question.

Christine Bechtel – National Partnership for Women & Families

That's okay. We've got a lot of those. Okay. So the good news – so I assume there's nothing more on this. All right. The good news is we are essentially done, because the remaining pieces are all – already certification – oh, I'm sorry, except one. Oops. So the last two are already certification only, so we don't need to talk about those. And the query outside entity, actually, is it also? Oh, it is a menu objective. So it's for patient –

Michelle Consolazio Nelson – Office of the National Coordinator

The – Christine, those are the IE workgroup ones. I would just defer those, because they're still working on those.

Christine Bechtel – National Partnership for Women & Families

Oh, you did tell me that. I knew we were done. You did tell me that. Okay. So yeah, so our group – the subgroup did consider this and they did suggest making it certification only criteria for lots of really great policy reasons, but then Michelle did tell me yesterday that the IE workgroup is actually making changes to this. So we just need to wait for them to say what they would like to do, I think, unless anybody else has a different – okay. So we'll say awaiting IE workgroup, and then we're done. So thanks again to the group and to all of you, because this is, as you can tell, it's hard work, but it's worth it.

So we do have our list of some parking lot items in terms of the care summary content and the potential care plan. Michelle, I think we covered the five others that we had agreed we really needed. Would you agree with that?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

Okay. Good. So Paul, I'll turn it back to you.

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

Okay. So do you need another call before the April meeting? The goal is to somehow present this in an easy to understand way that gets the message across and has some illustrative examples that sort of give people a face validity test of saying, oh, okay, I see how this works, and I see how it makes sense.

Christine Bechtel – National Partnership for Women & Families

If it's okay, what I would suggest – I don't think we need another call to be able to accomplish that.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

I think if – if we can separate and pull out all of the things that become certification only, and then we have two tables, one is just certification only, and one is use, so people can have some confidence that the stuff that they felt was important is still going to be capable, and then we can focus on, you know, we'll do some nice visuals where – there needs to be, sort of like our slide deck today, but we need to have one big visual that sort of shows the number getting smaller. But I think the key to that is the two separate lists. So are you okay with kind of creating two separate lists for that presentation?

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

And then ____ –

[Crosstalk]

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

So certification, maybe put in people's minds to ____, hey, so this important stuff is still going to – is going to be part of the EHR certification, so the tool will be capable. And then some illustrative – some examples of the thought process of how you consolidated, so that they can also take comfort in saying, yeah, you know, by the time they've gone through one and two, they've already blown through the threshold, they're not going to turn this stuff off. Here's how we're going to capture meaningful use at a much higher level.

Christine Bechtel – National Partnership for Women & Families

So I think there's probably three examples, Paul. One would be something like ePrescribing transmission, where it's – we've got great performance thresholds. They're going to keep going it. The second would be kind of what George described. One is the implicit – you know, we can't do this without doing that. And then one would be the merger, where we're saying, look, if you just show the, you know, status of CPOE referrals in care summary, then you don't – you know, blah blah blah.

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

Yeah. Yeah.

Christine Bechtel – National Partnership for Women & Families

So I think – I think we can come up with those with Michelle's help. What we really need to do, though, is – and I don't know if we need a separate call before the Policy Committee or after, but we do need to go through particularly the care summary content and figure out, number one, this vexing little issue of how CMS in Stage 2 has required only a limited number of those fields to be there, and make sure that our consolidation effort doesn't unnecessarily kind of let people off the hook for some important things, like the referral piece. And then go – and then also talk about this issue that we've heard before, but making – you know, is there a way to make it – people have the fields filled in where, you know, so that the data is recorded, but it's customizable views. So that's kind of the big one.

And then we should talk about the care plan piece. We also have amend button on the list, but I think we agreed in consolidating. We just have some details to work out there.

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

Yeah. Whatever –

[Crosstalk]

Michelle Consolazio Nelson – Office of the National Coordinator

So this is Michelle. Sorry.

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

No, go ahead.

Michelle Consolazio Nelson – Office of the National Coordinator

I was going to suggest, so maybe, Christine, you and I can work on – offline to put things together for the Policy Committee, but it sounds like we might need to have another full workgroup meeting, because – to have the detailed discussion that we had today. And perhaps there will be things coming from the deeming group that we might want to talk through.

Christine Bechtel – National Partnership for Women & Families

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

So perhaps we should set up another full workgroup meeting before the meeting on the 3rd.

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

Yeah, that might make sense.

Christine Bechtel – National Partnership for Women & Families

Yeah. Probably true.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

Because I think I would feel better about the care summary piece, having – make – just really making sure we're not inadvertently doing something we shouldn't.

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

So the objective for the 3rd is we need to find something we're comfortable and confident about, and then it needs to be presented.

Christine Bechtel – National Partnership for Women & Families

Yep.

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

So that it is easy to understand.

Christine Bechtel – National Partnership for Women & Families

Yep.

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

Because we can't have this kind of – this is a very healthy discussion, but it wouldn't be very productive in a big setting.

Christine Bechtel – National Partnership for Women & Families

Agreed.

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

Okay. Very good. So in order to leave an hour for deeming, is it okay if we resume at your – what would it be? Your 1:30 –

Michelle Consolazio Nelson – Office of the National Coordinator

One thirty.

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

Yeah. Is that okay?

Christine Bechtel – National Partnership for Women & Families

Yep.

George Hripcsak – Columbia University

Sure.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yep.

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

One thirty works.

[Crosstalk]

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

So we'll call back in at 1:30.

Christine Bechtel – National Partnership for Women & Families

Okay.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Bye.

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

Thank you. Bye bye.

Michelle Consolazio Nelson – Office of the National Coordinator

Bye.

[Break 03:00:25 to 03:26:13]

Christine Bechtel – National Partnership for Women & Families

Hello.

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

Hello. This is Charlene.

MacKenzie Robertson – Office of the National Coordinator

Are we back in the subconference, or are we on the main line? Latanya or Caitlin?

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

I guess we have the answer.

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

Oh, we must be on the main line.

[Music]

[Break from 03:27:03 to 03:30:37]

MacKenzie Robertson – Office of the National Coordinator

Thank you. Welcome back after our lunch break, everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT, and this is our continued workgroup meeting of the meaningful use workgroup under the HIT Policy Committee. So Paul, I will turn it back to you.

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

Okay. Well, welcome back, everyone, and thank you for a very productive discussion in the first three-quarters of today's talk, discussion. In this next section, I'd like to go to – turn towards the deeming subgroup, and I'll try to explain where we are with that. We'll probably just skip to the point where we have the approach and your agreement and feedback on the approach we've taken. We have some questions that were handed to us as part of the larger subgroup when we – I mean, the larger workgroup, when we met face to face. And we'll also go through some of the details – we have a spreadsheet where there's – or Michelle and Jesse put together a spreadsheet where we can map some of the quality measures to a deeming category.

I just want to really give you an idea where we're headed and get your feedback on that. So why don't we start with the next slide, please? I don't know whether I have – okay. So here's an example of quality measures that fall into the bucket of preventive care screening. And you can just sort of see there's a lot of sort of health maintenance kinds of things here. So we're return – you'll see that in our spreadsheet when we go over that later on. Next slide, please.

