

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
February 19, 2014**

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of the call. And I'll now take roll. Paul Tang?

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

Here.

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

Good morning, Paul. George Hripcsak?

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

Here.

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

Hi, George. Amy Zimmerman?

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

Here.

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

Hi, Amy. Art Davidson?

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

Here.

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

Charlene Underwood? Christine Bechtel?

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

Good morning.

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

Hi, Christine. David Lansky? I thought I heard David come in, maybe not. David Bates? Deven McGraw? Greg Pace?

John McGing – Senior Advisor – Social Security Administration

John McGing is attending for him.

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

Thank you. Mark Overhage? Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Hi, Leslie. Marty Rice? Marty Fattig? Mike Zaroukian?

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

Here.

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

Hi, Mike. Neil –

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

Hi.

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

Neil Calman? Patty Sengstack? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Good morning, Paul. Rob Tagalicod? And are there any ONC staff members on the line?

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

Hey Michelle. This is Charlene I'm on.

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

Hi, Charlene.

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

All right, thank you.

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

Thank you. And did we get David Lansky; I know that I thought I heard him come in. Okay. Back to you Paul.

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

Okay, thank you very much Michelle, and thank you all for joining this call. We have this call and one more before presenting to the Policy Committee with our final recommendations. Is the Web up or is it just mine – right now I'm just getting the circles. Everybody else can see it.

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

It's working for me, Paul.

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

Okay, so –

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

I'm just seeing the circle, too.

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

Okay. Huh, that's interesting.

W

I'm okay.

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

Okay, mine just came up, so just refresh Mike, maybe that will work for you, too.

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

Okay, thanks.

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

Okay. So thank you all for participating in the voting that, I think, was really helpful. So we have actually a total of 10 where the – so what Michelle did was to list the votes for each of the items and then also list the mode, which is sort of our proxy for consensus. And what I thought we would do is go in reverse order, meaning talk about the ones with the most removes and then work backwards. And as I said, in 10 of them, the mode was remove. So let's just work backwards and try to go from easy to harder and see how far we get. I think our goal needs to be at least six to remove, that would bring us back in line with the previous stage number of objectives. So I think it's going to be a little ha – .

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

Paul?

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

– difficult – pardon me, yes?

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

I'm sorry it's Christine. Can – I did a quick sorting and I found only eight remove, can you just list quickly what they are?

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

Okay, I have what I listed –

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

But two –

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

Go ahead.

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

Sorry, there were two that had – it was like a tied vote and that was family history and registries, so those are listed as part of the 10, because the remove and the keep were the same.

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

Okay, thanks Michelle.

Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator y Officer – Palo Alto Medical Foundation

So those will be the last we talk about, yup.

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

Okay. Any other questions or any other comments about the process for getting this?

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

It's Christine, I'll just say one last thing, which is, I understand the desire to get back in line with Stage 2 in terms of the number. But I think we have to be careful on that, because a lot of them are certification only and don't require EPs and EHs to do anything with them, but make some important functionality available. So, I just want to be a little bit softer on the number.

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

Okay, I mean, that's fair. As you know, there's not complete unanimity in terms of certification only, but a fair comment. So, they're not all the same, that's for sure. Okay, let's review the slide before you now. And the guides we got from HIT Policy Committee one is, so the key word was focus, and that's both focus on things that are really needed for the new health systems and to do a better job of taking care of – have a tool for doing a better job of taking care of folks. The other is to reduce the overall number of objectives, especially in the later stages. Weigh the physician burden of use that was particularly noteworthy for Karen. Consider the value of performance improvement, so how does this functionality help providers to measure their performance, to improve them, and to enable the new models of care. Be flexible, it's a little bit hard to know how to do that, but that is one of the key words that came up.

Consider the needs of specialists, and that's why we have these separate columns, one of which is what's the focus, is it primary care or specialty. And avoid requirements where standards are not mature, what happens is, you end up implementing things, not – can't necessarily combine things and it may change as standards become more mature. And promote usability, it's a hard thing to do, but where possible we want to improve the usability of these systems, as they contribute both to the burden as well as potentially patient safety issues. Okay, let's – what's the next slide please?

Okay, overall in Category 1, huh, I'll just go ahead and say this, but then I think we will work in backwards order. In Category 1, there were three that we pretty much agreed to all keep, there were five that we suggested removing and three candidates for removal. Now remember, all these things, removal means remove from the Meaningful Use objectives, it has no judgment on the importance of this, it's just we've got to focus and get some of these critical few that are needed to do at the sort of the public infrastructure, public interest perspective.

So let me read off the 10 that were – had a mode of remove or as Michelle just said, tied for remove and that's in order of most removed. So one was reminders, two were amendments, three, eMAR, four, case reports, five, med adherence, six, electronic lab reporting, seven, syndromic surveillance, eight, imaging, nine, family history and 10, registries. So we're not going to suggest removing all of these, but that's the order we're going to discuss them.

So if we could advance please to slide number seven and that would be reminders. So this actually is not a change in the objective, as you know, we've had this all along. What we were suggesting is to be able to share according to the preference the patient has, yes important, but is it something that we need to cause everybody to concentrate their efforts on. Remember the other point we've been hearing is when you concentrate your efforts on one thing, of course there's an opportunity cost of not doing something else. So the consensus and the mo – the mode and the majority vote was for remove. Are we okay with that?

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

Uh, it's Christine. I want to remind the group that this is not the same objective because we consolidated earlier in this process and built in communication preferences into the reminders piece. So we would lose the structured recording of the way patients want to receive reminders and we did that for two reasons. One was, consolidation, so we had fewer things but the other was that if you list out communication preferences alone, it's much more difficult to do because it's contextual to what you're being asked to be communi – or what the communication is. So if you lose reminders. The patients will no longer be reminded by – and have a record of, I'd like to be reminded by phone call for my follow up appointments or email or whatever it is that the provider – whatever the options are that they offer. So I'm not in support of losing this because I think a) its important and b) we would lose this other really important dimension of communication preferences that is contextualized to what patients really want.

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

Let me just remind – just a reminder comment, remember, remove doesn't mean that we're prohibiting any vendor and any provider from doing anything like this, it's just removing from the Meaningful Use objective.

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

But it also means you're removing the certification criteria that would build those communication preferences in, which are not being done today.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, that's actually an indifferent objective, building that certification criteria.

