

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
July 16, 2013**

Presentation

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

Christine Bechtel?

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

Good morning.

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

Good morning Christine. Neil Calman? Art Davidson? Art are you on the line?

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

Here. Yes, I'm here.

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

Great. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Thanks Paul. Marty Fattig?

Marty Fattig, MHA – Nemaha County Hospital

Here.

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

Thanks Marty. Leslie Kelly-Hall? David Lansky?

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Here.

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

Thanks David. Deven McGraw?

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Here.

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

Thanks Deven. Marc Overhage? Charlene Underwood?

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

Here.

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

Thanks Charlene. Mike Zaroukian?

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

Here.

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

Thanks Mike. Amy Zimmerman?

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

Here.

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

Thanks Amy. Tim Cromwell? Joe Francis? I think we have John McGing for SSA in terms of Greg Pace? John, are you there? Okay, we'll wait for him. Marty Rice? Rob Tagalicod? And any ONC staff members on the line.

Michelle Consolazio – Office of the National Coordinator

Michelle Consolazio.

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

Thanks Michelle. Okay, with that I'll turn –

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator

Elise Anthony.

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

Ah great, thanks Elise. And with that I will turn the agenda back to you Paul.

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

Great. Thank you MacKenzie. And thank you MacKenzie for leading us in this whole FACA process, we really are going to miss you as you transition to your next assignment. But thank you so much for all you've done for Meaningful Use.

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

Thanks Paul.

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

And we will welcome Michelle as the new MacKenzie, but also doubling as herself, so thank goodness we will have Michelle for both Meaningful Use support and for running the whole overall FACA process.

Michelle Consolazio – Office of the National Coordinator

And my name has changed, sorry.

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

And what?

Michelle Consolazio Nelson – Office of the National Coordinator

My name has – the Nelson’s finally gone.

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

It’s gone?

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

The Nelson’s finally gone.

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

It’s gone? How are we going to know you?

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

We’ve got to practice your last name. Okay, we do have a rather long agenda today. Basically it’s sort of a summary before we go before the full committee in August and share with them – bring back our entire work, which is everything from the new look at things, our consolidation and our deeming options, as well as all the details we’ve just been through in subgroups to reconcile the RFC comments. So we have a – how long do we have in the meeting MacKenzie, is it two hours?

Michelle Consolazio – Office of the National Coordinator

Yes, two hours.

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

So we’re going to essentially do a dry run and a lot of us haven’t been through the whole thing together, so it’ll be good practice to make sure it all fits together. One of the things we haven’t paid attention to during our reconciliation process is back to the consolidation and deeming, so hopefully – I know we haven’t done much at all with the deeming part of it was related to the Quality Measures, trying to get Quality Measures that are deemed, deemable, and the others, I don’t know, Christine whether you have any other new input on consolidation, although we’ve been doing some of that in the subgroup, actually some of it’s been deconsolidation, right?

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

Yes, exactly. So that work is all reflected in, I think, what Michelle has for us today.

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

Okay, very good. Any – how does that sound as an agenda? Essentially we’re going to go through the deeming consolidation summary and then go through each of the workgroups.

Michelle Consolazio – Office of the National Coordinator

We’re not going to do subgroup 2 today though, because of quite a few open items.

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

Okay.

Michelle Consolazio – Office of the National Coordinator

So we’ll skip that one and we’ll do subgroup 2 on the July 30th call.

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

Okay. Thank you. All right, so why don’t we advance the slides, we have all the members. Is David Bates on?

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

He's not.

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

Okay, so George might be able to help us with that one, that subgroup?

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

Yeah, we'll work our way through it.

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

Okay.

Michelle Consolazio – Office of the National Coordinator

Yeah, between George and me, I'm sure we'll get through it.

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

Okay, got it. Okay, next slide please. Just to remind us, this is our famous Stage 3, when we promised everybody in the community that we're going to start working towards the outcomes, we've been doing a whole lot of work to get to this point. The good news is I think we are at the point where we have the tools in place and we can start making progress on the measuring and improving outcomes. Next slide please. Remind ourselves that part of the assumption going in was that we were going to focus not on the – we're not going to put tools into instrument or to facilitate the old way of doing things – go ahead and fill out all of the bullets – is we're going to work with the assumption of the new model of care. It's team-based, it's outcomes oriented, it's dealing with population management.

And our eye on the prize is really around the National Health Priorities as they're being defined by HHS, whether that's through the Quality Strategy, which actually I think reflect our original categories quite well, the prevention, cardiovascular disease, etcetera. That we are looking for broad applicability, MU's a floor, people do say that it's become somewhat of a ceiling in the sense that it consumes a lot of the bandwidth of effort, but I think the product of that has been extremely exciting. The amount – we've gone from zero to 60 in such a short period of time, it shows that it's working. We just want to be respectful of how much work people put in to get to this point. But it has to apply across the specialties, across patient health needs and across the areas of the country. We're not working on things that are already driven by market forces, once we kick-start something, we don't need to keep pushing, and in fact, that can have the deleterious effect of affecting innovation. So we've got to be enough, but not too much and go where the standards are mature, otherwise we'll just be creating more cacophony.

Next slide please. What we've learned is that every time we get these updates, the adoption rate is really quite impressive, people hold the gains and the new people coming in, unlike some of the fears we had, was that oh gosh, there was just the early adopters that are going to come in with these high rates, but no, everybody who's been coming in, and now more than half of the providers and more than three-quarters of the hospitals are already in, they come in at that same high level. So, our worry about 10-80 percent is fortunately not warranted. So we really have created this rising tide and what we're after now is to focus on the real prize, the real getting the measures that matter and the tools to get there and that we want to reduce the burden, because there's so much on everybody's plate, not to mention the ICD-10, the movement in pay – outcomes oriented, value-based purchasing, etcetera. So we're trying to point the tools and people in the right direction, but let innovation carry them through.

Next slide please. We want to keep our eyes on the gaps that remain such as interoperability and patient engagement, reducing disparities and that's the reason why, next bullet please – two more – that we're working on alternative pathways where we want to reward good behavior and we want to reduce any of the burden of complying with a regulation. So that's part of consolidation and part of deeming. Two slides please.

Paul Egerman – Businessman/Software Entrepreneur

Paul, do you want to do questions now or when you get all done?

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

Let's see, I'm going to get to – well, is there some question on that overall approach?

Paul Egerman – Businessman/Software Entrepreneur

No, it's just a couple of issues on the slides.

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

So is it something you want to just an email on or – no, go ahead.

Paul Egerman – Businessman/Software Entrepreneur

Well, you referenced interoperability. I think you mean information exchange; interoperability is actually a different concept than information exchange.

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

Good point, thank you. Let's see here – it's included, it's just broader than interoperability, right?

Paul Egerman – Businessman/Software Entrepreneur

It's different. I don't want to argue the difference, but we think – we've been talking about information exchange in the Policy Committee and we ought to stick with that concept. Interoperability could be within an organization, information exchange is between separate organizations.

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

Got it. Okay. Thank you. Any other comments about sort of the overall – it's sort of the setup for what we're presenting. Okay, next, under deeming assumptions, we're – I already sort of spoke to this, is we're trying to let the market and innovation to drive the future – the tools and the way you apply the tools. We're not trying to get in the way or force anything and we're trying to offer an alternative, this optional pathway. It is optional to get deemed in satisfaction of some of the functional requirements by being a high performer, mirroring essentially the value-based purchasing model. Next slide please.

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

And just a catch, you might want to put those in the positives, I mean not right now, but think of this making a statement in the positive, like to achieve these it's going to depend, or something like that. Just a thought.

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

Say a little bit more.

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

Just put – you can't do it without, maybe you must – to be able to do this, you must use blah, blah, blah. Just put them in the positive, that's all.

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

Okay.

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

That's it. After the fact.

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

Great, thank you.

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

You're welcome. We're dry running, right?

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

Yes, we are, so please, these are – we want to – if we – the better we state it, the less confusion and less questions in terms of what we meant, so thank you for that. So this slide talks about some examples. Now we haven't gone beyond this, and so this is one of the things to ask this group –

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

Um hmm.

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

– so our example criteria, I mean they're not bad they are what we first thought about is first is the point of demonstrate what's high, so high and improved. So the strawman high was top 30th percentile and that's determined by CMS, for example, through the benchmarking, and you know that ahead of time. Improved performance was, you have two ways of achieving it, either you're a high performer or you are getting to be a high performer. And so the strawman was 20 percent reduction in the gap between your last year's performance and the top, maybe we say the top 30 percentile instead of making two different ones, and that there's a – you pick things from prevention and chronic health conditions. So you pick two that are relevant to you, in terms of prevention, and pick two from controlling chronic diseases, and these, of course, are on the National Health Priorities. That's for EPs.

And then for EHS, which is next slide, we focused on patient safety and care coordination. So again, pick two from patient safety, pick two in care coordination area, doesn't have as many measures to choose from but it's certainly an important piece – aspect of hospitalization. Let me pause there for comments on any of those assumptions. So one is, what does high mean, and the draft is 30 percentile – top 30 percentile. What does improvement mean, and the draft is 20 percent reduction in the difference between your performance and the top 30 percentile. And then the high priority disease – prevention and chronic disease management for EPs and patient safety and care coordination for hospitals. Comments on those concepts?

Paul Eggerman – Businessman/Software Entrepreneur

This is the other Paul.

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

Um hmm.

Paul Eggerman – Businessman/Software Entrepreneur

I have a number of comments. First on the issue of high, 30th percentile, that actually strikes me as too low, 30th – depending on what we're trying to accomplish, but 30th percentile, I mean that's like getting like a "B-" on a grade, I mean it's not top quartile, the top quartile would be 25 percent, which is 30 percentile and that's like you're 30 percent of the people are better than you. The improved performance, I like the concept, but if you do 20 percent reduction of gap and the top quartile, you're making it really hard for somebody who's low; I mean if you're currently in the 50th percentile, so if you're low and you're trying to get up to – you have a bigger challenge and if you just missed it. And so I think you need to measure improved performance in a different way. And then I look at the actual metrics and I have a little bit of a concern about each of the – some of these issues, like you have mammography screening and yet we talked about disparities in healthcare. But if you're dealing with a poor population, you may not – these things that you list, you just don't have any chance of getting – of doing in that your population is not able to use transportation to get to the facility, your mammography preventive screening is going to be low. Those are my reactions.