So the idea is to be a little bit like the insurance exchange, where you basically get – there's various levels of deeming, and these are just the thoughts, to get your feedback. So you could have – you could qualify in the performance standards for gold, let's say, and that might mean more measures that you have to report on and achieve a threshold, or harder measures. You know, more on the control side rather than process measures, as an example.

You know what? I skipped a piece of – let me just go over some of the assumptions, you know, the principles behind deeming. One is when we are going from Stage 2 to Stage 3, we're sort of at an inflection point where we're trying to get off the guardrails and the forced march into the area of rewarding good behavior, and that's sort of the principle of deeming, that like with the consolidation workgroup, once you've done certain things, you're not going to stop doing, and that most people, once they do it, they just want to go full bore, and that's why we've had such high performance in the meaningful use objectives so far, and that it does not drop off over time. All of those are good things. We count on those, and we now want to take advantage of those.

So this pathway we're talking about, unlike the consolidation, where everybody benefits from the drop in total number of meaningful use objectives and measures, in this case, you're substituting for some subset of the meaningful use objectives by being a good performer. And left to – it's left for this group to decide, but we tentatively decided there's two ways of being a good performer. One is that you've accomplished some threshold. It's not 90 percentile. I mean, it's not really high – the highest, and yet it's good enough. So it's probably somewhere in the 70th percentile range, I mean, just making it up. So it's very achievable, in this sense.

And the second way to achieve this performance threshold is by narrowing the gap in your performance from let's say full performance. So the – you might be starting low in your baseline year, but if you make significant improvement, that's another way to qualify for this deeming pathway. So those are some of the things, and this will all be open for discussion.

Okay. Returning back to the slides, there's a notion that there's a set of clinical quality measures that would deem you in fulfillment of more or fewer meaningful use objectives, and that's the notion of bronze, silver, gold. So either more quality measures or harder quality measures would get you deemed in compliance with more of the meaningful use objectives. So that's the notion that's being displayed here. Next slide, please.

Same thing. There's three dimensions, really. We've – sort of three buckets. One is preventive healthcare; another is longitudinal care; and the third is care coordination. So you can recognize those are important objectives, part of the national quality strategy, and just part of the ... here's an example of managing chronic diseases over time, and you see important national priorities such as diabetes, heart failure, coronary artery disease, hypertension, AIDS. Next slide, please.

Same thing. You can imagine multiple – and it doesn't have to be three – but where you have – you can qualify for more meaningful use objectives, the more quality objectives you meet. Next slide, please.

And finally, in care coordination, there are fewer measures, and actually, as I look at these right now, I'm not sure all these necessarily fit in the care coordination. Probably the reason is, for example, diabetes, eye exam means that they've gone to an ophthalmologist. So that's a – you know, one of the very few things we have for coordinating care. You also see they're closing the referral loop, which we talked about earlier, about that being one of the things that applies to every specialist. Next slide, please.

Same thing. The more – the more stringent or the higher demonstrated performance, the more credit you get over in the meaningful use side. Next slide, please.

So in the end, you might see a matrix like this where you see, well, what do I want to qualify for, or what do I want to be deemed in compliance with, for which meaningful use concept? Now these haven't been reconciled with the consolidation concept, but in that second column you see the meaningful use objectives, and then the three, four, fifth column, you see where you could – you know, what strategy you could take in order to qualify for the most – the most meaningful use objectives, and what would it take in terms of your performance? And you would sort of just make that decision. And within each of those green fields, you'd have choices of multiple packages. Next slide. I think that might be the last slide.

Michelle Consolazio Nelson – Office of the National Coordinator

It is.

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

Okay. So that's the overall – that's the overall strategy, and maybe I'll pause to get feedback on just the strategy, and then we can go down and see how that would look at a more fine-grained level, by going into each of the quality measures. So again, this is a reward good behavior kind of approach. You've already gotten your EHR implemented. You're using it. Now how can we both measure and drive performance in outcome areas? Comments, questions?

Christine Bechtel – National Partnership for Women & Families

Paul, it's Christine. As you know, I like the concept. It's, you know, devil's in the details kind of a thing.

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

Right.

Christine Bechtel – National Partnership for Women & Families

But conceptually, so at the strategic level, one of the things that I thought about was how we – so if we think about chronic disease I think in particular, and to some degree probably care coordination as well, they apply to very particular pieces of the population. So how do we make sure that the full patient population is seeing the benefits? That's kind of my base question.

The reason I'm asking is because one of the problems and challenges we're seeing with the patient-centered medical home is they overlay – you know, they've got their IT system and they overlay care management and care coordination, and they do these things, but they only do them for very specific subsets of the population, and most of the time, that's driven by the payer. You know, it's only for Care First Blue Cross/Blue Shield patients, or it's only for people with diabetes, or it's only for really sick people.

But their practice as a whole for the rest of their patient population, which is a lot, isn't changing. They're not getting reminders. Only the people who are falling into those populations are getting reminders. You know, they're not getting the after visit summary. Only those people get that. So how do we – how do we help to address that here?

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

Okay. So I think – so the way is by playing our role in the overall system. As you know, this is an EHR or HIT incentive program, and we've taken the position that what we want to do is make sure we have the very best tools across the country in place so that each and every healthcare organization, small or large, can perform well. We don't determine the rules or the priorities, and we don't, quote, ensure that these tools will be applied throughout the entire population. But we make those tools available and make sure they're meeting – they're effectively using them.

So we've always worked on the exemplar approach. What we're trying to do is, through the quality measure, to follow the national health priorities, and those are determined, as you know, from the Secretary and the Public Health Service and so on and so forth. So in the end, it'll be the public health sector and the Department of Health and Human Services that determines what's the most important thing globally that we should work on as a country. And of course, those are not going to be small tasks, diabetes, hypertension, obesity. So they're going to be very important things.

And then the payer will have a continuing role, but unlike the situation you described, hopefully, it'll be much more in a population-oriented fashion, and we won't have this dichotomy of you isolating by payer. I'm just going to take care of the Blue Cross payers – patients, or the Aetna patients. But really, it's looking at managing your entire population according both to your local priorities as well as national priorities.

So I think the first answer to your question is we don't ensure the equity. We make sure the tools to delivery high performance across your entire population are there, and then the other market and national priorities drive where you apply them.

Christine Bechtel – National Partnership for Women & Families

So I understand your answer, and, you know, maybe – maybe when we get to what the quality measures are and the conditions are, it will be helpful. I don't mean payer. I mean, really like only patients with diabetes are going to get reminders and education material, which might only be ten percent of my patient load, right? Which is not I think what we're aiming for here. So that – so just a clarification.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

But going forward, I think the difference I see is twofold, between, you know, sort of what you described and where my head's at, which is number one, the program's previous design was broadly applicable to populations. So, you know, we made sure that lots of different types of patients and families saw benefit, and what we know from research is that that's key to their ability and willingness to trust in the system.