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

I'm sorry – you.

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

(Indiscernible)

Paul Egerman – Businessman/Software Entrepreneur

Yeah, this is Paul Egerman; I believe that's already in a different objective.

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

Under – so we still – I think Christine where we found it was under demographics.

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

Yeah, so it's in a number of different places, so when the consolidation exercise happened, we added it to reminders, the visit summary and –

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

Patient education.

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

– yes, patient education so that they would all be provided in the means necessary for the patient and then what it also added to demographics so that – to enable that functionality to be entered from front office staff was kind of the thought that we were thinking of.

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

Which that I think is not as necessary in demographics because again, that would set up a situation where the patients going to say, well, you want to communicate with me about what, like – and it'll be different in terms of how I want to receive education material versus how I want to receive reminders. So, you would lose that here in a big way and reminders, communication preferences is probably most closely tied to reminders.

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

Okay.

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

And this is Mike, I'll just chime in by saying, on behalf of physicians, I don't want to have to record five different ways that five different kinds of ways of communicating with patients for different things that are done. I'm going to ask patients to say, pick one method by which I should be communicating with you as your preferred source.

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

I'd agree.

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

I can understand but that's not what patients want, I mean, I don't think that's realistic. Patients are – I think it's going to create more workflow for you guys just because when you ask a patient they're going to say, well for what purpose? If you don't have a system that can match – it's going to lead to much more problems.

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

And I'll just say, that has not been my experience.

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

So let's –

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, I have a couple of comments, one is, on reminders, a lot of organizations have mature processes in place already. But also, isn't this what we're supposed to be doing is sort of like doing an agenda check, do you want to do this Paul, to like we argue for these issues.

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

Yeah. So what I'd like to do is one, if someone feels moved to state a point, that's okay. Let's not debate it because as you pointed out Christine, we have talked about each of these on multiple occasions. So the process that you suggested, and I think is a good one, is that we do a vote, let's look at the results of the vote. This does seem to be quite heavily in favor of removing this and let's try to reserve much more of the discussion towards the end when there's less predominant vote.

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

Yeah, but let me make a clarification which is, I think there was a piece of information that I'm not sure the workgroup understood when they were voting, and there were some comments made that to me don't reflect that understanding. So I agree with you that we shouldn't be reopening all these debates, but then again, we've also spent like the better part of several years coming to agreement around these things, too. So I want to make sure that when there is a new piece of information, we're able to share that.

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

Okay and it's fair to share and if – I can ask if people want to change their vote. But the other thing let me just really emphasize this, we're talking about one program, it does not banish the function either from the developers, the vendors, or from the providers. A lot of providers make – add their own functionality, so, this is not the same thing as "thou shalt not," this is just a removing from this particular incentive program.

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

Right, but thou shalt go to additional expense to add stuff that isn't part of certification.

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

If the vendor – so, many of these things, I would say that many, if not the majority, of these objectives, vendors already have in their systems. So some of these things we're talking about trying to raise the bar for everybody where there's a pressing need. So I just want to make sure – distinguish between what is setting a floor for everyone versus what is or is not available and will or will not be available; it's not the same thing.

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

Right and if this was just the same reminders that it's always been, I would completely agree with you.

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

Okay. Is there anybody that would change their vote from remove? Okay, so I think this is a fairly strong consensus around removing this objective from this Meaningful Use Program. Okay, so could we go to slide 20 please, and this is amendments. You see the vote there, pretty strong for remove. And again, no one is denying the value of this, it's do we create this additional objective; it is certification only, as a way to request amendments.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie, may I make a comment?

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

Sure.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

One of the concerns that has come up is that with the Blue Button download functionality in Meaningful Use 2, one of the biggest requests are fix this, change this record and so this was – this came about in direct response to a need that we've heard from Meaningful Use 2. So how do we approach things like that, where we have a cause and effect, and we're trying to be responsive to the actual requests in the market?

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

Well, by doing what we did which is, we put out a certification criteria, we've heard that although we all have all of these objectives all on their own are very worthy things to do, the total number required of everyone and the burden associated with both the development and the compliance. As you know, most of the people, probably the burden of compliance – documenting compliance is as high or higher than actually doing it. So that's the reason why we've been asked to focus to reduce the number. So –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree, and my biggest concern is, for instance, the development effort high, we just spent a year and a half doing the patient-generated health data data and one of the templates developed was actually around this use case and so, did we have all the information going out –

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

Paul, this is –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, go ahead Michelle.

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

Sorry, so I just wanted to add, for background. So a few members from the Standards Committee actually had seen these slides from the last meeting and agreed with most of them, and I think Paul was on the call with me with John Halamka where he had mentioned that. But we did get feedback on a few of them, so places where they had suggested changes, we did make those changes and those are reflected in the PowerPoint that was shared today. An additional note is that we have created a Task Force on the standards side to look through all of the Meaningful Use recommendations and as this group obviously moves forward, they are also going to weigh in on standards readiness. So, they're going to try and kind of work with us as well.

Paul Egerman – Businessman/Software Entrepreneur

That's helpful, Michelle. This is the other Paul. One of the observations I would make looking at this slide is it does say standards maturity, immature and that was, I believe, one of our criteria, was –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, but as reported to the Standards Committee, when using an existing standard the – that is already in place and in Meaningful Use for providers, and considered immature for providers, even though it's being used at first for a patient. It came in in the middle of the road, so this is inconsistent with what we've been talking about at the Standards Committee.

Paul Egerman – Businessman/Software Entrepreneur

I didn't understand what you just said so when it says immature here, you're saying the Standards Committee gave it a higher rating?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, we did – when we did the patient-generated health data, which is really this request for an amendment to come back and say, here are my corrections or additions or updates that is a Consolidated CDA, which has already been adopted in Meaningful Use 2 with the ability to have a patient-generated component. So when we reported on that standard, we reported it as a high provider maturity, low patient maturity, moderate provider adoption, low patient adoption and came out somewhere around medium. So, I'm just not quite sure how to reconcile these, and Michelle, maybe you've already done that with this process, could you let me know.

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

Well, it's Christine before Michelle weighs in. Remember too that you have to be specific about how you're approaching amendments because one of the mechanisms is secure messaging, which is very mature and has standards, so –

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

So I can't speak to the perspective of those who I heard from on the Standards Committee, but I can say that they did weigh in and this is the result. It was only a select few, so that's why we have also four in that Task Force on the standards side.