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

Good questions. So let me – let's start with – .let's go in order then. Your top 30 percentile you're saying is too low. Your right that 30 percent are doing better than you, but you're leaving 70 percent behind, what do people think about that? Where should we set that threshold?

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

Well remember – this is George, you have to get 30th percentile on four of them, so it's not like you just need 30 percent on one of these four, you have to do – so that makes it a little bit more stringent –

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

Yeah.

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

– than it looks, so that helps a little bit. And then if you're going to make say 95th percentile, basically no one is going to get 95th on – 95th means there's really just a couple of institutions we expect to use the deeming pathway, I would think, I mean to my perception. So whether it's 30 or 25 or something, I don't know, but if you go for really high, I think it just doesn't become a useful – we might as well just skip it if we make it 95 percent.

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

Other comments?

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

Yes, and this is Charlene. When we look at the general population and our current track record. I mean, gain, there's been significant improvement in these targeted areas, but again, the literature shows people are at 50 percent and 60 percent, so I'm, especially since you've got across four of them, I'm not troubled a whole lot by keeping it at – I mean, you could make it 25 percent if you wanted to tighten it, but I don't think there would be any need to tighten it any more, especially in the first year.

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

This is George. Let me clarify two things that both Paul and Charlene just said. Remember, this is not percentage achievement, like 50 percent, this is 30th percentile, so if everyone's in the 90s, then you have to be in the high 90s to reach the 30th percentile.

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

Yeah.

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

And then Paul, when you said this is like getting a "D," actually it's not like getting a "D" because you're in the top third of your class, it is like getting an "A" or a "B+" because it's not the percentage of the test you got right, it's where you scored within everyone who scored on the test and probably most people passed. So it is like an "A" or an "A-," it's not like a –

Paul Egerman – Businessman/Software Entrepreneur

I have to tell you, where I went to school, the top 30 percent did not all get "A's," I guess there's been grade inflation.

W

But the top 30 percent of areas is sign of improvement –

Paul Egerman – Businessman/Software Entrepreneur

Thirty percent of the class did not get an "A," I'm just saying, that's not how it works.

David Lansky, MD, PhD – President & Chief Executive Officer, Pacific Business Group on Health

Paul, its David, David L. I'm sympathetic to Paul's raising the issue. I think there are two factors that I'm thinking about, one is what gets deemed by virtue of good performance on these measures, so what are we waiving that this is a proxy for, that's good performance on these four measures let's say is a proxy for something and I'm not sure I see the connection between what we're going to see in a minute – what credit you're getting and how if you perform well on mammography screening, let's say, that's a correlate.

And the second thing I'm puzzling over is the – many of these measures are very old time, HEDIS measures been around for 20 years, a lot of institutions, and individual providers have already figured out, without IT, how to perform well on them. And so in a sense we're giving them credit for competencies, which may not be related to the adoption of HIT. And the reason I'm thinking about that is to me, I think as I said before, we're less interested in this particular program on the clinical performance than in the effective adoption of IT in support of clinical performance. And so rather than reward what might be an underlying care competency, which is great, but not really our purpose, we want to make sure we're rewarding applications of IT that are manifested in clinical performance, and I don't quite – from this list of measures, I don't see – I understand some of them correlate pretty well, but when I look forward to the deemed – the credit you're getting, I'm not sure these measures do a great job of connecting the dots. So I'd be sympathetic to raising the bar, but more conceptually than numerically.

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

So let me ask – Paul Tang –

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

This is – no, go ahead Paul.

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

I was just going to ask David Lansky for a clarification please. You're saying you think that high achievement on let's say prevention and chronic disease management would not indicate – would not necessarily indicate effective use of HIT?

David Lansky, MD, PhD – President & Chief Executive Officer, Pacific Business Group on Health

I think there are plenty of doctors and organizations that are already in the top 30 percent of providers who achieved that without – prior to their adoption of IT or independent of their adoption of IT, by their overall clinical workflow or patient selection as Paul's suggesting or other things. So to have a good rate of colonoscopy screening or LDL control, well might have predated the HIT and EHR Incentive Program, and they're still in the top 30 percent of their class, we're just now giving them credit for it on Meaningful Use Program, where they have already achieved credit for it in HEDIS or in IHA or some other program. Your own organization, Paul, probably would meet this criterion, you might attribute it to the IT adoption, but your organization has had a strong track record on these measures for a long time.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and what you just said too is also true about some of hospital things like the surgical site infections, the catheter associated urinary tract infections. People have done a lot of good work there already and they may be in very – they may be in the 30th percentile or above, it's not clear to me it has a huge amount to do with their computer system.

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

Amy, you were going to say something?

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

Yeah, no I was just going to say that, I mean, in my mind while we want good use of HIT and that's what we're focusing on, the purpose of that is all to get better health outcomes at lower cost and higher quality. So to me it's less about – I mean, if they're already achieving really high rates, I understand the concern that maybe it's not the right measure to see whether they're effectively using HIT, but if they did it – I mean if they're doing it without HIT, they're getting to an ultimate goal. I just – I was uncomfortable with saying that our goal was only on the HIT side, because HIT is in support of something, and I don't think we should lose perspective of what it's ultimately in support in, which is better, safer, higher quality care at lower cost. So I can appreciate maybe it's not the best measure, but I wouldn't want to say that – because to me it's one of many tools. HIT in and of itself isn't going to get anyone these rates either, they're going to have to have a combination of efforts in their approach; so I just want to point that out.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

This is Deven. Amy, I don't disagree with you at all, but I think we have to be mindful that CMS has the statutory obligation to make Meaningful Use payments for meaningful use of an EH – of a certified EHR technology, so in some respects we do have to make that EHR HIT link or we're arguably running afoul of where the statute requires us to go.

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

Right, I agree. I'm just saying in principle I –

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah.

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

– I mean, if some of these measures are easy to meet or some places are better at meeting them because they put in their own tracking systems on paper or something, ultimately we think it's more effective and the statute says you should get away from that. But I just want us to keep in – so it's tricky, I just – I was reacting to I think David's comment earlier saying, it's sort of, I got the sense he was saying it was all focused on HIT and I guess from a statute perspective it is. So if these measures aren't going meet that, that's okay, but I think ultimately we should just recognize we – that those top performers are doing something right and I think over time they're going to find it harder and harder to do it without HIT anyway.

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

Or at least more costly.

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

Paul, this is Christine. On the statute thing, the statute does reference using meaningful using an EHR for clinical quality measure improvement and reporting, as well as information exchange. It also talks about reducing health disparities, so there's a clear link here and I'm much less worried about that and more worried about making sure that people are able to use the more advanced functions and features of an EHR to set them up for success under new payment models and potentially in those areas where the market still lags, as you mentioned. So as I look at some of these, and I get David's point about pre-existing measures and etcetera that people may already be performing really well on, and I think that's fine. But when I looked at like for example the EP measures, the sort of hesitation that I've always had is that there are enough and there are more on the EP side, sort of process eMeasures, not that they're bad, but they're pre-existing and because they're more process oriented, they're more likely to have been built into workflows predating EHR.

It makes me wonder whether we ought to ask the Quality Measures Workgroup to really dig into measures that are more sort of directly reflective of really good EHR use, patient engagement, reducing health disparities, because I like this pathway a lot and I don't want to lose it. I also like the fact that under this pathway folks would be required to stratify quality measures by disparity variables, which is much more closely tied to EHR use and the ability to do that. So maybe we could hold that idea out as an example and ask them to really think outside the box, and maybe you don't just look for, oh, these are really cool IT enabled measures, maybe you look for measures that really are more like disparity reporting stratified measures and improving on those, because they do really require more sophisticated functions.

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

So, this is Charlene, there's two points. Number one, if this was changed to state these had to be reported through eMeasures, then you'd link it to the EHR and let me promise you there's an incredible amount of work doing these eMeasures and the providers are going to have to do a lot. So that's a possibility. The other thought that I would like to propose is when – in legislation or regulation, when you prescribe these specific measures, and I know this is just an example, then let's just say time moves out or programs get delayed and what's prescribed in regulation becomes irrelevant. Is there any mechanism to point to a set of measures that they might use instead so that it enables the advancement of the measure set at the same time that it makes them appropriate measures for them to use through use of their EHRs? So there's kind of two points there. We could qualify it a little through reporting using eMeasures, assuming that's going to be in place by Stage 3 in some form, because I know they're working toward that, as well as potentially use a set of measures they could point to as opposed to necessarily prescribing it in the regulation.

Paul Egerman – Businessman/Software Entrepreneur

It's a – this is Paul Egerman. I just want to respond to what you just said. I like the idea of having some e – what you called eMeasures, because then it does relate to the EHR and as I think about this entire discussion, if you have the concept of eMeasures, and if you were to drop this concept of the high performance, the 30 percent, and solely focused on improvement and provided a way you can be deemed as a result of improvement. Because no matter where you are you could improve, if you're in the top 10, there's no reason why you shouldn't be achieving – trying to get to the top 9 or the top 5, and so if you had eMeasures and focused on the concept of improving, then I think you may have accomplished what we're trying to accomplish with Stage 3. We're saying we're outcomes oriented and so now you have a vehicle here to say, well people are focusing on the outcomes and eMeasures and they're showing that they're using the system and they're improving year over year, well then we're deeming that to be successful use of an EHR.

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

Well this is Mike –

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

Go ahead Mike.

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

This is Mike, can I weigh in on a couple of things?

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

Yes, go ahead.