The other thing is that the payers here are actually taxpayers, right? It's not just Medicare/Medicaid, in a way. It's – but even – and they're large payers, too, but – so it's either all Medicare beneficiaries and Medicaid beneficiaries that should benefit, or it's taxpayers writ large, because this is unlike PCMH in that it is a federal investment. So I want to put that lens out there for people to keep in mind, so that we make sure we don't set up a situation where you could have, you know, a practice only focused on a small percent of their population, because they have shown to be able, even though we're talking about systems of care, they have shown that there are lots of dimensions of the system, like patient reminders, that could only be deployed for a very limited number of patients, and that would move in the opposite direction of where we've been before. So just food for thought.

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

Okay. We're not so specific, though, you'll see, I think.

Christine Bechtel – National Partnership for Women & Families

Okay.

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

Other comments?

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yeah, Paul. This is Amy. Maybe you said this in the beginning and I missed it or whatever, but can – is the point of sort of the bronze, silver, gold, whatever, to just help from the like marketing point of view distinguish who's met more of this than not? Or is there any other rationale behind it? I'm not sure if it complicates ... or not.

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

Yeah. And I think it's fair that it may complicate – part of the thinking is flexibility. So if we define – if we said, okay, you've got to perform on these five. You have to have a high performance on these five measures, well, gosh, did we pick the right ones for internal medicine versus infectious disease? You know, that kind of thing. So there's some flexibility.

And some people may want to be much more oriented ... where I want to point my organization is to have a high performance on these measures of quality. Now we know no measure is perfect, but let's take this set, and that's where they want to shoot for and have as much fall out of that activity of achieving high performance, have as much fall out of that as possible.

Another might say, you know, let's do some of each. You know, let's do some of the – let's get the meaningful use of these functionality – these functions done, and let's also work towards more and more measures, because measurement is new to them, you know. They just got off of paper, for example. And they might choose the, quote, bronze, which is fewer measures, let's say, but at least they're going down that pathway. Does that help? And that doesn't have to be – that may not be the right answer, but –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Well, so I guess what I'm missing here is – and again, I apologize if I spaced out and didn't hear this, but are you saying that you – in the bundling you would have to pick one gold and then in one category one silver and another –

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

No, no. It'd be more like you pick the gold package or the bronze package, and in general, the gold is going to deem you in fulfillment of more of the functions, of the objectives.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Ah, okay. So if you pick bronze, silver, gold, then there's more functional objectives that you don't have to ... on –

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

Correct.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

– because you're going to – but you are going to end up having to meet more clinical quality measures.

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

Correct. And this – the devil's in the details, but that's an example of an approach to give flexibility.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

All right. Maybe when we get to the details, because –

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

Yep.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

– it seems – it seems like it could be –

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

It could be very complicated.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Yes, and we're – while we're trying to simplify, we inadvertently make things more complicated to even explain.

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

Very fair thought. Other comments, questions? Okay. Maybe could we switch over to the spreadsheet? It's labeled MU deeming. Who is controlling the presentation, by the way, just so I can use a name?

Caitlin Collins – Office of the National Coordinator

This is Caitlin at Altarum.

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

Okay. Caitlin, do you have access to the spreadsheet?

Caitlin Collins – Office of the National Coordinator

We just pulled it up. Are you not seeing it?

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

Oh – well, okay, so I'm looking at the tab 2014 EP measures.

MacKenzie Robertson – Office of the National Coordinator

Hey, Michelle, are you on the line? This is like a Word document.

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

Oh.

MacKenzie Robertson – Office of the National Coordinator

Are you looking at an Excel spreadsheet, Paul?

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

Okay. Here's – this is good right here. I think this is the same one. Is that right, Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. That's the same one.

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

Looks like it. Okay. Any way to make it bigger? And then just scroll over a little bit. Okay. And since it's a Word document, you can't hide the – any – okay. So here's an example. So – and we're not sure that we got these Xs right, but – so one of the measures talks about use of antidepressants in patients who have a diagnosis of depression. And the thought there, if you would scroll a little bit more to the right, please, is if you score well on that measure, you – let's see here. Like I'm not sure that that belongs in the preventive care screening, for example, but if you score well on the treatment of depression, then that fits into chronic disease management, essentially.

And the next one is in screening, if you use PHQ-9 both as the screening and then periodically, then you would be in both preventive care screening and chronic disease management. Those are – those are quality measures that would fit in those respective buckets. And you can see how, and I'm starting to see Amy's question, that we may find some algorithm where you say here are measures that you can pick from, and maybe the notion is, for these bronze, silver, gold, is – and if you do score well on five of them, you get bronze, and if you score well on seven, you get silver, something like that. And that determines how much you qualify for in the objective side. Does that help? Let's scroll down another page and let's see if we can give some more examples.

George Hripcsak – Columbia University

Yeah. Thanks, Paul. You've got to go over it again.

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

Sorry?

George Hripcsak – Columbia University

This is George. Yeah, do another example, because I'm not quite –

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

Yeah. Okay. Okay. So look at the one, closing referral loop, which is where you see two Xs. That's – that – and again, I don't know why it got into preventive health, so I – so maybe we didn't finish that column. But that's one of the examples of care coordination. And the one before that is screening for LDL. That clearly is in prevention. The one below that is screening for – okay, that's LDL again, but –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So – Paul, this is Amy. I think the trouble that I'm having in connecting these is while I see that the – as you meet the clinical quality measure at whatever level is set, or you meet several of them, then there's an X in the bundle, and then I'm assuming that means that you don't have to do those – reporting on those MU measures –

[Crosstalk]

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

Okay. So then I think –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

– under that bundle?

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

So let me – I'll go through another tab. Let's go one more window – one more page, and let's see if we can pick some more examples. Okay. So stop there. So you can control of diabetes. See the A1C poor control? Or the foot exam? So the control of diabetes – so the middle column is the disease management. The one below that, the foot exam, got credit in both disease management as well as care coordination, presumably because you had to make a referral to ophthalmology – I mean, to podiatry in that case, although you don't really necessarily need one. But eye exam you see below that would be ophthalmology.

Scroll down another page, just so we can sort of get more of a feel for this. Okay. So here's diabetic retinopathy, and they're getting ongoing examinations by the ophthalmologist, which is why you see it both in the care coordination as well as the disease management. So you can see how the assignment to these categories makes sense.

Now let's go over to the tab called bundles, which is where the – some of that color coding was. I think it was higher up in the document. There. Now this hasn't been all worked out, but so if you – let's look at let's say the bronze for the chronic disease. It's sort of approximately to the right of middle in the screen. No, no, no. Where you were. There we go. Okay. So now that's about in the middle of the screen.

So if you are doing well in managing chronic disease of some type, then you've got the demographics, so that's how you're generating your reports. The reason you're performing well, we believe, is you're using the tool and the clinical decision support to remind people what to – what to do when they have a patient in front of you. The way you're getting that is because the computer understands the lab results, like A1C in the case of diabetes, that you are – to do well, you have to be managing this according to a patient list, and ideally, a real time dashboard.