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

So, Charlene – this is Charlene, I've got two comments on this one. I did review these with some of our customers who are actually implementing this and again, and listened to the testimony last week relative to adoption of some of the Stage 2 stuff. And the clear message was in some of these areas, even though it's moderate, they felt like this one, because it's a new process in health information management, there are new workflows that go around it, so it was a little bigger than a moderate take-on process. And so – and then, just with the process itself, there are just a lot of details to figure out. So it was not considered a low effort for providers to figure out how to do it.

On the other side, if customers come to us and say look, our patients want to communicate back, the vendors are going to do this kind of stuff. You've put the plas – the big get we got let's turn the big gear. You've got the capability out there with view, download and transmit, once it's there, then as a vendor, we need to improve upon that and make it better and workable. So, I think you're 90% there, if the standards in place, we'll be happy to adopt it, but I think you got it. I think you turned the big gear, you know, this is a little piece. This is not a product management function on this committee this is the policy capability.

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

So I think that the reason to consider removing it is probably less around whether the standards are there or not, because I think there's debate about that and some of them definitely are there. But it shouldn't be that much of a new workflow for providers because under the law, you have the right to request an amendment and we're just trying to make it easier for patients to be able to do that, given all of the data that they're going to have access to, which is the new component. So the law does cover this right, we're just trying to make it easier, and that's a little bit different than the standards component.

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

So this is Mike, if I could just jump in real quick with an experience. So my patients do this with me on a regular basis, they just use the secure messaging function.

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

Right.

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

They indicate what it is that they think is inaccurate, they let me know and I make the change. It would be great to have this other functionality, I'm really glad people have worked on it, but I don't need it for Stage 3 and if I have to prioritize vendor work on development, I'd rather prioritize something else.

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

Right, and I agree, its Christine again. I mean I think if we're going to remove it, to me that's the reason but I think the market will have to drive the functionality, making it – I don't know what that sound is but, you already have a right under the law to do it. So if –

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

Right.

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

– so providers have to figure it out anyway.

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

Yes.

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

Okay, so let's – I think we've heard the discussion, let's see if there's any change in the remove votes. Okay, so I think it's fair to say that the removes have it on this one. The next one would be slide number eight, eMAR. Same number of remove votes of nine. This really is changing from menu to core and the report on discrepancies. Clearly, this is something that would be useful, but in our combined votes, we felt that this is something we could let go from the Meaningful Use objective, not saying that it wouldn't be done by the market anyway – move forward on this one?

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

Yup.

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

Okay. Next one is case reports, slide number 32. Total number of remove votes is eight; there were four candidate removes and two keeps. And this is a new objective and it's to support the ability to one, use external knowledge of saying what's reportable, which is useful in the sense of not everybody knows and keeps track of what is reportable. And the other is the function to facilitate that reporting. We have both a change in provider workflow, which is presumably, why the high is marked there in that column and a developmental effort of high with the standards maturity being emerging. Anyone want to change their remove vote there or anything we hadn't considered? Okay, the next one is...

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

This is Art. I just want to understand where we head with this. So, we're headed to send a recommendation to ONC, right.

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

Right.

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

And then they send out the Notice of Proposed Rulemaking.

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

Well so to be a little bit more precise, yes we send our letter of recommendations to ONC, to Karen, and it is shared with CMS, who actually writes the rule in this particular case.

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

Um hmm.

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

So they would – the combined two agencies, working together CMS and ONC come up with an NPRM that'll be available, in theory, in the fall of this year. We will, along with the public, view that and make our own response.

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

Right.

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

They, by the way, can decide to include this or not. They have all of our materials and consider our recommendations, but they have all the materials, all the public testimony and all the public comments to make their independent decision, for the NPRM even.

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

Right. So let me – once again, I just want to ask this same question about, when it's around certification criteria, is that something that CMS promotes or is that something that ONC promotes?

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

I'm sorry Art, you're absolutely right; ONC is more responsible for the certification criteria.

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

Okay, so –

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

They work together.

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

This is, as Leslie and Christine were mentioning earlier, we've done this work, several years of work, and here we are, and I understand we need to reduce the total number of objectives. But ONC has received all of this and while –

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

Right.

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

– the Policy Committee may make a recommendation, there's plenty of other material that they have that they may review and decide differently than from our recommendation.

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

That's absolutely correct.

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

Okay. Thank you.

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

No, thank you.

Paul Eggerman – Businessman/Software Entrepreneur

And this is Paul. What you said Art is also important, because the Policy Committee also has an influence on all of this, too.

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

That's correct.

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

I'm sorry, Paul, I didn't quite hear that.

Paul Eggerman – Businessman/Software Entrepreneur

I'm just saying, it's not just our votes and this material, it goes to the Policy Committee, the discussion at the Policy Committee also possibly can influence ONC and CMS, too. That's part of the record on this whole process.

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

Sure, thanks. Yes.

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

All the main players really are participating and listening, so it's – nothing is lost. But thanks for raising that, Art. The next one is medication adherence, that's slide 15 please. This one is new and it is really – and there was confusion around this. It was – we had found out that although many states have already implemented the PDMP and you can, presumably, integrate some of that in EHRs, it's certainly not across the country and so we had changed this to make it straightforward to get access to PDMP, and that could be as simple as a link to the PDMP login. And the other thing is to access and integrate PBM information related to refills as a way of helping us understand medication adherence. Provider use effort is high and development is high and the standards are immature, presumably, that's what influenced the vote. Any further discussion or change in removal votes?

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

Paul, this is Amy, I just have one question. Some of these are not close at all between the remove and the keep and some of them are very – are pretty close.

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

Yeah.

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

So are we handling them the same way and just going with the majority?

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

No, no, we've been – up until this point there have been fairly substantial majority and I would say, just like you're noticing this one, I mean, we had 7 remove and 5 keep, so it's far more in the gray area. So I would expect there may be people who want to speak on one or the other and let's make sure that we had the information we needed in order to make an informed vote. So did you want to speak to one of the sides?