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

So first, I think there – this is a great discussion. I think we need sort of three areas. I do think we need to keep the high performers in, because I can assure you on some stuff people are so high they can't get much better, and that's okay, because we're also trying to use the talent that they exhibited to get where they are to innovate around other areas that are important to outcomes. So I do think we need high performers, whether it's the top quartile – I'm big on quartiles rather 30 percent only because it's easier to keep in my brain. But that's a small potatoes issue. I think improved performance against a percentile improvement compared to that is helpful, but I think an absolute performance is also another area where it might be worth considering – it should be taken care of by the high percentile, but I think to someone's earlier point, it could be that a lot of people are already at 90 percent and getting to 94 percent is probably incrementally a small difference, and yet those people ought to be able to innovate as well.

I think all of the things that we're talking about here, virtually all of them with enough brute force can be done without Health IT. So I don't know that that's the point. I think all of these things, in my practice and in many that we've been with, these are easier to do with Health IT that's certified, that interoperates, that can be exchanged, and that makes it easy to have reminders, alerts and population-based care. So, I'm not too worried about the fact that it's possible to do this without Health IT, because I see all of them as being easier to do with Health IT and to the extent that I think we could all assume that they'll be e-reported. They're clearly reflecting that someone's using Health IT, whether it was essential or simply facilitatory to me is not the big concern. My question then becomes so if you look at the burden decrease, which Paul mentioned very nicely in an early statement that docs are looking for, if you look at the movement from focusing on the sort of widgets of care that are delivered to the goals people are striving for, I think this deeming process is really essential to re-engage and re-energize providers to make real differences in outcome. And especially when I look at the slides that are following on what relief is being given for those who are deemed and what can they focus on instead, I think is – for the kind of direction that many of us would like to go, less of the functional issue if you will, and things related to numerators, denominators and more towards the evidence of improvements in actual outcomes.

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

Hi, this is MacKenzie. Can everyone please mute your phones, we're getting some rustling papers in the background. Thanks.

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

So let me try to summarize some of these excellent points. The six excellent points I've heard in the past several minutes. One was Christine saying the measures that matter basically is if we focus on the things that both are more important to patients and providers, less process, that's one of our goals. The next was a very interesting idea of focusing in on eMeasures, because then almost by definition, clearly the easiest way would be to get that information out of an EHR, probably almost the only way because a lot of that will be dependent on data that's captured in the clinical record. Third point was to refer to a set of measures rather than some static things that are in regs. Paul Egerman's point about combining Charlene's about eMeasure plus tying it to improvement rather than the specific threshold and I think somebody else mentioned improvement as well. I think this theory's really, really good. The part that I think we're going to struggle with is how few quality measures one are even in eMeasures and two, that are what we would consider measures that matter.

One of the limitations of eMeasures themselves, the current eMeasures and NQF is working very hard on trying to define what is an eMeasure, to inform and educate the measure developers. But the existing ones are, as you know, mostly retooled old measures and so not only are they old measures, but they're actually something that's even harder or less relevant than the old measures that were based on the administrative data. So, the fact that I think these ideas are great, what do we do in the meantime before we get to eMeasures that matter?

And that was the accompanying commentary to the set of slides I forgot to mention is, what we were hoping to do, since the time we proposed deeming and the time we would come up with our final recommendations, is to have at least in the pipeline new eMeasures of things that matter. We've started – it just wasn't happening, or happening quickly enough, and so actually there's a new Tiger Team that's going to look at what can we do to advance some of the work that David Lansky led like a year and a half ago, in these new concepts. And most of the concepts that were proposed, not measures, but at that point concepts, were much more of the type of measures that matter, and how can we bootstrap – so how can we have accompanying recommendations that really restate and reinforce that desire to have new measures that – new eMeasures that matter as part of our recommendations for Stage 3. So we're trying to re-emphasize that point and potentially even sort of give some examples. But in the absence of that in 2016, what suggestions do people have, what do we do in the interim? I think those are excellent directions to go towards, but what do we do in the interim couple to few years?

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

Paul, can you remind me, does deeming – can you deem out of Stage 1 and 2 or just out of Stage 3.

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

I think we were just thinking of out of Stage 3.

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

So these are people who have done all the Stage 2 stuff –

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

Correct.

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

– on the objectives listed in the substance of the slides.

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

Correct. So we've got the Stages, we're still – I mean everybody has to go – you know, walk first. So we thought that was all valid and actually, that's some of the assumptions if you recall the two column slide of why it gives us now ability to sort of relax the process-oriented functional objectives.

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

Okay.

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

Paul, it's Christine. I'm just thinking of this idea, so, I think we should think about it more carefully, but I'll say, what about if in the intervening couple of years we focused only on reporting measures and improving on them by disparity variables? So you took the same measure list, and people can still pick two and pick two, but you've got to stratify them, select the population you're going to work with, which could be race, ethnicity, could be language based, it could be LGBT, disability status, right, because those things are coming into Stage 3, but it's hard to imagine that we have such high performance on – across vulnerable populations, but if we focused only on improvement and not just high performance, which could be sort of pre-existing, but I doubt it, but we focused on improvement in those populations, but still used the same approach. Because in my view, focusing on measures by disparity variables takes you to using more of the EHR functionality, you're going to have to do patient engagement and outreach, etcetera.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and Christine, this is Paul. I would have a concern if you're going to only focus on a disparity variable, the way you describe it. I don't think we want to say, well gee, we're going to look at a certain race and certain gender and a medical groups only going to focus a lot of attention on that one group of people, to the exclusion of others, because that by itself is a disparity.

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

No, Paul. So let me clarify. My assumption, and I think it's a valid one, is that improvement is really a system property, right. So if you're focusing on improving vaccination rates for flu and pneumococcal vaccine, but you're really focused on, in particular, African Americans with diabetes, for example. Because it's a system property, you're going to put in place the kind of workflow and EHR uses that will benefit all patients in the same way that by adopting an EHR, it affects all patients, not just Medicare or Medicaid, right, you don't use it only to treat the population for which you're – the incentive program is operable, e.g. Medicare. So that's what I am assuming here, but you still have a core set of EHR functions you have to use, but in terms of the quality measures piece and really incentivizing improvement, I mean we have study after study that tells us that we need to make much better progress around disparities. So I'm assuming though that even if you had that focus, because it's a system property, rising tide floats all boats.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah and thank you for that clarification, because that's what we'd want to do is you may want to have some focus, but it's got to be a rising tide for everybody and that makes sense, I appreciate what you just said.

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

So just a comment Christine about the evenness of paying attention. Unfortunately, most of the pay for performance are on capitated lives and I would say a goodly proportion of folks focus only on those populations. So that's not good news, but it also makes us think a bit more about focusing only on specific subsets.

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

I'm so – I just am not quite following you Paul.

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

So I think one of your assumptions was that if you do something for one subset of one type that you'll do it for the entire population, and the experience in these pay for performance programs, unfortunately, show that providers will focus their attention only on the measure – the targeted population. So, it's not necessarily a safe assumption to say that –

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

(Indiscernible)

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

– you'll take – yeah.

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

But I'm also assuming that David Lansky is right that these measures that we're looking at here, I'm talking specifically about these, which are the existing ones and longstanding, that there has been a sufficient focus on those measures and processes and workflows for many years. So I wouldn't be as worried about really focusing on reduction in health disparities for those kinds of measures.

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

So Christine, this is Mike. I really like the idea you're describing and I'm trying to imagine in Stage 3 I could move my organizations towards more carefully looking at the performance across all these populations and using it to target some improvement goals and the like. So I'm trying to imagine how to incorporate what you're describing into what we might measure in Stage 2 and then how we might use it to deem in Stage 3, because I think it really is a helpful way to try to attack the problems we're seeing, plus it does demand more robust use of the technology.

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

I would agree that both her disparities and Charlene's eMeasures are both things that essentially indicate they're using an EHR.

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

Right, but the thin – the concern I have about the eMeasures piece is I don't think that says very much. I mean it's a reporting mechanism, it's not an indication – so when I think of more robust eMeasure or an IT enabled measure, we've talked about sort of Health IT sensitive measures, and when I think about stratified measures, then I know you've had to use your patient list to do it. I know that you've had to use your population health dashboard to look across your population. I know you've had to figure out who your population is demographically and where the disparities fall. There's just a lot more than oh now I can push a button and report my mammography screening rates that I have been working on for many years, right.

So that's the difference I'm trying to get at and if there was one other – the reason this came to me is because you have these measures, some of which are outcomes measures and some of which aren't, but we're stuck with them, I think, for the immediate future, which is the issue that you raised, Paul. So how can we take the measures we're stuck with and turn them into something more meaningful with technology? So maybe it's this and something else, but I'm just struggling to get to the something else piece. And by – I'll just say one other thing, coming back to Mike's point about kind of Stage 2. Stage 3, these measures, at least on the physician side, are all part of PQRS, so there is a very good correlation that in Stage 2 you could be thinking, oh wow, Stage 3, these measures are coming so I'm going to pick them in Stage 2, I'm going to focus on them as some of my reporting measures, so I make sure I'm up to speed and I know what I'm going to do here and I can work on that. And then in Stage 3 I'm going to get deemed for all these other pieces because I will have been working on that, so I think there is a very good link with – in that respect.

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

That is a good point.

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

And that's actually what I was trying to make explicit, how to help encourage that and give some direction to folks as they're doing it. Maybe we don't need to give anymore, but I'm just wondering.

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

Oh, I think we do. People are not steeped in this like we are, but that's a really good observation, is, it's sort of like a two-fer, I mean if you pick the right measures, focus on them, then it just carries you through, which is sort of where we want it anyway. So what are people think – so Christine's approach deals with one, really tying it to use of EHR, two, not necessarily tying it to eMeasures, of which there are very few right now. So that seems – so then the question I guess is, and which disparity vari – you get to choose from the list of disparity variables of where you want to show improvement?

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

Sorry Paul, you cut out a little bit. Can you say that again?