So when you – you're responsible for your entire patient population of diabetics, not just the ones that come to see you frequently. Therefore, to get a good score, to be doing well in managing that population, you're going to have to do outreach, which means you're going to have to formulate lists, and then you're going to have to act on them.

Part of – part of acting is – are things that you do, you the clinician, in ordering things or counseling or administering treatment, like medications. Part of it's going to rely on what patients do, and that's why we implicitly feel that that's going to – you're going to take advantage of the system tools for reminding patients. You're clearly going to use the electronic notes, and part of making sure that you control your diabetics is to get – to monitor their control. And if they don't come in to get the – if you don't remind them to come in, and you don't know that they haven't come in, you're not going to be able to manage that population. That's where test tracking comes in.

And part of having patients even come in and doing their part is to be able to give them enough knowledge, patient education, about the implications. What does this test result mean? What can you do about it? How do we work together? So you can see sort of the logic flow of saying if you do well, there's a lot of things you need to do take advantage of the tool you have at hand to do well, and that's the basis for this deeming.

And now I think I'm ready to entertain the questions that you have, Amy. Does this help any?

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

A little bit. I don't know if I'm the only one who's having a hard time sort of piecing it all together.

Christine Bechtel – National Partnership for Women & Families

Well, it's Christine. I mean, I get the concept for sure. I think where I'm falling down a little bit is some of the measure examples you went through, and I know that you did it on the fly, are like did a test get done? Like we do that today, you know. It's not an outcome associated with the test. It was like –

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

Right.

Christine Bechtel – National Partnership for Women & Families

You know. And so that is a little bit of concern, and I would probably want to look at, you know, are – based on – it depends – I think you're not proposing the specific bundle of measures here, right? Or are you?

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

Not yet. So for example, just to address the question you just raised, the process measure of getting – of surveillance could qualify you for the, quote, bronze, because you need the things that I just went over with you, even to get people to have had a test done with some frequency. If you're controlling a much higher population of diabetics than the national norm, then you're probably in the gold area. So it's not going to be just getting a test done to get you there.

Christine Bechtel – National Partnership for Women & Families

Can I ask a question, though?

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

I mean, so like – so in the example of, you know, HBA1C test, whether it was done, right? So not an outcome measure, just was the test done.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

I – there are lots of paper-based processes that enable people to perform well on that today. That's what they're accustomed to.

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

Yeah, but they're – once you have an EHR – remember, these people have already been through two stages.

Christine Bechtel – National Partnership for Women & Families

Yeah. Uh-huh.

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

It would be silly for them, and they would know that – I've not seen people go back to paper once they've done an electronic – so you – this is not a program that you're going to say – again, we're getting out of the prescription business.

Christine Bechtel – National Partnership for Women & Families

Right.

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

We're saying, look, we're in the outcomes stage. If you're doing something well, we can't say, oh, well, we've got to make sure that you're using the expensive thing that you put in, and aren't going back and doing a very labor intensive – I mean, that's sort of –

Christine Bechtel – National Partnership for Women & Families

Right.

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

... point.

Christine Bechtel – National Partnership for Women & Families

No, I get that. But I think – what I'm getting at is the concern I have about particularly some of the bronze level bundles, where, you know, I think – so you – where I worry that you're – you really don't need to do patient education materials electronically for things that are just was the test done. That might be in patient education where it's – you actually hit the mark in terms of outcomes, but I don't – I'm having trouble seeing how it's in the bronze category.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

Again, so you see what I'm saying? Like again, it depends on the bundle. But the other I think challenge I have, and CDS is a good example, makes complete sense for the prevention rule and the chronic disease rule that we called out, right? Because we said do 5 of 15.

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

Mm-hmm.

Christine Bechtel – National Partnership for Women & Families

But then I worry about the remaining two rules in CDS would be appropriateness of lab and radiology orders, which I think is more of an efficiency measure, a cost measure, and advanced medication-related decision support. What if I'm not on medication? And particularly in prevention, right?

So like prevention bundle could hit the preventive care, but how do you know, if you're only looking at prevention, and then somebody else might pick the chronic disease, and somebody else might pick the care coordination, how do you know that you're hitting the mark? I mean, I almost wonder if there's a way to – if you're going to do bronze, you have to do more than just one of the three categories. You have to –

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

That may be – so one, I can see your points about CDS being in bronze as chronic disease, and these are not vetted bundles, for example.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

But – so that's – but we're – I think we're thinking along the same lines. You would get the minimum amount of credit if you're going to be doing bronze process-oriented quality measures, for example, and you get the maximum when you're control measures or outcome-oriented measures. That's part of the ... that's being met.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

I think philosophically, in order for this to work, just like with the consolidation, we're not going to go down and say – I mean, we're just – the program will no longer exist if we say, now we're going to do 404A, and you have to – it just – then there's no program anymore, in a sense.

Christine Bechtel – National Partnership for Women & Families

I'm sorry. I don't – I'm not following what you mean on that.

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

If they're – there either is or isn't going to be a deeming.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

You're either going to say good perform – reward good performance with a tool that's in front of them that they already have and they're using, or not.

Christine Bechtel – National Partnership for Women & Families

No, I agree with that. I think the issue is how you define performance, and is good performance good performance on basic standards of care, like you have somebody with diabetes, they should have an HBA1C test done. That's a pretty basic thing, right? I don't think that's performance necessarily. That's where I think I'm struggling, is, you know, particularly at the lower end of the level, you know, you don't want to micromanage, but on the other hand, you want performance.

So it's – for me, I'm completely on board with the concept, but how – it's really hard to make a judgment about how it's executed without looking at the specific bundles of quality measures that would be proposed and how they might align, particularly to the lower level pieces. I also would want to look at – it doesn't mean ... care coordination piece, is I see what people have considered care coordination measures, and I think you agreed, not so much.

So it's difficult with – it's really about, well, what is a meaningful good performance? If we could get to that, then I'd be fine. And I'll ask one quick question. I think what this means is if you're deemed for those functions, you're not deemed for others. So like view/download/transmit doesn't show up anywhere on here. So that means everybody has to do it?

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

Again, so these are – these are – these are draft bundles that have not been reviewed. And so it is hard – I would argue, if I were to make a draft of this – these bundles, that view/download and transmit would show up in the gold or possibly each one of these, because to do really well in screening, you probably – your patients probably have to be knowledgeable about where they stand. You have to have engaged them.

Same thing with chronic disease management. So I probably would be tempted to put VDT as one of the things you get deemed in compliance with in the gold section of these things.

Christine Bechtel – National Partnership for Women & Families

Which – I have – I'm not – I'm not sure I agree, and so I think with the care – like same thing with the care messaging. But let me just – before we get – because you said the bundles aren't vetted, is that a valid assumption, that if the functionality doesn't show up in your list under gold –

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

Yes. That's correct.

Christine Bechtel – National Partnership for Women & Families

– it means they need to do it? So if it's not –

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

That's correct.

Christine Bechtel – National Partnership for Women & Families

– listed here, they still need to do it –

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

Correct.

Christine Bechtel – National Partnership for Women & Families

– along with the performance ____.

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

Right.