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

Yeah I just – I mean I think that this piece, from a public health perspective, making it easy for providers to use the PDMP is just very important with the increasing heroin and drug issues that are happening. I know in our state they're critical, I just heard in Massachusetts there were like an inordinate amount of deaths since the beginning of the year, and the same in Rhode Island. So, again, I know it's a growing public health problem and I just would like to really think about – I know we're struggling in our state about how to do some single sign-on stuff between EHRs and PDMP and our HIE. And I just think the more we can – I just – I know we have to cut some, this is one that I feel like is a growing, pressing problem and anything we can do to make it easier for providers to get the information they need to address this problem would be critical.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie. I would like to add to – the other use case we talked about initially was the fact that access to this was the first and only infrastructure we knew of where we could communicate and get pricing information at the time of drug prescriptions. And to provide that information both to the provider and the patient, give them a chance to do some decision-making about the drugs, cost and efficacy that we haven't seen before. And this was one of the very first use cases that we discussed, we heard testimony about this and I just would remind us that we really don't have very many places to get pricing information at the point of care. This would be a huge benefit.

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

So you're referring to the PBM input?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I am.

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

And are the standards available so that one – so the PBM would have to – well somehow the EHR would have to represent what's the out-of-pocket cost to the patient. Is that – are the standards in place – ?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The PB – the standards on the PBM side are there and what we heard was that there is ability to link. And I think that Amy said it well, getting that information through an external source, an external query with some sort of single sign-on method helps us to link to the information without having to have everything imported into the EHR. So there are good ways to do this and I would hate us to lose the first opportunity we've talked about getting pricing information available at the point of care.

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

No, Amy talked about PDMP.

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

Sorry, it's Christine I had a question. So – I mean based on this, I actually think I called this a candidate for removal, because I wasn't sure about this, so I would certainly change my vote on that. But I wonder if there's a way to build the certification element that Leslie's referring to into the medication reconciliation requirement, which is in there already? Would that make any sense? I'm not sure.

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

No.

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

I think she's talking – okay, I think we're confusing a number of things let's separate them.

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

I think – because I think we voted on the wrong thing, too. Because we vot – I voted on giving refill information, I think, so –

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

Okay, so let's separate this a little bit, because I think it's confused. So point number one, bullet number one was PBM. My understanding actually it says fill information, was to have fill information that is the history of refills, available to clinicians as their way of understanding med adherence. Leslie introduced a new use case, which is, having the out-of-pocket cost to the patient would be influential. The question I have would be do you really get that from PBM? So they would have to understand the patient's health plan and what their out-of-pocket costs are, so that's –

Paul Egerman – Businessman/Software Entrepreneur

And – yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Which they do in the retail world today, so it was a matter of linking. I think we consolidated and that's what's so confusing; we had a couple of ideas here that got consolidated.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul. First of all, the pricing is a little bit difficult also because of the presence of deductibles in some of these plans. But the other comment I give you as I look at the screen is it says, provider use effort high, standards maturity, immature and then I think about what our criteria is supposed to be. It seems to me with those two columns make this a good candidate for removal.

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

And this is Mike; I'll just add a couple of other things. One is the relatively low trust that physicians have in the accuracy and completeness of PBM data and to the extent that, and I'll just be honest about it, and the extent to which we would also then also trust any of the data we got on cost and pricing is also questionable. So again, fabulous idea, great concept, at least in the world that I live in, it doesn't seem ready for primetime in terms of it actually achieving the goals. And the actual measure in and of itself doesn't really include things on pricing, per se, in the way that we're looking at it.

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

Any other comments? So let's – let me look at this first bullet first and is there any – are there any changes in your vote, either as a remove or a keep? Have there been any changes in the remove votes for the people on this call?

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

You're talking about access to fill information from PBMs?

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

Correct.

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

Yeah, I would keep that.

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

And what were you before?

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

I'll have to go dig it out.

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

Okay. Any other changes to the remove or keep?

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

The other factor on this one is that sometimes there's a transaction fee to actually get that information, so there's a business consideration, too. So –

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

Absolutely.

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

Okay, so we have a reasonably close between remove and keep, right now the majority is remove, are people comfortable with going for the majority – now, what I'm talking about right now is bullet number one which is fill information from PBMs. Is it okay for us to remove that bullet?

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

Yes.

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

Yes.

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

Okay, let's talk about the second one, which is the one that Amy spoke to and remember that we already determined that we can't do this across the land, so that's why we back off to accessing in a streamline way and really that it was acceptable just to have a link to the sign-on for the PDMP systems.

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

And so this is Mike, I'll just comment. It may obviously differ between practices, but all the practices I'm familiar with, this is a staff-delegated task to run the various reports to see how things are going in these areas, so that's part of how we deal with the issue of drug abuse and narcotic contracts and so on. So unless it lead to a really slick way in which physicians could do it as easily or more easily than the current way they delegate it, it's not going to add as much value as I think it's hoped to.

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

We wanted it to just be in our face, where appropriate and we found out that today we can't and we're just hoping that tomorrow we will be able to.

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

Yeah, this is Amy again. I mean I know some states have very good use, I think it's New York that they've legislated and mandated and required that this be used. We're struggling in Rhode Island to get it used and we keep hearing it's a work – partly workflow. So again, I think the fact that we don't have this everywhere, I don't know off the top of my head, unless somebody else does, the number of states that have these or localities or regions. But if your state doesn't have it, like any other public health objective, I almost see this more as a public health objective than anything else, at this point, it's gotten to be such a bad problem, but you'd get an exclusion if there was not one. But it's giving the EHRs the capability where there is, so obviously this is one I feel pretty strongly about.

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

Amy it's 36 states and probably now there are more deaths due to this drug diversion than there are to automobile accidents every year.

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

I mean to some extent this is more important, if not more important but as important, if not more important than some of the other public health ones that we have.

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

And this s Mike, I'll just say I agree, but this is not going to change it from my perspective. I still can link to the website if I need to; I can still do or have my staff do it, either way, unless it builds into my workflow, the ability to see that somebody's gotten narcotics from somebody else, the placement of this as a certification requirement in this format won't move the needle for my groups.

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

Okay, so let me – these are fair arguments, and this is a close vote, let me call the question, are there any changes in the remove or keep votes for bullet number two?

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

So this is Art and now I'm going to come clean. I did not submit my votes to Michelle, and she knows that, and I would put this in the keep category for the second bullet.