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

So your idea captured – addressed a number of issues. One is how do you tie the measure to EHR use, so you've got that because you almost can't do it on paper. Two, you overcame the problem of there just aren't enough eMeasures today, and maybe that changes in the future. But now in order for you to specify your idea, you'd have to say what, here are the list of disparity variables, pick the ones you want to improve upon, just declare that and then show that you're in the either top – that you have reduced your gap?

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

Yeah, I mean somebody with maybe more expertise in the current state maybe looking at the AHRQ report on health disparities, but it's just hard for me to imagine that at least in theory you couldn't go with a straight improvement approach?

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

Yeah.

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

Which would get to I think Paul Egerman kind of suggested that, because that does answer a couple of other issues and knowing that there's such a wide array of potential disparity variables, that if you felt like, well, I'm already a really high performer of mammography screening among African American women because I did some improvement work around this, then you're not going to pick that one, you might do mammography screening among another population or you might do a completely different measure, completely – you can go with different measures, different subpopulations, etcetera, in order to find something that you genuinely need to improve on, if it's only improvement.

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

So is that saying not a close the gap to measure some kind of absolute improvement?

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

No, I don't think I'm talking to absolute versus relative improvement, I think that's a different issue. I'm saying Paul Egerman raised this issue of, if I'm in the top quartile or whatever already, right, that's either not high enough or maybe you're getting credit and you're not really using the EHR in the way that you should, so I'm just saying, one option would be at least if you look at doing this by disparity variables, the you could – there's more – it makes more sense, again we need to think about this carefully, to focus on improvement only and not just high performance, if that answers some of the issues that he raised.

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

Let me hear from some other members of the group on this latest proposal, it's basically what Christine is proposing, improvement in your performance in some disparity variables.

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

This is Mike. I would say for the deeming process I would like to see those people that are paying really close attention to disparity variables and tracking that and that an ambition for Stage 3 would be to really close some gaps and develop some best practices that are part of that difference in outcomes. So I'm not sure it's – the stars are aligned to do that as part of the deeming process per se, but if I knew that people were paying close attention, and I could actually stimulate my own organizations to pay more attention to the disparities if they knew that Stage 3 would reward those who are paying attention to them and starting the processes, that they can really make those projects for Stage 3.

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

This is George. I'm not – I'm worried about the improvement only proposal because it opens us up to too easy criticism. Now I understand what Christine is saying, well you just have to pick one where you're not that good and show you've improved there. But if you have someone who has all four, like we go some of these only have four choices, if you're good in all four, then you say care coord, pick two from three, right, at the bottom of the slide, if I'm good at all three, then I can't participate in this, even though I'm good at all of them. And if you look at public policies and education and stuff and where they do improvement only, I haven't been impressed. So I think it's hard to do improvement only. But you could argue to have a higher bar on high performance, but I don't know that you can reasonably eliminate it.

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

You also do set up the perverse incentive, we've been talking about even for Stage 2, to go to Stage 3, it's a lot easier to improve when there's a big gap, so people might actually be perversely rewarded for not improving until you get to Stage 3.

M

Right.

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

So that makes sense, so maybe you need both –

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

Yeah, I think both is good. I mean, you certainly don't want to penalize people who've been working on the problem. I still haven't heard some other comments, are we going with the latest proposal to work on disparity variables as the way to tie improvement and EHR use?

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

Are we talking about – Paul, this is Mike, as the only method or as a method?

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

I think Christine, correct me if I'm wrong, we still can use the prevention and chronic disease management for EPs, but the way you qualify is you pick the things that are most relevant to you and you apply the improvement or high threshold to a disparity variable. So I guess you can pick it –

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

Right so instead of having to do – what I'm – I think I'm suggesting two things. One is, instead of having to do pick two, pick two plus stratify, it's pick two, pick two stratified only, right, so it's only focused on disparity variables. The second thing I think I'm suggesting is, this is what comes to me to tie it to EHR use, but we might think about asking the Quality Measures Workgroup to see if there are other ways that they think they can tie quality measurement to EHR use more tightly, in addition to disparity variables for deeming. And again, if you think you can't get there on this pathway or its not meaningful to you in some way, then you don't have to choose the deeming alternative either.

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

Right.

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

So this is Amy, and I just want to clarify, yet again, and I'm sorry. You're saying if you're going to meet the measure, you're going to meet it for a subpopulation based on a disparity criteria, you don't have to meet it for – you don't have to do improvement or meet the percentage or whatever for your entire population, you just have to do it for some sub-disparity population that you choose because our belief is that in order to do that dispar – to look at it from a disparity point of view and closing the gap, you would need an EHR, do I have that right?

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

Yes. The other – yes. And then I just thought of another idea when we're ready, but it's different from this one.

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

I will say that we might be making it – I totally understand the thought process of getting to where we're talking about. It is more complicated and it does open it up to more gaming of focusing in on a pop – or figuring out after reporting, which one is the easiest for you to maximize. And we might be losing sight of the prize, which is basically just do a really great job at caring for patients.

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

I mean, yeah, my –

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

My reaction to that though is, number one, I think that we should kick it to the Quality Measures Workgroup to figure out can you game this any more than you could game the deeming pathway as it's originally proposed. I don't think so, I think it's harder to game this one, it's definitely easier to game, in my viewpoint anyway, the deeming pathway as proposed. The second thing I would say is, back to David Lansky's point, I think it's a very important point that we do want to reward people for providing good patient care, but we need – this is the Meaningful Use Program, so we do need to reward them for EHR-enabled, high quality patient care, which is a little different than just taking the measures that have been around for a long time, that there are lots of systems that have done a good job on in the absence of an EHR. So that's what I'm really trying to get at.

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

So this is Amy and I mean when we started this discussion going way back, we sort of had this concept that outcomes is where we wanted to go, so the whole deeming was to say you needed an EHR to be able to get to these outcomes. If we're saying there are certain measures that you can get to easily without an EHR, why don't we just take those measures out?

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

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

Instead of making it more complicated with disparities, I feel like we're sort of getting ourselves tied up in complexity beyond complexity trying to almost overthink this. For those measures that are very – where a lot of providers can meet them in other ways without HIT, let's just take that out, because our whole premise on deeming was the concept that in order to get a good – in order to do good outcome measures through these clinical quality measures, you would need HIT. I meant that's why we have them –

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

Right, but the problem is that there aren't very many measures that are genuinely HIT-enabled, or sensitive maybe is a better word, in the way that we hoped and assumed under that. So what Paul started out by asking was, okay, acknowledging that there is that gap and we worked those back in 2010 that we – the Quality Measures Workgroup had a series of Tiger Team's trying to identify those next generation, more HIT sensitive measures, and they're just not done yet. So what do we – Paul Tang's question was, okay, until we get to the point where we have those measures available, how do we take the existing measures we have, all of which are going to suffer from the same problem of having been around for a long time, HEDIS measures, lots of different programs, and really make them HIT sensitive.

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

So let me just –

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

Yeah, I might go back to the eMeasures part again, because if you look at the broader strategy, the providers are still going to need to do eMeasures out of their EHR for other programs, and the payers and the plans are looking at – they're going to be collecting the same clinical quality measure that we have out there in terms of how they're going to pay. So –

Paul Egerman – Businessman/Software Entrepreneur

So this is Paul Egerman, I just want to make a comment about these things. You look at any of these measures, like the infection rate, you do need the HIT system simply to report how you're doing, so a lot of these measures involve simply reporting how you're doing plus a combination of a whole series of workflow issues. And it's – like the quality process works is you get the reports and you see how you're doing and you say, oh, gee, I'm not doing as good this month as I thought I did – as I did last month and then you dive deeper and you say, why is that? Some of that you get from the HIT reports, and some of that you get from like talking to nurses or something. But that's still –

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

(Indiscernible)

Paul Egerman – Businessman/Software Entrepreneur

– a good use of HIT. Pardon me?

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

You should get it from chart abstraction – you get – I mean all these measures have been –

Paul Egerman – Businessman/Software Entrepreneur

Well you should be doing – we should be doing – you could get it from chart abstraction, but hopefully that's not what we are motivating here, we're hopefully motivating people to use reporting tools to get the information that they need.

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

So this is Mike. I want to try to see if I can level set us on a couple of things. So this reminds me a little bit of going across the country. You can – there's almost nothing in here that with enough brute force, ledgers, paper, etcetera, etcetera, you can't do, it's just that it's tremendously harder, it's harder to sustain, it's much more expensive, etcetera, etcetera. If we're really looking for things that can only be done with Health IT and can't be done otherwise, we're going to be talking about getting information from point A to point B in structured formats in two seconds, which can't be done on paper and can't be done by fax. So that's Health IT but are we really looking at things that have to be absolute HIT only or are we looking at the how we're improving quality and value with HIT enablement, even if it's possible to do it in another way, it's just not as easy and the whole idea was using Health IT to make it easier to do it right and to add value.

So from my perspective, I think we're perhaps getting too wound up in this. I can even improve disparity without Health IT and so I think a lot of providers might be a little confused about where's all this stuff for disparity coming from as such a central piece of it. I think some will resonate with it greatly, others will sort of scratch their heads. So I'm just hoping that we cannot be so concerned about whether it's an absolute if you don't have HIT you can't do it, but otherwise we're going to start looking at how do we combine data that's so difficult to combine otherwise that in a paper chart world it virtually doesn't happen, but with Health IT it does.

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

This is Amy, I concur with that. That's kind of what I've been trying to say, so I agree with that perspective.

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

Yeah, this is Marty. This is a very thought provoking discussion and I really appreciate it. I think that the thing we should be looking at in Stage 3 is, is meaningful use meaningful to the patient, and I think if we back up and look at the fact that we are going to have to be monitoring these quality measures with an electronic record in order to achieve Stage 2 Meaningful Use, they're not going to suddenly stop using – calculating these measures when they get to Stage 3 and looking at deeming. So I think the fact that we're looking at improved quality doesn't require the use of HIT or an EHR I think is irrelevant because I think they will have already done that to achieve Stage 2.