[Crosstalk]

George Hripcsak – Columbia University

Paul, can I ask a question? And sorry if this is duplicative of what you said. The concept is, the individual measure would be bronze, silver, gold. It's not a – but there's no additional thing where 90 percent is bronze and 99 percent is gold?

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

Yeah. No.

George Hripcsak – Columbia University

Okay. Good. And that would be too complicated.

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

Good.

George Hripcsak – Columbia University

Number one. Number two, is there a number of measures you have to achieve to get the bronze? Like what – how does that – a percentage of the measures, or just one measure?

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

That I'd be interested in people's thoughts. I – what's ringing my ears is Amy saying we don't want to create something that's even more complicated or at least as complicated as what we have. The notion is – the notion is, and other members of the subgroup can speak up, the notion is it's probably a function of the number, and you'd have to hit all of these numbers. So let's say gold had seven control measures, or – that's pretty hard, actually. So let's say it had five control measures, and you were exceeding the performance in all five. That's when you hit the gold.

Christine Bechtel – National Partnership for Women & Families

And so there is a minimum performance threshold that they have to meet?

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

Right.

Christine Bechtel – National Partnership for Women & Families

Okay. And if they miss it by one percent, what happens?

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

Okay, so that's – that's a problem, and that's part of the question of double jeopardy. So you would not want to say have a full reporting year, and it wasn't until December 31st that you realized, oh, darn, I'm not making it on the deeming. Now I've got to go back. So just to throw out a straw man, one possibility is you have a six month reporting, and so if you were smart, you would certainly not put the six month set ends on December 31st. You'd make it sometime – enough time before, so that you could know whether you're going to make it or not.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

But there's some qualification – it takes – and the details would have to be is it all or none or what. There's – it takes meeting this threshold in order for you to be deemed in compliance with a subset of the meaningful use objectives. So in some sense, it is – there is some risk in it, and it is very much outcomes and performance-oriented, but that's sort of where we wanted to go, and we want to make sure that people who are doing those things, which was the intended goal, get plenty of credit for that.

Christine Bechtel – National Partnership for Women & Families

Paul, one other way to look at this might be that instead of – you know, like bronze, silver, gold, the three levels, what if we didn't focus on process measures at all, and we focused – you know, since we're only talking about five or six or whatever, three, whatever it is, the number, measures in an area, what if we had them as performance measures? So there's no process measures. There is never a HBA1C test done or not. It's HBA1C in control, but that you're – you know, to get goals, you need to have it at X percent, but to get – you know, to just get to bronze, it's some lesser percent.

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

Let me throw it open to the group.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Well, this is Amy, and I apologize. I had to mute you and take another call, so I might have missed this. But, you know, you may have addressed this as well. So if you don't get the ultimate percentage, but you have a percent increase, are we allowing some room for percent increase versus total percentage?

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

Yes. That's one of the things we're proposing.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So I'm trying to figure out how that – so for each – for each clinical quality measure, it would be either you reach this benchmark or you've increased by such a percentage from where you were last? And then if you get all of those bundled, then you get either the gold, the silver, the bronze? I'm also trying to think about this quite on a – I'm trying to think about this from like an audit perspective, because, you know, like running an EHR incentive program in Medicaid and having to audit this stuff, I'm trying to think how – you know, also think about from that perspective where and how – you know, where the logjams may be in thinking about being able to do that as well.

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

That's fair. I don't think we have – we're there yet, but that's one of the things we have to work out.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Okay.

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

What are some of the other – George, Neil, what do you think about some of these questions that are being raised? And what's the – and Christine's latest, which is instead of stratifying by number of quality measures, how about performance level, just have one set or sets that you can pick from, and then you just – and then the level of performance decides whether you're bronze, silver, or gold?

George Hripcsak – Columbia University

Well, but you worked out a system where by the nature of the measure it would map to your color. So even if you have perfect performance on a measure that doesn't test anything that's in your gold group, then I guess it doesn't make sense, and – but how do we – I think doing one measure and then being gold in three – like, you know, I don't want to be able to pick one measure and be – have Xs in three areas, and be gold across – you know, and be done with meaningful use. So it would have to be, you know, a portfolio of measures that get – but then if we get it so complicated that no one understands it, that's no good, either.

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

Right.

George Hripcsak – Columbia University

So I would think that the – that there's one threshold for performance on the measure, which might differ by measure, and that means you've got the measure. If you achieve that level of performance, and then maps – just what you said, to the bronze, silver, or gold, would be ... we have to figure out how to deal with multiple measures.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So yeah, I guess – when I was thinking about this, and I, you know, know I wasn't on the workgroup – this is Amy again – I guess I was thinking more of a one for one versus all the bundling. So in other words, if you met a certain, you know, percentage increase, or a certain total number on a measure, it would auto – and I'm sure there's a reason why you didn't do this, so I'm asking to understand that. You know, that particular measure then – well, that individual clinical quality measure would then deem you in one or two – you know, in one or two specific functional measures where you don't have to measure it. Was that too simplistic, and the concern was that it wouldn't – there wouldn't be enough rigor with that, and that's why you bundled them?

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

I think the goal is to hand this off more and more towards, okay, we're in the performance business now. We're not in the picking, you know, each little function and mapping one to one. And maybe after I answer this, maybe Charlene can chime in on the care coordination and see if there's any insights that helped us to answer these questions.

I think the goal is if we can prove essentially that you are performing well, then you really are deemed out of the forced march/guardrail approach to using an EHR. And it's really a handoff over to the next level, which you've always said, you know, we're getting people on the escalator. Once they've arrived at that higher plane, it's really the market forces, it's the nationally set priorities that are going to carry the day. And –

Christine Bechtel – National Partnership for Women & Families

Wait, it's the higher plane piece. So like that's really where I'm stuck, because I just – there are just – you know, get – you know better than anybody our stated quality measures. So there are just measures that to me are not the higher plane. I have absolutely no concern or debate about the concept. It's great.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

It really gets to me like how you measure it in a simple but yet a way that also, you know, is actually meaningful performance.

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

I think that's a fair – I like your idea about only pick the ... ones, then all of a sudden we're going to find ourselves, well, there just aren't many, which is exactly –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

Well, that's true, or, you know, or proximal to outcomes, right?

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

So, I mean, I think part of this discussion is really hard to have without digging into the individual measures and saying, okay, I like this one for this bundle, that one for that bundle, and then stepping back and going, wow, we have 20 in each. Well, let's see. Should we do all 20? Because once you look at them, you figure out that five of them aren't very hard, and you – there's lots of publicly available performance data. The performance rates are pretty good. The other five are fine. You know, they're good. So that's okay. You know, without getting into that level of detail, it's really hard to argue and – or discuss.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

Because the concept is pure. It's right.

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

Okay. Charlene, do you have –

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

Yeah.

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

– insights you have from the care coordination side?

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

Yeah, and again, we did recognize that on the care coordination side there was some limitation of the current measures, but we were – I guess what ... to use, we tried to be very optimistic or aggressive in the fact in terms of what was deemed relative to meet that concept. So we did expect a couple of things. We did – and, okay, we're recognizing ... we're slowing down in Stage 3 till we learn what's in Stage 2, but we also recognize concurrently, there's a lot of work being done to advance the measures. So we thought maybe there might be some more by the time we actually finished this process, so we were optimistic there, so there would be some more that could be coherent.