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

Okay. Thanks for your admission, Art. Okay, we have a very close vote.

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

Paul, maybe we hold this until the end and see where we are with removing and –

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

That's fine.

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

– comment or this goes to the Policy Committee for further discussion, if we're sort of split. We may have
– I don't know how close the other ones are for split, but –

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

All right.

Paul Egerman – Businessman/Software Entrepreneur

This is the other Paul. I just still want to remind you, it says provider use effort high, that's what it says. And it says – the combination of high provider use effort with immature standards is not a good combination.

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

These three reds are not great, so –

Paul Egerman – Businessman/Software Entrepreneur

Everything's red, everything – in those three columns, it's as bad as it can be.

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

And the other problem is it's a certification criterion, which we're using in this way to get in extra objectives without impinging on the providers. But I think they have limited value, so because of that, I am less thrilled about it. Because it's a huge develop – if it is true, that it's a huge development effort, and then we're not demanding use, and there's differences between states, all that is why I voted remove.

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

Right, and as a provider, if I go to my vendor and ask them to do things but they can't because they're spending so much of their effort on this, then I will not have moved my needle and I will not be able to get some of the other things I would like for usability or whatever.

Paul Egerman – Businessman/Software Entrepreneur

That's right and we'd really like you to move your needle towards us, right?

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

Um, Amy and Art, do you want to cede or do you want to hold it out?

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

I still – I think we should do what I said before, which is wait and see where we come and if it's still very close, it's 6 to 7 or whatever, so I'd like to just wait and see where we are at the end and come back to it. Although I will tell you, I do have to drop off the call a little bit early, so that's going to disadvantage me, so I'm putting that out there.

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

I do think we've had a full discussion –

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

I'll leave it to Art to advocate on my behalf.

M

The vote is –

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

And I recognize that these three are in red, and part of it is that, how do we get this not to be red by the time that Stage 3 starts? And if there were a message from the Policy Committee that this should happen, those states might decide to do this differently and the standards may be much easier. I know those are all “may” statements and Paul Egerman is going to say, that's not the way for us to proceed, because the burden is still likely to be there. I recognize the burden is there, yes.

Paul Egerman – Businessman/Software Entrepreneur

And also, the provider use effort I think is unlikely to change in three years.

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

Well I think that – Mike gave an example that this is assigned to someone else, and if there were a call to a state PDMP, and it just came back to your EHR and said, this is a patient at risk, that would be helpful. Rather than having someone else do that with our work arounds – I agree, there are work arounds and in some states, they take that very seriously.

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

Right, but just to sign in to a PDMP system does not give me any new functionality I don't already have.

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

That's – okay, let's move on and we'll put this in the “hold” category. The next one is electronic lab reporting. There is no change, actually what – why – is this just literally a hold over?

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

This is only a hold over, yes.

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

Okay, so right now we have a little bit stronger consensus for remove, because there are three candidates for remove, anybody want to change their vote on this or can we let this go?

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

This is Charlene. The feedback I got on this one was that LOINC is still maturing in the market it hasn't taken hold. So the preference was to keep it so that we can continue – this is a huge piece – labs are critical to care, so we don't have enough traction, LOINC is just emerging, so keep it there through this phase so that we can nail it. So don't change it, but don't take it away.

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

But Charlene –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul – this is Paul. I just can't see how people can say LOINC is still emerging –

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

They're on the frontline of the implementation of this trying to hook it together among vendors, that's how they can say it.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well this is Leslie, I ran a commercial laboratory in the early 2000s and we were using LOINC to do most of our reporting back within an HL7 message structure. And so I agree with that. Now, I can imagine that it's not adopted at the public health level to receive it, that's absolutely true, but it is available within an EHR.

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

So this is Mike, could I jump in and just make sure we're talking about the same thing. So I'm seeing on hospital labs, LOINC, but I'm not seeing it on the electronic lab reporting, which is what I'm seeing on the slide. So I was in favor of keeping hospital labs precisely for the LOINC commentary that was part of Stage 3, but for electronic lab reporting per se, I was okay with considering that a candidate for removal. So are we talking about the same thing? Are we talking about electronic reporting for public health or are we talking about hospital labs being sent to EHRs.

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

I was in the hospital labs area.

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

Thank you, so that's what I was just trying to clarify. So Paul, we're talking about the electronic lab reporting to public health agencies?

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

That is, yes.

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

So just an anchor on that one, because I do want to come back to –

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

I was on the wrong page, my –

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

Okay, no problem.

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

Yeah, so this actually, looking at the titles, this did come from Category 4, so it is the public health agency.

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

I voted to remove.

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

So let me – this is Art, and again, I did not vote. And the reason I did not vote is I'm trying to find out from my public health colleagues, and we have a call this afternoon, what sort of strategy they wanted to take regarding the current number of objectives in area 4, and the future number of objectives that we would have. Assuming that we could not expand, what would be the right ones for us to ask for in Stage 3, and that was part of my reason for holding out here. And this is one of them that I hope we'll have a debate about this afternoon with my public health colleagues to say, if in Stage 2 this is ongoing, how important is it for it to be in Stage 3? Already mandated by every state that you report labs and physicians as well are required to report, but here in Meaningful Use, it is only the labs or the hospitals that run the labs that are reporting. And if Stage 2 is successful, I think it's a question about whether there's really a lot of value in keeping it in Stage 3, since there's already a mandate, we figured out how to do this. And the states and the locals are going to have to figure that out at some point, how to keep that going with hospitals, whether it's at the end of Stage 2 or at the end of Stage 3. So my point is that this is likely to be something that we could let go.

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

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

So I think that's where most of the people were feeling, we can tell how precious each one of these is, we don't want to do something that's just a continuation of Stage 2.

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

Right, and since –

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

Paul, if we continue –

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

So, let me just bring up one thing that came up in some discussion with my public health colleagues. When we get to Stage 3, and there's this new version, let's say version 2017 of product "X," how can we assure that these functionalities remain in the next version? We're not trying to make it a Meaningful Use objective, but there was a question from one of my colleagues, how can I be sure that if I let ELR go in Stage 3, that the 2017 product is still going to have that?