David Lansky, MD, PhD – President & Chief Executive Officer, Pacific Business Group on Health

Paul, this is David. I want to go back to the list of what's getting deemed by virtue of performance on these measures. And I think maybe the handoff to the Quality Measures Committee is to ask them to do the math – between the measures we're now today proposing for use to get deemed, and Christine's suggestion about potentially using a disparities reduction task to achieve deeming, taking those two strategies and seeing whether or which of those deserves to give you credit on the competencies that are on the deeming slide, number 12 I guess. Because I would feel better about either – any of these approaches, even if it's one of the old measures, if we felt like giving Christine's caution that there aren't many good measures on the menu at all. Recognizing that, and all the good discussion we just had, which of these things deserve to be weighed because you perform well on say mammography.

That's – I don't think this Committee at this time can really resolve all that detail, but it's important that we not – to me it's important that we take – because an older measure like mammography, where we already know there's very high performance for a high proportion of providers and that there's a lot of compression in performance, that is, the vast majority of providers of between 80 and 90 or 75 and 85, then the – and so the differentiation by quartile or tertile or whatever is not meaningful, then – and neither is HIT enablement as a meaningful differentiator within that highly compressed existing performance. That's the kind of thing where the measures committee could look at that and say, you know, that's really not a discriminating measure of IT enablement, for achieving the competency like CDS or reminders maybe in this case. Is having an 84 percent mammography rate evidence that you're using reminders effectively? Well, I don't know, I'd let the Committee give us input on that, but I'd like to see the connection between what we're deeming and what measures we're using.

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

Yeah.

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

And somebody proposed, it might have been Christine, that okay if mammography screening is already at a high performance, then by some of our guiding principles we're not going to – we should just drop it and pick on things that are a high priority because one it's important and two, there's a gap. So we can follow that rule and then – so that the list is – truly follows National Priorities.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

That was Amy's question.

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

Yeah, and that seems like an easier fix than to throw out the whole baby of saying hey, there are things that matter a whole lot to this country still, there's a lot to choose from. Let's pick on those and make that a very clear – so that people who are not spending as much time as we do on this can say, yup, that's good for me to do, yeah, I understand why this is important for the country, and doing it, no matter how you do it. And really, I don't think people can just do it for very long without these tools.

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

So Paul, the – I still see a lot of benefit in the approach I proposed, and it's not really so much part of what we're proposing on the slides because on disparities all you have to do is stratify your reports by disparity variables. So I'd rather see, because there is a very good correlation between reducing or improving on health disparities and EHR use, I think we should revise that to add some kind of closing the gap requirement there, right, so we're asking for performance on measures in the other buckets, but we're not asking a performance in terms of disparities on those measures either.

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

Okay, what do you think about – so slide 11 states that to stratify and what I hear you proposing is, instead of saying – so we have two buckets in each EP and EH, maybe have a third and require improvement in one – in a disparity variable that's important to your population. So that not only gets the reporting, but gets the mindset of improving without making it so reliant on that, which opens it up much more to gaming.

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

Yeah, I mean I guess I'd rather see – yes, I would probably rather see more emphasis though on improving in disparities in more than just sort of one area for one subpopulation, and if we did reporting only in some of the outcome measures, I'd be fine with that, but I think the disparity piece really adds a direct – more direct connection to the EHR. So, there's a way to think about actually improving or performing highly on at least two of the four or hey, all four, right, that would be better.

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

This is Art.

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

Go ahead Art.

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

Yeah, I just wanted to ask a question. You talk about improving here, so are all of the items that are listed on slide 9 and 10, are they reported in Stage 2?

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

I believe so.

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

They're options, right, they exist already and we –

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

Okay. So how would we know in the first year of Stage 3 that someone is in the high category, is it compared to what they did in Stage 2, compared to what everybody did in Stage 2?

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

So in theory, on the high category – the high performance, that's something that in theory – so CMS would announce for this measurement year, here's the top 30th percentile based on whatever, last year or the last three years, whatever they choose. But from the past, they determine a threshold cutoff so you would know ahead of time, at the beginning of the measurement year, what you'd have to strive for and where you are with respect to that. The improved performance I think it is an interesting question and I guess it would have to be based on your own – well it would have to be based on your own past performance, and that's where the prospective education of people, that they look, when you're choosing Stage 2 measures, at least the one before the year before you're doing Stage 3, think about that, that would require a lot of education.

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

Yeah so –

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

Well remember – year we said it was going to be only a 6-month reporting period –

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

That's correct.

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

Yeah, so I thought we talked about they would report their baseline – they would have to have calculated their baseline at the beginning of the 12-month period and then for improving performance, then the measurement is 6 months or –

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

Yeah, that was so they don't get caught in the trap of – yeah. But I think you still have to have had a year's period before that, so you would have had to do Stage 2 last year reporting period has to have included this measure.

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

So that would be – this is Amy. That would be important because I wasn't going to bring this up until we got through the first discussion, but thank you Art, because I'm sitting here thinking about it from an auditing, from a state auditing perspective, let's say for Medicaid. How would you know who actually fits in those categ – you know, the same sort of question and how would you have the data to know to compare back on an aud – because we need to think about – not that audits should drive this. But we need to make sure that when we make our decisions of what we want to do, we can educate individuals about what they're going to need for auditing purposes, whether it's CMS or the state that's auditing.

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

So I assume that CMS would use a similar process to that which they already had done in some of their existing public reporting programs where there is an improvement – a baseline and an improvement calculation. But we should get feedback, obviously, from CMS.

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

Yeah, we would need to make that really explicit up front.

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

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

Yes.

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

This is George, just commenting on David's previous comment. Our original framework for this was we want to find high performance institutions and then infer that they're probably doing something good on HIT because they already got through Stage 2. So we had purposely avoided doing a 1:1 map – many:many mapping from the measures that you'd have to meet to what gets deemed, but instead said let's come up with a criteria that says – that proves to us that this is a high performing institution and then from there, what would any high performing institution have to do. So we didn't want to get into the business of saying, okay if you do this measure, then this is the thing that can come off the list and if we do that measure, that other thing will come off the list and get deemed, because we thought it was complex and it kind of wasn't what ONC was kind of working with us on. So that's wha – but I think it is reasonable to say, we should have measures in there that should deem some set of things in some reasonable way, but I don't think we want to get to the point where we're doing a 1:1 thing.

So now you bring up disparities. You could say that a high performance institution should be able to prove it's doing well in disparity, so that would be another measure. But I don't think the goal of this is to close a gap, this is to prove you've already a high performance institution – so we started off with a threshold, we only added the delta later on. We – you're a high performance institution and therefore we're going to deem these things for you, and it wasn't that you achieved these things in order to improve yourself, at least that was the original conception, right or wrong.

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

I think you're right, about the – that was how we conceived it. Let me see if – so first I want to ask if people are okay that we've gone over – this is a discussion we haven't had, hopefully the reconciliation will go faster. Let me try to summarize where I think the prevalence of compromise view is from all the great discussion we've had, and see if I can get close. So I think one of the things is people wanted a higher – so, let me propose the top quartile, and then for this strawman draft anyway, the 20 percent reduction between where you were and the top quartile, as setting a high bar.

And try to incorporate Christine's points by saying, let's say if we kept the same prevention and chronic disease management, which hopefully over time will have better measures, more HIT sensitive and more measures that matter. But in the interim one of the ways to get at the use of EHRs and to highlight the need to improve upon – or reduce your disparities, to say out of the four measures, you need to improve your performance in disparity variable of your choice for two out of the four. I'm trying to compromise on everything but yet preserve the principles and – that were raised and also not make it too complicated and lose track of the prize here. How does that sound as some middle of the roadway of negotiating the important points we've talked about?

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

Mike, I support.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Sounds good to me, it's Deven.

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

Is it worth, I don't disagree, is it worth also going back to the Quality Measures Workgroup and seeing if they can come up with any additional ideas or thoughts? At one point, for example, we had talked about a patient experience pathway, right, I don't know, so there may be other things like that.

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

Yes. And actually, as you know, that's part of the charge to this Tiger Team to try and take advantage in this remaining two months, everything that we've said and try to move that ball further. So yes, I just don't think it will be done by 2016. But that's been our hope and attempt all along, I think.

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

Yeah Paul, so maybe – let me – sorry, well I'll just clarify. I think what I was thinking of is the idea that we discussed at length around disparities, what if there's another similar thing that if we offer it as a pathway, would solve some of the problems that we think are inherent in our discussion today. So I like the approach you've laid out and maybe we have that as our kind of placeholder, but just asking them to do some quick work in the next couple of weeks around, gee, are there other – any other innovative, out of the box ways that we should think about this?

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

Yup, I think that's part of the charge they have, this is such a short time. But fortunately, you're on that Tiger Team, right, or at least you're on the workgroup.

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

No, I'm not actually, I didn't know there was a Tiger Team, but I – and I'm not on the workgroup, no.

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

Okay.

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

If I'm on the Tiger Team, I don't know it, which is another problem.

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

I don't actually know who's on it either. Okay, so let me use that as a draft, and again, we were going to the full Committee to present that. Slide 11, we've already covered; essentially we've incorporated into the deeming draft. Slide 12, I think George is right and part of our overall assumption too is to reduce complexity, because I think that actually creates a separate value and again, distracts people from the prize. So we're saying, on the left column, this is basically, and I don't know whether it's up on display – could you advance the slide please to slide 12? In the left column, there are some things that everybody's really going to need to take advantage of in order to accomplish your objective. The addi – slide 13, the additional considerations, we talked about the 6 months so that you don't get into this catch-22 of if you require a whole year, then you actually won't even know until you're done. So we proposed a 6-month reporting period, you can pick what 6 months in that year.

You can advance the slide one more please. And then we pointed out that this is an optional point – this is an optional pathway and so if for some reason it's not – doesn't fit your situation well, then the consequence is you can't take advantage of this optional pathway. And go ahead and advance to the next slide. So Christine, you think that we're – I guess we'll need for the presentation, we'll need a summary of where we are now, after having reconciled it with the comments and I think the net is that we've consolidated fewer, correct?