We also recognized in the process, as we looked at gold, silver, and bronze, we were actually excited about that for a couple of reasons. Number one, we recognize those people that are doing gold today typically are your Kaisers and your Geisingers, who are way out in front of everyone else, and to get there is kind of the march we want everyone to take. But then again, we just don't want to give credit to those people. So that was one thing, again.

The other thing that was really powerful is we looked across these different segments, and that's why we've got to think about, do we argue not accepting the process measures or not? It starts to give people a roadmap of how to get there. This is one of the biggest challenges in terms of advancing people to take on more patient engagement, take on more care coordination, take on more care management responsibility.

So we looked at it a little bit differently. I mean, recognizing some of the caveats, but we also were aggressively optimistic in that we could address some of those by the time Stage 3 came up. So that's a little bit different in terms of how we thought about it.

Christine Bechtel – National Partnership for Women & Families

Charlene, it's Christine. I'm sorry if I missed this completely, but I'm looking for – it seems like you're talking about a specific set or at least some examples of care coordination measures.

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

Yep.

Christine Bechtel – National Partnership for Women & Families

Are those in this spreadsheet somewhere? Because I only see –

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

Yeah. We had five – Paul showed those five measures, and again, you identified them. It was things like feet exam, you know, the ability to be able to do, you know, a referral network. So there were like five measures, and again, they aren't potentially your most powerful measures yet, but –

Christine Bechtel – National Partnership for Women & Families

But I think – okay. All right. That –

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

We recognize that, but again, we were optimistic in how we looked at how we identified functions in those different categories.

Christine Bechtel – National Partnership for Women & Families

So – and I'll just say this is a really good example of how it's hard to have a discussion without it, but there's only one of those measures that in my humble opinion is actually a care coordination measure, and that's the referral loop, because a lot of – and Paul pointed this out earlier, the other four are –

Christine Bechtel – National Partnership for Women & Families

– diabetes ones that are – you don't have to coordinate. So – but there's some missing, I think, like, I mean, the CTM3 I don't see on here, and that is a measure of care coordination. You could also, frankly, do patient experience. That was another thing, Paul, that we talked about, because patient experience like the PCMH cap, definitely asks did your doctor coordinate with others? I mean, patient experience would actually – I don't know if people did the work of looking at it, but it actually does hit a whole lot of the functions of meaningful use, as well as the – some of the quality measure concepts we're discussing. But I just want to flag for folks that there's only one that I think passes the sniff test as a care coordination measure.

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

Yeah. And we recognize that some of the measures were put in there for – because there weren't better measures. We understand that, so –

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

So being on MAT, Christine, you know that we're just limited by what we have.

Christine Bechtel – National Partnership for Women & Families

Right.

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

That's the same limitation that CMS has. And then we have whatever CMS has, you know, declared as part of the quality measure palette to choose from. Charlene's right that there's some in the pipeline, and hopefully those will be better. But I like the way Charlene described it, which is in a sense, this is yet – this is another trajectory. This is another glide path. This is another escalator. And a reason to start out with process measures, because people coming off the paper world and into – I mean, they have to start somewhere. And we're trying to give them credit for doing the work on the – on the glide path.

And it's either going to work or not. I mean, if we can't find – if we're going to be – if we say there aren't enough good quality measures, so we can't have this program, that's one conclusion to have. But yet, you know, JCAHO and CMS, they still have these programs, so one of the ways if you've got to make due with whatever you have. And specifically –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

Well, yeah, but –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

I'm sorry to interrupt, but part of what I'm saying is I don't think this is the total universe of available measures. I don't see the CTM measure on here at all.

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

Yeah. And I – Jesse and I know Michelle did a lot of that work, so we can certainly –

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

I mean, I think that is –

[Crosstalk]

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

– look at it.

Christine Bechtel – National Partnership for Women & Families

I think it's part of VQRS, too. So I think it is an available measure that's not here. You know, the other way to go about it – I mean, here's my –

[Crosstalk]

Michelle Consolazio Nelson – Office of the National Coordinator

The 64 measures that are available are there for EPs. We only did EPs, though. We didn't do EHs.

Christine Bechtel – National Partnership for Women & Families

Oh.

Michelle Consolazio Nelson – Office of the National Coordinator

So just keep that in mind. Nothing related to hospitals has been done yet.

Christine Bechtel – National Partnership for Women & Families

So is the CTM measure – I don't – I thought it did – work for EPs? And it's been tested and validated. I'm not sure if there's anything that prevents us from putting it in. But I guess what I'm saying is I think there's like two options here. One is in my opinion you either have to make this actually a meaningful bundle – you can't have, you know, the four that I think we talked about. And you could do that by either adding the CTM or some similar measures.

You could also make the thresholds of performance higher for data – electronic data exchange on the transition of care summary. That could be a measure. You could make it higher on closing the referral loop. You know, so you could look at some functional measures that are process measures, but they're genuinely indications that care coordination is happening. You could also – I mean, can we get creative here and think about could the – if we put out a standardized question, could they – could the providers who choose this bundle ask their patients this standardized question, and then report the responses so that we see what patients think of that? I mean, right – like how do we just get some stuff in here using technology and maybe even some, you know, process pieces, but that are better processes? So that's one path.

Otherwise, I think you have to question whether this – whether we could have a bundle that would deem performance on all of these things when we really can't measure how well coordination is happening. I would question that bundle in its entirety, and say maybe we don't have care coordination. Maybe we do something else, like obesity or heart disease or something that is – you know, maybe it's different kinds of chronic diseases that are names or – I don't – you see what I'm saying?

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

Yeah. And there was actually – Jessie had done some work for I think Million Hearts and some of the others, too. So that's a possibility, but –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So this is Amy, and I want to take a step back, and you can all tell me I'm the only one struggling here. I feel like even – I agree that this may not be the right measures and the right bundles. I still believe that this concept of how they're bundled and how they offset one another is hard to explain and hard to understand, and I'm concerned that it's going to be hard to get providers to understand this. I mean, we're all very close to this and work with this, you know, regularly. I don't know if it's worth asking, just before we take a lot more time, just a couple of providers or docs or whatever that are not as involved in this on a day to day basis and see if they – you know, get a little input on the concept.

I mean, I love the deeming concept, and I love going to outcomes versus the functional measures. I just feel like the way it's structured here, although I don't right now have a better offer, so I want to caveat that, and I appreciate all the hard work that's been done, and if I'm the only one that feels this way, I'll be quiet on it. I just don't think it's easy to grasp and explain and see the connections.

George Hripcsak – Columbia University

So this is George. First of all, Paul, you're going to have to summarize soon, right? It's 2:28.

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

Right.

George Hripcsak – Columbia University

I kind of feel like – I mean, my philosophy on this is that we don't have to map exactly –

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

Right.