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

I don't actually – Michelle, unless you know – I – as you know, ONC – the certification program is starting to decouple from Meaningful Use, so certification always has to be responsive to Meaningful Use objectives. But I don't know that it's true that certification requirements can – it must be responsive to Meaningful Use but it doesn't mean that it can on – it only is restr – constrained to be only responsive to Meaningful Use. Is that fair to describe, Michelle?

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

Yeah, I think that sounds right Paul.

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

So in other words, it's up to ONC to decide, those questions you asked Art, whether you maintain. It would seem to me that it's logical to maintain certification for past things, but, as you know, we're going to be relooking at the whole certification program a little bit later this year. But, I'm not imagining people are going to just drop something just because – either because the certification process doesn't require it, why would a vendor go drop it?

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

Right.

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

I mean, that's the logic.

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

Good. Thank you Paul.

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

So with the majority voting remove, any changes to that remove vote or any issues with letting this one go to be removed? Okay, syndromic surveillance is number seven, slide 33. The same vote of seven remove, four keep. And this is actually a no change as well.

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

Right and I think it's a little question – this is Art again, there was a little question about why the development is listed here as –

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

Yeah. Yeah, I don't understand that.

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

Right. But I think this is a similar sort of logic to the discussion we just had about ELR. Again, I'm canvassing my public health colleagues this afternoon about some of these issues, but assuming that we get a good pickup as a core objective in Stage 2, and that just as you described Paul that certification criteria maintain that functionality. It's between the states and the locals and their hospitals to encourage them to continue reporting syndromic surveillance data.

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

Right. Okay, any further comments about removing this. Okay next is imaging, slide 9. The vote was six remove and three keep. This is access to the image, one other confusion was, no we're not requiring people to have a PACS system or to have the images stored in the EHR, but available. I'll make a commentary that many people already have this anyway.

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

Right.

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

So –

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

So this is Mike –

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

I just – George, the imaging results largely are being included everywhere I know of, in other words, the report that came with chest x-ray. Access to the images via link is such a vague thing I just thought if we could – it wasn't an objective that clearly was going to change the way things occur and it depended on an outside source to provide the images anyway, which makes it complicated from the vendors how to implement it.

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

Okay.

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

So this is Mike. I can live with whatever the decision is I just wanted to make sure that – one of the comments I made was, because the percent of images that needs to be available is relatively low, and because at least from my experience there's good penetration of making radiology images available. But not necessarily other types of images, that it's worth at least thinking for a moment about whether it's worth continuing it to assure that other types of images are put in. But since the objective itself doesn't actually comment on that, I'm not sure we'd get there anyway with the thing written the way it is.

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

Okay. Any changes in remove votes and any problems with us leaving this stand at remove. Okay, next one is family history, slide number 10. This is – okay; actually, this is a little bit weaker. This is only a candidate six, keep is six and this is no change – this is giving the ability to take family history into account for CDS, recognizing that family history really doesn't have standards yet. Most systems actually do have it coded, in their own code, which means that it could be taken into account for CDS, presumably is why development is low. So probably, a lot of the systems or most of the systems already allow you to take family history into account for CDS and there was no formal standard for the family history element itself. Votes for – so this is a candidate, anybody want to speak for either keeping or removing this?

Paul Egerman – Businessman/Software Entrepreneur

Well this is Paul, I'm just going to speak for removing it, I was one of the votes to remove it because I think there aren't mature standards for this and there are a lot of nuances about family history. And if you just try to say we're going to structure it and make it part of CDS, I think that there's potential for a lot of confusion and a lot of false positives.

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

Someone want to speak on behalf of family history, not family history itself, but family history as an element for CDS.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and be clear, my comments are about structuring it and then using it automatically in CDS.

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

So my understanding is – its Christine, it is in Stage 2 though, so we've got some level of standards I thought, I could be wrong on that, but because it's in Stage 2, that's why we thought it made sense to link it to CDS and make it really usable.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and they did – we did discuss it in the Standards Committee, I think that's why it says the development was low, and we did have structured data capture there.

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

So Christine –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, I gave an example when I talked to Jacob about this, I said, you know my father when he died had colon cancer. And Jacob said, well that's a good example CDS could use it. And I said yeah, but it was first diagnosed when he turned 88 –

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

– and my comment there is, that's what I mean by saying it's nuanced, it's a tricky thing. If you just take the fact that he had colon cancer and use that for CDS, you'd do extra screening or possibly the physician would override the alert. It's a complicated thing, and then you get into things like half-brothers or it's – to take the step, I question if it's ready for primetime.

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

Well and this is Mike, I'd go the other side of it too with the same result which is, number one, even though its menu, I think lots of people are going to be doing really well on family history. Number two, many of us already are deep into using family history to inform clinical decision support and precisely the example there, it counts if the person developed it at a certain age, but not others. So that's one of the reasons why for me, even though it's a no-brainer, it doesn't need to be in Meaningful Use for Stage 3 from my perspective.

Paul Egerman – Businessman/Software Entrepreneur

You're agreeing to remove it.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

I mean, that was my other comment, too. I mean, CDS doesn't have to do everything, there's a physician who listens and makes judgments, because a lot of this stuff is also anecdotal.

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

So it's Christine, I think the observation I would make is, and you can take this comment really both ways, this could be an important source of patient-generated health data. So that's something that's on the list to keep, although I don't know whether or not it could be entered by patients in a way that is structured enough to get tied to CDS. If we think that's a possibility, then we might leave the functionality in around CDS, but really rely on the collection of the data to come through PGHD.

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

This is George. Medically I don't think this is going to add much just because people are doing what they ne – remember, the original version we picked three areas where we wanted the nation to advance. We've gotten rid of that and made it much more general. So including this is a lot like including the past medical history or the physical exam or something, I mean, they're things you do. Christine makes a different argument, which is that this helps us with patient engagement, so I think that's another factor that we should take into account in deciding.

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

So this comes back and I would have to put the argument on the table relative to the standards again, the – there is a current direction to use SNOMED to enable some of these fields, and that needs to continue. There are other models for family history – family history, in my experience, is every physician takes it somewhat in a different way, there's a lot of variability around it. So to adopt a standard is really tough, because the practice is tough. So, I think we've got to keep focusing as an industry on standardizing some of these data elements so that patients can collect them and/or they can be used to populate family history. But to standardize family history, I think, is hard.