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

Yeah, sorry, I was getting off mute. Yeah, we have. We had to take some of them out because they just created too many problems. So I don't know if Michelle has sort of a handy list of those, I know family health history was one of them, and so that was originally consolidated with VDT, but was taken out based on public comment, for example. Michelle, I don't recall if you know others off the top of your head.

Michelle Consolazio – Office of the National Coordinator

So we're kind of back to even. So we pulled family history back out, but then it was for the future stage, but we consolidated the interoperable problem list with the care plan. They're both future stage, but those got consolidated together, in the end it's the same number of objectives, although those are future. So, I guess family history got pulled is the only big change.

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

Okay. That's good. So we still have a substantial amount – reduction in the number of objectives that you need to meet.

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

Right, and yet all of the criteria will still be –

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

Still be, yes –

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

– and so that's good. We just wanted to really focus on using data and functionality rather than the more basic things that people have been doing for a long time, like recording demographics.

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

Right. So instead of having check off, focus more, even though this is still process, focus on use. That's good.

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

Exactly.

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

Okay, how do people feel about in particular the deeming? I think we're – it was an excellent discussion, so we'll present that strawman to the Committee – the full Committee in August.

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

And Paul, this is Charlene. I don't know where we ended up on eMeasures, but for the amount of work that the industry's doing to try and figure that space out, I don't want to lose it. Because clearly through the use of those you have to use your EHR, now whether it's to improve or not is a separate issue – not lose that in this conversation, that's all.

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

I think the way that would work its way in, and I'm not sure who's going to take point on that, but – so for the – so we said prevention and there's two, four, six, like eight. So hopefully for the bullets, you would pick ones where there are good eMeasures, so that's how the eMeasures would work in.

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

Yes.

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

So you'd favor good eMeasures for the high priority conditions.

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

Yeah. Just, if we can keep those things aligned, that would be great.

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

Yeah. Good point. Okay, if we can start moving toward – through the subcategories. Then this is going to be just the high points, focus in on the red text, so in other words, the changes. George and Michelle, you're going to help us through category 1, beginning on page 23. So – if –

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

Paul, since we're 35 minutes behind, do you want to go straight to category – to the other two categories we're doing today so that David can be here for his part?

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

Oh, I see, okay.

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

Go to category 3?

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

Good point. Okay, so that would be page what –

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

Yeah, I got it, hold on –

Michelle Consolazio – Office of the National Coordinator

Slide 54 is where it starts.

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

Okay. So Altarum, could you move us to 54 please or 55? Great, thank you.

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

Right.

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

All right Charlene.

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

Okay, so again the focus of this category is to advance the process of care coordination with the end game to actually move to more collaborative care models. So what we focused on in Stage 3 was to actually implement more use cases in support of care coordination. There are three key processes in care coordination, communication, reconciliation as well as tracking, and you'll see we kind of tried to touch on all of those with the objectives that we ended up with. Where we could, we did consolidate concepts like tracking referrals as well as problem list, into other objectives and we did put the placeholder for care plan into a future stage because we really believe it's very important, that it's thought about and planned for, but it is in a pretty immature state at this point.

So reconciliation, next slide. The decision that we made on reconciliation, there were two points that we made. We decided for Stage 3, in terms of advancing the process of reconciliation, again, it's a key process, we actually maintained the current levels of reconciliation of medications that we proposed in Stage 2, leaving that at 50 percent of – reconciling of 50 percent of transitions, when a patient is transitioned, whether it's an EP or an EH. We spent a lot of time thinking about the reconciliation process for medication and allergies, as well as problems. And while those are capabilities included in EHRs for the current, for Stage 2, again in terms of reconciling in practice is really kind of not a current state of things happen, so we actually deferred those for a future state.

But the change that we made, which is really important is that the whole area, and we've talked about this a lot and I tried to document it here as clear as I could, the whole area in terms of having kind of a domain model around allergies, intolerances, conditions and problems. Because we talk about those things, but in some cases, even though conceptually they – you can talk about them, there's complex relationships between them, too, so we really believe it's important that the Standards Committee sort that out. In addition in practice, because we're currently moving toward ICD-10, there sometimes gets confusion in practice and by reconciling ICD-10 and SNOMED and what's the relationship and that type of thing, so there's potentially some research that could be done in that area. So for Stage 2 we made the recommendation that we continue to focus on the medication reconciliation, but put in place the standards work to advance the reconciliation function in future stages. Any questions?

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

Charlene, it's Christine. So at the end of the day, is there any change over Stage 2?

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

Um, what we did is, the big change was the ask for the standards work to be done, so that we can support some more advanced reconciliation processes around problems, medications, contraindications and intolerances. That's critical because if we move forward –

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

So –

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

Yes.

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

So does that mean there are certification only criteria for those things or, I'm not sure what it means to ask for the standards work to be done except that usually we say certification criteria for X, Y or Z, which means they can come up with the standards and they'll be built in, it's just not required to be used. But I don't think –

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

I –

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

– that's what you're saying.

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

I can't make that presumption, it is a complex domain space, it is – I just – I mean if that could be done in the time window, but again, it is – we're almost ahead of practice here because today there's – people don't even practice in terms of reconciling problems, as well as – so, it's the chicken and the egg here a little bit. So I think that the modeling of that space needs to be done and it needs to be thought through and then it might be clearer, in terms of how we enable that process.

Michelle Consolazio – Office of the National Coordinator

Charlene, this is Michelle. I just want to clarify, so, during the last call there was some discussion about where to put the certification criteria. I had put it in with the CDS objective, to think about clinical decision support for meds, allergies and problem lists. If you prefer to signal it here, to show that there is some progress being made for Stage 3, we can certainly indicate it here as well.

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

Okay. I think you want to put it in both.

Michelle Consolazio – Office of the National Coordinator

Okay.

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

Again that point was, and I forgot that one Michelle. We were trying to get it so that we were improving the accuracy of those. But again, any of this modeling that can be done will just help us with that over time. Okay.

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

So this is Mike, I have a couple of quick comments. One is, since Stage 1 I've been asking that the measure reflect the objective with regard to the comment or believes an encounter is relevant. Because I and many of the folks in my group that take the medication reconciliation seriously do it at every encounter and it's actually more burdensome to us to figure out whether it's a transition or care than it is to just do it every time. And yet technically, we'd have trouble reporting it accurately –

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

That was what we were challenged with a little Mike, so that was kind of how we get the denominator. Because –

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

Right –

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

...yeah, encounters are hard to match, too, right?

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

No, they're easy to match. Every office visit's an encounter, so that's easy. But every office visit that's a transition of care, I have to – yeah I have to – I actually have to click a button saying, this is a transition of care visit and other ones are not. Yeah.

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

So, but if it's a follow up visit and that kind of thing, those are still encounters, right, so we were –

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

Yeah, but we do med rec every encounter because they can change.

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

All right, we did not make that presumption in the planning that was all, so –

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

Yeah. Sure.

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

– that was the – again, it's kind of open to the group, but we didn't – we tried to be a little bit, at least from a policy level, a little bit more general in defining transitions of care.

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

Yeah. So that's actually, and I don't want to delay things – but the principle was, we had – many of us had the feeling that people put in transitions of care because it was considered to be too burdensome to do all encounters –

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

Yeah.

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

– even though updating the med list at every encounter is probably a really good idea, and so the – CMS or the Policy Committee or whomever may have tried to make it easier by saying, well you only have to do it for transitions of care. And for us, that made it harder because now we have to figure out what's a transition of care or we have to just say, we're not going to be accurate and we're going to hope because we're at 99 percent, nobody cares that we actually don't know how many of those were transitions of care.

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

So we face this problem with patient education materials, because not everybody needs them, but it's the reason why we used a low threshold, because that way it gave people flexibility to choose. And so we made the denominator be all patients, but we chose a very low threshold so that people could do it at the moment that made the most sense. Does it make sense – I think Mike, based on what you're saying, to have it be 30 percent of all encounters instead of 50 percent of transitions?

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

That would be one way to handle it, that way I wouldn't have to worry about figuring out a transition of care. But, I also think you could leave it to say 30 percent...50 percent of transitions of care or if a provider believes the encounter is relevant, just like it's in the objective.

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

We can do that. We can – that's not a hard change to make, I don't think.

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

But I don't think that solves the problem, I think –

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

It doesn't but –

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

– because if the numerator or I mean the denominator is now A or B, you still have to count A.

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

No, no question, but now – you see, the thing is I count A by counting everything.

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

I gotcha.

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

See, and since I'm counting everything, I still have the 50 percent threshold, which is probably not bad for my patients who don't have the advantage of being in a transition –

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

Right.

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

– and yet I'm still doing my job and I don't have to worry about, did you see a cardiologist since you last saw me.

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

But I think what'll end up happening is it'll just be people only tracking encounters, so might as well make it 50 percent of all encounters.

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

Yeah, that works for me, too.

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

Any – the vendor community to be real happy, they hate to change these denominators and maybe other practices will hate to change denominators.

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

Well that's why – that's why the most flexible thing is to be able to say that you leave it as the "or" – somebody put it in as an "or" in the objective for a reason. I think that makes good sense and I think it's okay to just mirror it in the other – in the measure itself. That would be a big win for us.

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

Actually, is a specialist considered another setting of care?

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

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

So you're saying that dermatologist or the orthopedic surgeon has to do a med rec, well, that's a question. Is that correct?

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

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

Paul, wouldn't they have to do a med rec, if we say only transition, a specialist is often going to transition people back, so they'd have to do it at almost every encounter, so does it make sense to shift it to encounter for everybody?

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

Yeah, but then I'm – the number's going to be – this is a menu item that – is this a menu item –

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
No.

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

– in Stage 2?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
No. No, it's core in Stage 2.

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

Okay.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
I mean if you read it, it applies to specialists, too.