George Hripcsak – Columbia University

– from the indicators, the outcomes indicators to the measures, because our presumption coming in is that they've done – they've bought an EHR. They've done four years of functional measures. And if we're over-deeming, it's okay, because – like we're – like are we going to be doing this in 50 years or not, I don't know, so at some point we're going to just say, we want everyone to have good outcomes, and we know you're using electronic health records.

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

Right.

George Hripcsak – Columbia University

So one thing you could do is say, listen, you have to meet the core – I mean, not the core. The important quality measures, and it deems the entire meaningful use panel, period, done.

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

Yeah.

George Hripcsak – Columbia University

That would be another approach. We'd like to hold on to patient engagement and care coordination, because we're not really done there yet. So I'm coming back from deeming the whole thing, not starting off with we have to do everything and see which three we can get rid of.

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

Right. I – I'm sympathetic to that perspective.

Christine Bechtel – National Partnership for Women & Families

I am, too, Paul. I mean, I think it's – you know, the ideal circumstances where you have, you know, a parsimonious set of really good measures, and, you know, right, like there might even be an efficiency measures in there, or some sort of resource use measure, so you can, you know, not have to worry about the decision support rules and things like that. You might have a – kind of a variety of types of measures. But the – I think in an ideal world, if they're robust, and they really do paint a picture of performance, not box checking, then yeah, you get deemed for I would say the vast, vast majority of the – of the meaningful use functional requirements.

But I think there are a couple of areas, and George mentioned them, where it's like care coordination and patient and family engagement. And the other one that I would add is health disparities. Either we have to say these measure bundles have to be reported and you've got to stratify – and maybe we don't hold you accountable, but you have to know, you know, how you're performing with respect to disparity variables. You know, then that starts to get us, like, ooh, we know they're doing some population health stuff. you know, we know they're seeing that they have some health disparities, and they might be – that may trigger more of the patient education and engagement components if those pieces are in there. Things like that.

But I think it's – we've got to get to some details around what are the measures, what are the bundles, you know, areas, how is it going to work, and again, just, you know, what are the functions that are deemed. But I also want to remind us that patient experience, if we can take a good look at that, a patient experience survey, some of those questions would take care of probably all of the functions, including engagement, including health equity, you know, all those things. Care coordination, everything. I think.

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

Those are questions off the experience of care surveys, right/

Christine Bechtel – National Partnership for Women & Families

Yeah. Right.

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

I don't know that we really have, quote, access to that, in terms of use of that – using that in that way in this program.

Christine Bechtel – National Partnership for Women & Families

Well, I think it – that's a question that we have, and I don't know if ONC has started doing any work on it. But we had – you know, in early 2010, quality – I chaired the patient and family engagement tiger team of the quality measures workgroup, and we talked about having sort of a platform, right, because CPC, run by the Innovation Center, they're providing the platform for the primary care practices. They do the same thing in the medical home or medical group demonstration project. Hospitals already have to collect HCAP data and report it publicly. So there's a big opportunity to look at how those questions crosswalk, and they are different than the ambulatory space.

But I think it's a good idea to at least look at the HCAP survey and see how it might map, if there were – you know, if they were reporting performance on certain questions, they're already collecting, what could that deem, number one. And then number two is to have a conversation about what's the – you know, is there a way that we could do something similar in the EP setting, either by providing a common platform, or, you know – you know, those kinds of things.

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

I don't know whether anybody at ONC can answer the question of whether we can use questions from HCAP as –

Michelle Consolazio Nelson – Office of the National Coordinator

Paul, this is Michelle. I don't have an answer. Sorry.

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

So Paul, I think you can on the hospital side, because remember, we talked about people being an X decile on such and such question a lot. So I think they already do that on the hospital side. But we should look. I mean, we should – I'm just asking, do we want to really pursue this idea, if – as part of the deeming and the quality measures.

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

If you also want to join the group to help us flesh some of the – you know, flesh out some of the ideas that you have, that would be welcome as well. And remember that we – we aren't dealing with an ideal situation. We have to deal with what we have now.

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

Yeah.

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

But let's – let's try to – if people like the idea, still think the idea has merit, and I really think some of the points that George raised, this is – this is a get people on board. And once we have them on board, we're really passing it off to the things that drive performance. And we're not that vehicle. And I – part of the way we thought about it is really giving people the benefit of the doubt. It's more than the benefit of the doubt. They do have these systems. They've probably had these systems in place. And the market's going to ask them to deliver better and better performance. So I think we need – we're trying to let up on the prescriptive parts of this program, and I think that's the appropriate thing to do by Stage 3.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So this is Amy, and I agree. I mean, I think anything we can do to simplify this a little bit more –

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

Yeah.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

– I mean, if it can, you know, deem more with less because the quality measures are showing really good quality care, I am all for that. I just feel like it's still a little more complicated than – I think there – again, I know I wasn't part of the group, and I'm sorry for sounding critical. I just – I feel like if there's a way to make it simpler, we'll all be better.

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

I definitely think that's true. And I think, Christine, you gave some good ideas, too, to look at how to spec out these bundles. And maybe there aren't so many of them, and maybe we just concentrate on a few, and – but I think we want to move in that direction. And – if there's any way at all.

Christine Bechtel – National Partnership for Women & Families

Yeah. I agree.

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

We need – we need to –

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

And just one last comment on – this is Charlene.

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

Yeah.

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

On this one, again, I – today – this is why this I think is so important. Today, if you look typically at how providers implement, they don't necessarily implement to outcomes. They implement applications.

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

Yeah.

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

So this is really important fundamentally. So I don't want to give up on this. And I think our customers could understand this.

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

Yeah.

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

I could show this – I'll get some feedback from them, but I don't think this is like a hard stretch for us. We know what the functions are. They know how to map – how they operationalize it is a whole different process, but they're going to – at least this gives them some tools to think it through, anyway. So I'm kind of in support of moving on in this direction, because, you know, kind of as an industry, we need to move here.

And again, your leaders are there. A lot of the, you know, others are just still implementing applications without looking and tying them to outcomes.

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

I think that's a really –

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

So – I know you've got to get off, Paul, so I just –

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

Yeah. No, no. I appreciate that, Charlene, because I think that's a really good bottom line. We – and that's driving us towards reorienting this program towards the outcomes. That is educational in and of itself for the folks who are just coming on board, and it's instructional in terms of reorienting from the application implementation to the outcomes. And even if we cannot map this one to one, that is a huge contribution.

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

It is.

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

It'll be – it'll be felt in the individual organizations.

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

And they'll have to think it through, and they'll be confused, and all that stuff, but they'll start that critical thinking. Okay.

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

Yeah. Okay. So I think we obviously need to discuss this more. Michelle points out that we have the – our next meaningful use call on –

Michelle Consolazio Nelson – Office of the National Coordinator

The 19th, next week.

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

– the 19th. So that should be on our calendars. I propose that we focus in on this topic. If you – at least the deeming workgroup, and really encourage other people – everybody who's on the workgroup, the full meaningful use workgroup, to attend, because we can use your thoughts, use your ideas, use your critique early on, and try to get a closer presentable idea, even if not fully fleshed out, but something that can really have some of the details worked out so people can get the idea and sort of rule yea or nay at the full committee.