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

Okay, so let's see if we can tally some votes here. We have a tie between keep and candidate, anyone want to change their vote from candidate to remove, based on this discussion? So, if there are no changes between candidate and remove, I think my reading of this vote would be that the keeps would be in favor. Is that – how does that sound to this group?

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

So Paul, I'm only seeing six keeps and a combination of removes or candidates for removal –

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

Oh, I see what you're saying, yeah, no I see.

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

– to be higher.

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

Okay. Yup.

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

I count eight.

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

So let me just –

Paul Egerman – Businessman/Software Entrepreneur

Yeah, it's just the candidates don't have as much enthusiasm to remove it –

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

– right, I understand.

Paul Egerman – Businessman/Software Entrepreneur

– haven't quite built that in yet.

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

What I'm hearing from this conversation is probably a slight bias towards the remove, and that's probably somewhat consistent with actually the votes in front of us. Let me test that that action is to remove this objective, it continues, of course, in Stage 2.

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

Um hmm.

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

And I will say that most of the folks that already have family history in some way, obviously it's coded internally –

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

Yup.

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

– make it available for CDS, so, that was my response to Christine's question.

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

And again – this is Mike, but for the average physician, this is going to be the first menu item they're going to pick in Stage 2. And so the – I think the penetration is going to be really high in Stage 2 for getting it in structured data, and then what we do with it after that, we'll go from there.

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

Okay, so let me posit that this is a remove. Okay. Let's go on to number 10, which is registries, slide number 34. This is under Category 4 and it's a reshaping. We – in Stage 2 there was a one from – one cancer and one other, I believe is what it was. This is changing it to one registry, but it has additional requirements either to upload from the EHR directly, using the Consolidated CDA or leverage some other national or local network with a federated query technology. So it's giving, at least here we're giving some flexibility, not for the vendors, of course, but some flexibility to the providers and change it to one registry.

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

So this is Art –

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

I think we did from menu to core in EPs, right.

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

This is Art. I would like to vote on this one and I'll vote in the keep area.

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

Okay.

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

And I just want to remind the group that with the current status of the voting, we've boiled down our improving population and public health to just one measure around immunizations.

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

So far, if we don't include this.

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

Right.

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

So this might fall in the category of, although the effort is high in both provider and development, it is one of – it is certainly one we've heard about, registries. Being able to use these outside – external registries in order to get better aggregate data, discussing everyone, including deriving a benchmark and assessing your own organization's performance against that and advancing knowledge. So it's one – registry's an important tool, even though it's high, I think this is where we're making the judgment call towards the keep.

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

I know that – this is George, when we – for the last stage, this was a very high priority for ONC at the time.

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

Yup.

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

And, I'll just say, I'm in favor of keeping. The reason I voted it to keep – its Christine, is the specialists. I really worry that in our removal efforts we're going to adversely impact specialists if we're not careful.

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

Right, many of those specialists won't have anything to do with population/public health because they don't necessarily provide vaccines.

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

So I'm hearing discussion about the value of this, this is a major pull – we've heard a lot about this. It has a lot of good benefits. It has a high effort involved but there's some sense that this is worth that – in that value equation, this is worth it. We have a close vote of seven to keep and six remove.

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

So this is Mike, can I also just throw in another piece? So I agree in principle, in fact, I have it listed as keep, so I'll just start with that as a framework. One of the key questions as I think about for physician burden is the – so the burden – and I would agree with Christine, the specialists will find greater intrinsic value in this because they're already reporting to one registry or another in many cases, so anything that helps that process would probably be perceived as helpful to them. I think one of the issues I would have to ask, in terms of physician burden is, what they need to do within the EHR to get these data out, but perhaps more importantly, what they might have to pay to external agencies to be able to do their reporting to the registries. So I'm a little bit concerned about they'd have to do, but now they'll also have a significant additional financial cost to the system with very little, if any, incentive payments to go along with it.

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

That's an interesting point, Mike, we did hear that – we actually had either a panel or a whole hearing on – I think it was a panel in our specialty hearing. And one of the concerns was the number of data elements that were being requested by these registries and the cost, frankly, and then some contractual constraints.

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

Yup, that's exactly it.

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

But I –

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

But Paul –

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

– in Stage 2 we already have that, right. Cancer I guess is going to the government –

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

Correct. The cancer registry's around the country.

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

– and then we had –

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

But –

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

– so as a menu, I guess, for this.

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

Exactly.

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

Exactly, its menu, so that's where, depending on the uptick, for us one of the upticks will be, how much work is it and what is it costing us.

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

Right, but going back to having both be menu instead of core for EP and menu for hospitals, would be – I think we should consider over for improving it.

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

Yup, I think that's good.

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

Umm, Michelle, can you clarify what was it in Stage 2 – what's the change in the core versus menu in both of these?

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

For EPs it was core, but they had the option to do two registries, so a specialty registry and the cancer registry. There was nothing core –

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

Well they had –

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

Sorry?

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

Wait, you said EP was core?

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

I'm sorry –

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

In Stage 3 it says EPs are core in the table that I have.

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

Wait, let's go – let's hear what Stage 2 for registries.

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

Let me just read it. In Stage 2 its menu for both EPs – I'm sorry, but there's nothing for hospitals.

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 the change would be, instead of menu of one of two registries, cancer and other, this one is asking for core of one, and I suppose you could find a public registry like cancer, but it may not be relevant to you. And EHs did not have any and they would be going to menu in the currently described objective. Christine's suggestion is we also consider not having core for either.

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

Right, but –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul; I like Christine's suggestion, which is saying make it pretty much the same as what's in Stage 2. I mean I have concerns about this from two standpoints; one is that my understanding is that these registries are not easy to deal with in terms of submitting the information. There's also the privacy and security situation that you're throwing patient data around at another location and both physicians and patients may not be comfortable doing that. If you make it menu, then they can judge if it's valuable or not.

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

So this is Art and in many states, it's a mandate that you report to the cancer registries, including patient identity. So I don't know that there's this option in most states around cancer reporting. That doesn't mean they always do what is mandated. I agree with you Paul that we wouldn't want patient data floating around when it's not required and the identity, rather that is. And in the earlier versions of this, the first thing is, back to Mike's point, this is trying to leverage the transitions of care document to C-CDA, which is just emerging now in Stage 2. We'll have several years of experience with that and the concept is that you would use that structure, you wouldn't necessarily submit everything, and that's when an earlier version of this described anonymized or a limited data set that did not require you to be sending all the data to a registry that may exist in a jurisdiction.