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

This is – I mean reconciliation unfortunately is a – the thing for med rec is it already exists for accreditation, like JCAHO or Joint Commission –

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

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

Right.

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

– that's one of the things where we're running into problems, like Charlene was describing. There's no other way to do it except for check off – check the box, and that rarely contributes to anybody's life.

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

Well and I might beg to differ on that. I mean, having been live now on an EMR for 7 months, we've gotten a tremendous amount of both benefits and potential risks from people either doing or not doing well, a statement about what medications they're taking. And EHRs can certainly put in a mechanism that says, mark all the unselected ones as taking or not taking or whatever to make the number of clicks manageable, but in internal medicine at least, I think we'd make the argument that that's probably one of the most important things you can do is get their med list right. And –

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

No, I'm talking more about the audit function, how does somebody know you did it –

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

Oh.

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

– the way they know you did it is a check box and the check box neither co – really validates that you really did it, I mean it just doesn't chan – you know what I'm saying? People who are going to do it are going to do it and then they have to do extra things and people who aren't going to do it are just going to do the check box. So the measure itself is not a very accurate reflection of what happens. That's the deficiency here, I think.

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

But I think there probably is a way to integrate the task of doing things that constitute med rec with a data field that demonstrates it without having to click it separately.

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

Right.

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

And the good news is a good faith effort is all that – we just had a Joint Commission visit, so I'm steeped in that right now and it's really about the effort – the good faith effort. They don't get in the business of trying to figure out what's "complete med rec," so –

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

So unfortunately we do have to specify or CMS does have to specify it, and because it's part of the all or none, so everybody has to do whatever this says, and it's a little hard to define. Okay, so what's the net change here, if any?

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

So my original request was to make it the same as the wording in the objective, which is to say, receives a – a patient from another care setting or believes an encounter is relevant.

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

Okay, but that's the same as the measure then, right?

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

The measure – yeah.

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

What he's just going to parallel the two, so that might cause – the vendors are going to have to think through what that means, but I think that should be okay. I mean –

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

So what's the discrepancy in what's written Mike?

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

It doesn't include that statement.

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

The measure doesn't allow for me to say I thought the encounter was relevant so I did med rec. Technically I should not be counting that in my numerator today, but I do all the time, because I think every encounter is relevant to doing med rec and so I click transition of care, even though there's no transition of care.

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

Oh I see, I see, where it says measure that – okay.

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

It just makes him accurate, so, just when they come in for a visit, there's no transition, he'll click it, right?

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

Yup.

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

Improves integrity.

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

Okay. Let's move on – sorry.

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

We'll make that change Michelle, and I agree with you, putting that – the reference to clinical decision support on that, okay. Okay, this is where we had spent a little bit of time last time, relative to care summary. And what we did was, there are three use cases that we're going to support as part of the care summary, and we started to break those out separately, which I think is pretty powerful. Again, supporting these types of transitions, depending on the type of provider you are and your particular use case. So we put in place the ability to support sending a consult note, and again, that helped us close that referral loop. Sending a consult request, because in cases you're going to – and we listed that below, PCPs to the consulting physician, PC to the ED, so there's a request, you want to rule out pneumonia or whatever. And then there's full transfers of care, and again, that is in the case for instance, you're going – you're transferring the care of a patient in a more holistic way from one setting to another, so the hospital to a nursing home, the hospital to the PCP, that type of thing. So there's just fuller data sets that are needed in each of those cases. And that's spelled out in the standards.

For Stage 2 what we felt was, in terms of – we changed it to have – we added additional data fields that are required in the transition. In Stage 2, it's the capability to tran – required data fields include problems, medications and allergies, and there may be one other field, I forget right now, because I can't read this. But in Stage 3, we added two – the proposal now is that we include in all cases a concise narrative of the reason for the transition. Again, we had a lot of feedback that again, sometimes there are so many variations of these transitions, just give us a quick way to tell what the purpose is and/or what is the goal and don't make – don't code it, just leave it free text. The other information that we – the contact information for the care team members and we put some placeholders – and again, this is a placeholder for advancing care planning in the future and then, this was the request last time. We wanted just to simply include an indication was there a designated family caregiver, just a yes or a no. So it's another step, so that was the proposal.

And then for optional, always when you do a transfer of care, but during the other transitions as is appropriate, and I think this is a – I kind of like the way this is written, overarching patient goals and/or problem-specific goals. Again, supporting free text, but clearly sending a signal that we would start to like to code these, and I think that's important to move us toward more sophisticated care planning. And then secondly, patient instructions and/or orders during the transition of care for 48 hours. And again, both of those are setting kind of a future stage of starting to do some advanced care planning. So again, those are required in the case of a full transfer of care and again they can be free text in Stage 3, hopefully we'll get smarter and they'll start to be coded, but those are dependent if they're clinically relevant and/or for full transfers of care. So let me stop there and we'll go to the measure at this point in time.

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

This is Paul Tang. Just for clarification you might – Michelle you might actually make the documentation to reflect how Charlene presented it, that is, there are three transitions we're talking about, a consult request, a consult note result and transfer of care, then we can add – so these three – so there's the cluster of three and then a cluster of two. The cluster of three applies to the consult request and the consult result and the – .anyway that just makes it a little clearer.

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

Yup. So we're really advancing the specificity of the care coordination process with what we're putting in place here.

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

It's Christine; I had a couple of questions and some suggestions. I think that in terms of one suggestion is we need to probably say family or informal caregiver everywhere we reference family caregiver, because sometimes it's not family.

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

Okay.

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

So that's an easy fix and that's in 2 and 3 and anywhere else we find that. I think in number two you probably mea – the role and contact information, is that for the professional care team and also you would include the family caregiver in that?

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

No. Remember, we separated that last time Christine; we just made it the care team.

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

Okay. That's what I thought we did, even though I don't love that thought, we did, and so I think you need to clarify that, because it looks like it is for everybody.

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

Okay, all right, we'll clean that up. I thought I caught it, but –

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

Could you talk a little bit about a placeholder for advanced care planning in the future, what does that mean?

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

Um, I think when we were thinking about that, because you're required to put the care team in place, it was going to enable us to know who's part of that care team for the care plan. But again, that may not be relevant, we should probably take that out or that's probably going to confuse them. So, let's just take that out. It's really –

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

Yeah, unless it's –

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

– .help me advance it, right.

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

Yeah, I didn't know if you meant as a placeholder – I mean the whole thing is –

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

The whole thing is a placeholder for – care plan –

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

Yeah, not just number 2, that's what's confusing.

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

Yup.

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

Um, you said on –

Michelle Consolazio – Office of the National Coordinator

Christine, before you go further, I'm sorry, before you started this conversation you said what was confusing? I just want to make sure that I track it back.

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

Um, number 2 says contact information for care team members including primary care, family or informal caregiver role and contact information. I think role and contact information is only for the other – for professional providers on the team, not the family caregiver.

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

Yeah so the caregiver is in that statement at the end of the line Christine, so – and we just carve that out separately in terms of the caregiver – it's the last two words.

Michelle Consolazio – Office of the National Coordinator

Thank you.

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

So I think what you need to do is say, on number 2, it should probably just read contact information for professional care team members.

Michelle Consolazio – Office of the National Coordinator

Thanks Christine.

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

Because then you have the indication is already in 3m you don't need it in both. So in terms of number 4, overarching patient goals and/or problem-specific, free text is permissible. You said this is required in the case of a full transition of care; what's a full transition of care again?

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

Okay, so that is – and I've got to think if we organize it, hospital to PCP, a transition from the hospital to –

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

Those two settings.

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

– nursing home, PCP to a new PCP, major transition. Like when you're fully – you're being fully transferred from one site of care to another, those cases.

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

I think – I think it's really important, so I think that's really good. My guess is though that we may need to simplify this and just put overarching patient goals or and/or problem specific and say free text is permissible. Because I think it'll be hard for people to figure out and track in the denominator what's a major transition of care and this is hard for me to see how it – that patient goals would not be relevant. And that was what Neil Calman talked about at the last call, that even if there are patient goals coming from a PCP to a specialist who's requesting a consult, then those goals are in there. So when the specialist trans – kind of transfers the consult back, they can maintain those goals or they can add to them if they change based on the consult. Do you know what I mean? But I think it's a lot simpler to just say – to add for above, because it's going to be clinically relevant for every type of transition, and then you don't have to have a denominator tracking for is this a major or a minor transition.

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

So this is Mike, I'm a little confused. To me a transition is very different than a transfer, and that's why the language to me seemed pretty clear as a doc. If I'm transferring the patient, even within my practice, I'm going from me to you; you've got to know these overarching goals and problem-specific goals. If I'm sending a transition though, just to the cardiologist to see do they think it's angina or do they think it's heartburn, I don't know that I need all of that stuff and so I like the option to be able to say as clinically relevant for the transition, if it's not a transfer. So I just want to keep that possibility.

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

And the feedback we got there Christine was at least in this case they could use that concise narrative to put that quick thing in and keep it moving.

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

Yeah.

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

But – although I'm not sure they – I mean, in the example that Mike gave, right, my patient goal might be I want to be able to resume playing golf, for example, I don't know, whatever, right. That would be mine, but that's probably nobody else's. So Mike's saying he's not sure that that's relevant if he's saying – if he's requesting a consult to make a diagnosis.

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

A lot of the times a patient will say, I'm here because my doctor told me to come.

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

Yeah, right, which is –

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

So, I mean, so that's not much of something I'd want to document. So where it's relevant, clearly I'm with you, I'm patient-centered around all that, too. But to require it in every instance is where I think we want to have more flexibility.

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

I guess I'm trying to sort of – I'm also trying to simplify because of the problem you raised earlier Mike –

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

Uh huh.

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

– which is, okay, how does CMS count whether this care summary is a valid care summary, because how they've done it previously is if you – it has to have all of this information, unless for some reason it's not known, and this does not qualify as not known, right, since you can ask the patient. So in order to count it as a valid care summary, you would have to be tracking, is this a major transition or not or transfer or transition.