Art Davidson – Denver Public Health Department

Michelle, how long is – when is the call, and how long?

Michelle Consolazio Nelson – Office of the National Coordinator

It's March 19th, which is next Tuesday, and it is from 10:00 to 12:00, so two hours.

Art Davidson – Denver Public Health Department

Thank you.

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

So hopefully, as many people as can will join, and we'll continue this. And I'll put a little bit more thought and maybe try to get a straw man here, but using the feedback we've gotten today.

Christine Bechtel – National Partnership for Women & Families

Okay. Paul, this is Christine. This may be an unreasonable suggestion time-wise, but I wonder if it would be a good idea to do some work about blending the consolidation piece with the deeming piece, so that we go off more of the consolidation in terms of what gets deemed and what gets used?

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

Yeah, we definitely –

Michelle Consolazio Nelson – Office of the National Coordinator

We already have, Christine, so that shouldn't be hard. We'll just have –

Christine Bechtel – National Partnership for Women & Families

Oh, great.

Michelle Consolazio Nelson – Office of the National Coordinator

– to make the adjustments we talked about today.

Christine Bechtel – National Partnership for Women & Families

Oh, great, great, great. Good anticipation there.

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

Yeah. So using that.

[Crosstalk]

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

Okay. Why don't we open public comment, and then, Charlene, if you and I could stay on for a little bit and let's figure out what to do with these bundles.

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

Yeah. Okay.

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

Maybe we can get a head start on this. So can we open –

Michelle Consolazio Nelson – Office of the National Coordinator

Can I stay, Paul?

[Crosstalk]

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

Of course. Not only of course, boy, we can't do it without you, Michelle.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

_____. Anybody can stay, really. I mean, I just wanted to not take up everybody's ____ or ____ time. But yes, please. So why don't we open up to public comment, please?

Public Comment

Mackenzie Robertson – Office of the National Coordinator

Operator, can you please open the lines for public comment?

Operator

If you would like to make a public comment and you're listening via your computer speakers, please dial 1-877-705-2976 and press star 1, or if you're listening via your telephone, you may press star 1 at this time and be entered into the queue. We do have a comment from Steven Waldren.

Steven Waldren – American Academy of Family Physicians

Hello. I just have a couple of quick comments. First, I think – thanks, everybody, for doing the hard work. I think this is really hard work, both the deeming and the consolidation.

On the amend button piece, I just want to make sure that just because if there's a button doesn't mean that it's defining any type of functionality. I don't think that was kind of the intent of a button. It's more making sure that there's a way for it to be common across multiple different systems. Otherwise, you're going to be required to, from a policy perspective, focus on the use by the providers, and them driving that adoption, where if it's a common ___ you have the ability for patient advocacy groups and others to push that, and I think we've seen that with the Blue Button, that it's – you don't have to – the providers don't have to drive that. The patients are driving that.

The other thing on the – on the deeming, just encourage you guys to continue to be bold. And I think making sure that you're making those measures hard is okay, as long as they're really meaningful and really are tied to the quality improvement and the cost savings that we need, because they're going to have to be tied to those, you know, value-based payment models. And if they are, then there's going to be a lot – obviously a lot better than being able to have to figure out, well, do I do these measures for meaningful use deeming and then do I do these because the plans are driving me?

So again, I think it's better to go – to go big here, because you do have that fallback of the other options of the consolidation that you guys have been talking about. Thanks for the work.

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

Thank you.

Operator

We also have a public comment from Josh Rising.

Josh Rising – Pew Charitable Trusts

Great. Hello. My name is Josh Rising. I'm the director of the Medical Device Initiative at the Pew Charitable Trusts. The Medical Device Initiative works to improve the safety of medical devices, in particular through improved post-marketing surveillance.

One issue that I would really want to flag for the workgroup's attention had to do with the unique device identifier, and I think people may be aware, but the FDA is developing the unique device identifier, or UDI system, for medical devices, and this is really going to serve as a cornerstone for many significant improvements in device safety and post-marketing surveillance. We strongly believe the UDI is going to benefit patients, clinicians, and public health officials by helping with more rapid identification of medical devices associated with adverse events. It will help with device recalls. It will provide a more easily accessible source of definitive device information. And it's also going to increase efficiencies in the healthcare system through a more accurate accounting of the device used.

We all know, though, that in order to achieve these public health goals, the UDI is going to need to be incorporated into clinical practice. Given the high importance of this objective and also uncertainty over whether providers are going to incorporate the UDI into electronic health records, we strongly urge the meaningful use workgroup to ultimately recommend that ONC and CMS include the capture of the UDI for implanted devices as a Stage 3 core meaningful use objective. And I think that would most likely fall under the improving quality, safety, and reducing health disparities section.

In addition to this, we are looking forward to working with the Standards Committee on our recommendation to include UDIs in the next updated EHR Standards and Certification Regs. Enabling this capture will facilitate several meaningful use objectives, including some that have been discussed during the workgroup today, such as SGRP405 and SGRP408. And we look forward to helping the workgroup with those particular topics as the work continues.

So finally, we really feel that prompt accomplishment of this goal is going to require recognition from outside experts, including this workgroup, of the importance of UDI adoption in improving patient outcomes. So finally, thank you for considering our comments, and please let us know if we can be of any assistance. Again, this was Josh Rising, and I'm director of the Medical Device Initiative at the Pew Charitable Trusts.

Operator

And we have no further comment at this time.

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

Good. Thank you very much. So I would like to invite everybody who can stay to continue discussion, so we have a head start on our meeting – our call next week, so –

Michelle Consolazio Nelson – Office of the National Coordinator

Paul, this is Michelle. We can't stay on this line.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

But I sent you and Charlene a number, and if anybody wants to join, let me know or send me an email, and I'll send you the number.

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

Or why don't you – you want to send it to the – well, who else wants to join, please?

Christine Bechtel – National Partnership for Women & Families

Paul, it's Christine. I'd love to join, but I have to do some other stuff. I mean, if you guys give me the number, I might be able to do a couple of minutes.

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

Okay.

Christine Bechtel – National Partnership for Women & Families

But I just had – I did want to build on Steve Waldren's comment, if I could, before we hang up, quickly.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I need to go. Sorry, folks.

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

Yeah. Okay. Thank you.

Christine Bechtel – National Partnership for Women & Families

Mostly just for you and Charlene.

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

All right.

Christine Bechtel – National Partnership for Women & Families

But did anybody else want the number?

[Crosstalk]

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

Oh, there it is. I've got a 3:00 I'm going to have to jump off for.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I'm going to have to jump off, too. Sorry. But I'll be on on Tuesday.

[Crosstalk]

MacKenzie Robertson – Office of the National Coordinator

So since this is a public call and this is still a public line, I would just like to conclude this call, and if you guys could dial into the one that Michelle did, just for the admin stuff related to the workgroup.

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

Thank you.

MacKenzie Robertson – Office of the National Coordinator

Thanks.

Christine Bechtel – National Partnership for Women & Families

All right. Thanks, everybody.