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

Right.

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

And I think you're saying, that's a pain, and I'd just rather do this for everybody so I don't have to count, which I think doesn't hurt in this case.

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

Well so actually I would say not quite. So we just – in fact, we just changed an order set to deal with this for consults. And one of the questions is, what do you want from the consultant, and one of the options is a transfer of care for the entire patient. And that I would put in there so they know what to expect and that could be the trigger for the numerator denominator issue that this was indeed a transfer of care, not a transfer for this problem or a transition for a consult or anything like that. So that puts it in the denominator and then it would look for well if you did that, did you include overarching patient goals, etcetera, etcetera, if you're transferring the whole patient.

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

So it should be transition, transfer or referral, those are three different things?

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

Yes.

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

The transition, I think, is our definition for a patient's going from one doctor to another; a consult is one type of transition.

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

Um hmm.

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

And actually a transfer is a kind of transition, but it's the big transition, so –

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

Right. So all I'm saying is I think we should tighten this up in that respect, so that people can understand what we mean. Because they might consider a transfer to be one kind of a transition, referral, consult, so we tried to tighten it up in the very top of the slide, but I think we start to get fairly loose. So it's fine if what Mike's saying is, okay there are different types and so we should flag those. But I think we have to outline them in order to flag.

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

We'll try and clarify that language. I think the – the team that worked on this did a really nice job of kind of modeling the use cases with this. So again, this makes it more sophisticated, but I think it breaks it down, it's not totally sophisticated but it breaks it down so it's a little more logical to the work.

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

One last suggestion and one last question, and I'll be quick. The last question is number 5 has patient instructions and orders. And I – this is a doc-to-doc document, it doesn't go to the patient, so is there a reason that should be in there?

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

I'll just say as a doc it's helpful for me to know what did that other doc instruct the patient to do so I can follow to see if it happened.

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

Okay, great. That – I just wanted to make sure that –

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

And it's really loose in the fact that we even have orders in there is a huge step to – it's a huge step.

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

Orders – oh I see, and/or orders.

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

It's not coded yet, but it's just, it's a huge step.

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

How did we end up with Mike's issue about the overarching patient goals?

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

It's basically the same as stated on the slide, but they're going to make some clarification in language because we've talked now about a transition, a transfer, a referral, a consult, etcetera.

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

So Paul, I would just break it down by saying if it's a true transfer of care for the entire patient, I'm fine – I would be fine and I think my colleague physicians would be fine that – of having that as a requirement for the numerator. If it's other types of transitions, it should be optional, so I would –

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

But, I think – so that's the purpose of having it – 4 and 5 separated out –

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

Right.

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

So – you're just going to clarify the language, okay. Thank you.

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

Yeah.

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

No the – well, I'm not – maybe I don't understand what you're saying, but 4 and 5 are two different things, patient goals from patient instructions and/or orders.

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

But those –

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

I just asked a question so I understood 5.

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

Four and 5 only apply to “true transfer of care” versus consult request. That’s why I thought it was separated.

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

Yeah.

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

Oh, I understand what you’re saying, yeah, separating 4 and 5 not –

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

Yup.

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

Yeah.

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

And consult repo – transfers of care or clinically relevant is how it will read.

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

Yeah.

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

Yeah, unfortunately or clinically relevant is a hard denominator.

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

Yeah, but what that tells – if they fill the fields, then we’ll sent them, right?

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

Yeah.

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

– maybe they – this is Mike, maybe the important thing for clarification then is just to say for transfers of care you have to have those, for others it’s optional. I’ll do it anyway, but for the transfers I have to.

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

Okay.

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

That’s easier.

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

Right, I think that’s what we agreed on. The clinically relevant piece I think is the signal to the certification folks that you need the ability to customize this in the same way that we created that capability for the after visit summary that goes to the patient in Stage 2.

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

Good point. Yup.

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

Okay, my last comment, I am just still really concerned that only 10 percent of these care summaries are electronic by Stage 3,

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

Okay.

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

I think that's really low, given the adoption rates for meaningful use that we have, which are exponentially higher than probably many of us expected. But now that we have a majority of the people, and this is – we haven't even begun Stage 2 yet with electronic records, I think that these – the electronic requirement needs to be dramatically higher.

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

So Christine, this is Mike. This falls into that category of if I can do it, it'll be 100 percent, if I can't, it'll be whatever short of that I can do based on the other entities ability to allow the electronic transition to occur. So, I guess part of the question I would have for you is, how hard that – how much of a driver that will be to get people to cooperate with each other about being able to transmit them electronically and whether that problem will be solved by Stage 3.

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

I think – well, I think the point that I am making is, everybody should have this – not everybody – many, many providers should have this capability because it's – this is exactly the same as Stage 2, the only thing that we've done is made it – changed the content of this.

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

Um hmm.

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

So there have been an enormous amount of discussions and concerns raised in Congress and in other places about the lack of interoperability and blah, blah, blah, and one of the things they point to is a 10 percent threshold for an electronic document by this point in time is way too low, and the statute talks about information sharing electronically. So, I think this is one where if it's going to be easy to do anyway, then it should be a much higher threshold. And I'm not sure it makes sense to have two different, by Stage 3, what I'm questioning is, does it make sense to have two different thresholds for this measure anymore? If we have most people doing it electronically, then why don't we just say, 50 percent or 45 or 30 – whatever the number is, some – that the summary is sent electronically for X percent of transitions period. Because this is a holdover, the 50 percent of transitions and 10 percent are electronic, really a holdover from even the Stage 1 days where we had this as a menu item and we thought, well gee, for now we're going to have to deal with faxing and other things in today's workflow. But workflows will have dramatically changed six years into this program. So I don't think it makes sense to have two different thresholds for this anymore.

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

So, this is Mike, I'm going to jump in one more time. So I agree in principle and I'm going to suggest something that hopefully meets both goals. And that is, if the receiving entity can receive it electronically. But I currently, in 2013, still live in the world where I couldn't do this if I tried and I'd like to believe that by 2016 it'll be true that I can and therefore can be held to that higher standard. I know I can be held to a high standard if the other end can receive it electronically, I don't know what I can do otherwise.

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

Yeah, I think – fine and we've had thresholds that were set at a certain place because of that, but what I'm saying is, I don't think that this threshold makes sense anymore and we should give thought to, based on the performance, what does make more sense and that is easier to track. But by then, we should have lots of folks who can do electronic sending.

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

Yeah, this is – I just push back on the should, until they do, I have to be cautious. So I would say if they should and if they do, you could hold me to 80 percent, you could hold me to 90 percent. If they can't, I'm – I don't have control over any particular threshold. I can send it to 100 percent of the people who can receive it and none who can't.

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

So can I just suggest that the group go back and think rather than – because I know we're kind of behind, rather than figuring out on this call, how to handle this. But to go back and really reconsider a different approach here that will account for Mike's concerns, but still actually advance the ball.

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

And I think, this is where, again I think, we could use – one of the feedbacks that came in relative to Stage – the feedback on Stage 3 was we had to consider the progress that's going to be made with Stage 2. So one of the reasons, I don't – and I actually potentially like just moving it to electronic in Stage 3, if we could just move it to electronic. I hesitate until we get some of that feedback, because this was clearly a challenging one in Stage 1 and we're counting on a lot of infrastructure being put in place. So we were kind of – from a team perspective or a group perspective, we were trying to wait until we got some feedback from Stage 2 until either we upped it and/or until we changed it. So I don't think you're going to get – if Stage 2 proves to be more successful in terms of achieving those thresholds and we get feedback that this works, I think we're certainly willing to consider changing that bar.

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

Well, since we will have not – this will not be in our hands by that point, this will be for CMS and ONC, right.

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

Yeah.

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

So my suggestion would be, why don't we do something like we kind of did under deeming where we say we think the threshold – if these are the assumptions that we continue to have these really high adoption rates, that Stage 2 certification included these two really important standards, because remember you have Direct in there, etcetera. But that it's really difficult to know for sure what's wise, so we're suggesting that the threshold be much higher however – and give a number. However, you may need to dial that back if the experience in Stage 2 warrants it. I would rather start in that position for many, many reasons, but CMS of course, and ONC, may need to dial that back. Because of course, Mike said, you don't want to penalize people for, well hey, I can send it, but I don't have anybody to receive it. So, I would rather dial it back and really be strong on this at this point, given that – I mean Stage 2 was supposed to be about information exchange, and it's being heavily criticized primarily for that reason. I would much rather make sure that we send a stronger signal here. And then dial it back if it's not going to work, of course, we did that under deeming.

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

Is that okay with folks? We're going to need to close off the conver –

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

– I'm okay with putting that in there Paul.

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

Yeah, this is Mike. I'm okay with that as long as we make it explicit that we're also empathizing with providers if they can't. But I like what you're saying Christine and I understand the principle behind it.

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

Okay. So, we obviously have a lot more to do. We have a remaining two-hour call, right Michelle?

Michelle Consolazio – Office of the National Coordinator

Yes, on July 30th.

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

So we're going to have to be vigilan – I guess I'm going to have to be vigilant and so we're going to try – these were actually tough cases where we hadn't sort of finished the session. Hopefully, well, we still have – any way, we're going to have to be more concise in our discussion, we still have another round at this after presenting to the Committee, but we need to know where we sit and what the discussion is, as we present it to the full group in August. So just have that in mind as we meet again on the 30th. So I think – are we ready to open up for public comment then? Why don't we go ahead and do that.

Public Comment

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

All right. Operator, can you please open the lines for public comment?

Caitlin Collins – Project Coordinator – Altarum Institute

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

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

Great, thank you. Once again we had a wonderfully stimulating and constructive conversation I think, and I appreciate people's willingness to accommodate the various positions, all of which are both well intentioned and reflect realities. So, thank you for showing that – allowing us to reconcile people's opinions. So thank you and thanks for all the work and we'll talk to you on the 30th.

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

Thank you.