Paul Egerman – Businessman/Software Entrepreneur

And so my response Art is, if there's a state law then that's fine, because there's been a public debate and the representative bodies made a decision and you have to do what the law says, and I don't have a concern. I'm still more comfortable with this as menu though, because not every state has that law.

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

Right, I wasn't trying to address the menu or core item, just wanted to let you know that there are state laws, as you just acknowledged, right.

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

And so that's a freebie in a sense, you get to use one menu. So I hear a sentiment for at least moving this to menu/menu and then we'll talk about the votes, is that acceptable, to make this menu/menu?

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 Healthcare

Yes.

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

Okay, now let's look at the vote, which is basically a tie vote –

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

Wait –

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

Paul, this is George. I'm sorry, for some reason my phone got dropped off I just got back on. What did we just vote on?

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

Oh, just instead of being core for EPs, making it menu. So the objective as –

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

I say yes.

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

– okay. Now, let's look at the vote, which is tied, and the discussion seemed – I think I'm hearing a sentiment in favor, one because of its importance, two because of its addressing specialists and these override the cost. So in the cost/benefit ratio, the value of moving more and more – having more seamless access to registries, so that we can build the benchmarks, build the new knowledge and compare yourselves and improve is useful. So there's a lot of in the learning health system mode, registries are important. So that seems to be the sense, now let me hear differences from that sentiment.

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

This is Art again, I just want to remind you that it is now seven for keep, that's my vote, it may be –

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

Okay, sorry. So we have a slight majority in the vote and we're having a discussion that has seemed to be a sentiment towards keeping this.

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

This is Amy, and I just actually looked up my vote and I think I had for some reason put candidate to remove, I'm not quite sure why, but I would say this is a keep now.

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

So the keeps are just growing, so any objections to moving this toward a keep.

Paul Egerman – Businessman/Software Entrepreneur

As menu/menu.

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

As menu/menu, that's correct. Thank you so much, we're now returning to the one we put on hold and let's see if – actually, it looks like Amy is still here, so we have Art, Amy and we – let's see this is case – not case, I'm sorry, ELR, right?

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

No, it's med adherence.

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

Med adherence, slide number 15, and it was bullet point number two having to do with the PDMP. And the point was whether to keep that a certification only criteria.

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

So Paul, can you sort of summarize how many have we removed now and how many are we keeping. Because I'm assuming we've decided – I did have to drop off for a little while, but I came back, but on the candidate, have we eliminating any one that's still there?

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

No, we've elimina – we've removed – out of the 10 we've discussed, we've removed eight, we've kept one, registry, and we have this one under discussion.

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

Okay.

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

So really, the arguments I heard, I'll try to summarize them. Abu – inadvert – I'll just call it, abuse of narcotic prescriptions is a rising problem, it kills more than actually I think heroin and think Amy said more than motor vehicle accidents. So it's definitely a significant problem. In place to try to address that is a centralized system where you can access the fill data for these controlled substances. What we heard is that it only exists in 36 states, so if we make that available in a way that could be integrated into the EHR, so we had left it as accessing the PDMP system in a streamline way, which meant really a link to the sign in. Another counter to that is, a lot of times it would be done by non-physicians and they would access the system separately anyway. So that's where we are. It's the value – the ultimate value of an integrated, in your face reminder was very high by everybody, and people thought we weren't there yet.

Paul Egerman – Businessman/Software Entrepreneur

So just to understand that second bullet, the second bullet would be the EHR system would be connected to the various PDMP systems, so that when a physician does something, there's some notice or alert that's in their face?

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

That is the desire, but we found that that could not be done in many of the states now, so that the proposed objective was that you – an EHR has a link, either I mean as connected in states where that's available or a link to the PDMP system, so that you could click it and sign in from there.

Paul Egerman – Businessman/Software Entrepreneur

Is there still a patient matching problem?

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

That's a good point.

Paul Egerman – Businessman/Software Entrepreneur

I mean, it's not like you can directly connect to these things, there's a patient matching problem.

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

That's a good point.

Paul Egerman – Businessman/Software Entrepreneur

I'm just trying to say, what's written here in red is correct. For a provider to use it, there's – they've got to do patient matching in some other system and we've got immature standards and we've got a high development effort. It just seems –

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

So this is Amy. I'm not sure I understand the patient matching problem. So it's not going to solve maybe every – I mean, there are levels, right. So as I'm understanding this, is there a way to try to do a single sign-on and pass credentials and then it's up to the PDMP to decide to be able to accept it, so that you're not having to log on to a whole other system. Whether you pass the patient information so it pulls up information or you then have to put in – type in more patient information, it's a beginning to integrate the workflow in one way. The idea would be complete bilateral interface and integration where something would come back and flag you and say, don't prescribe for this patient or follow up on this or something. But it's a step and I just – I know SAMSHA put out some grants, our Department of Health has one here to try to do this kind of stuff. I know it's – ONC used to have a CoP talking about how to integrate this with HIEs. I feel like if we don't do something on this topic, we're missing – and maybe these aren't the right bullets, but I feel like we're moving towards trying to get use of the EHR and this is a critical, growing, new public health – newer public health problem in terms of on the rise from where it's been recently. And I think that we would be remiss in not addressing it in some way, shape or form.

Paul Egerman – Businessman/Software Entrepreneur

Well – this is Paul. I hear what you're saying, but if SAMSHA's putting out grants on it, that's the right way to do it, is, people need to figure out what the workflow is going to be and how you're going to get this all to work right. You need to decide that before you do a national roll out, especially since 36 states do it, that means some states aren't doing it, you've got a high development effort. There's a huge risk that you're going to do the wrong thing or you do something that nobody uses.

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

Right, so this is Mike. So –

Paul Egerman – Businessman/Software Entrepreneur

The development effort that SAMSHA is doing is terrific, that's exactly what you need in something like this to try to figure out how it will work, what the standards will be and what is a workflow that really works for the physician, so it doesn't add 10 minutes to each visit.

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

Yeah, but I mean in fairness, I don't think we've put grants out for all of these things to see how they would work. So I mean I appreciate what you're saying, but I think that there's been a lot – I would argue that there are probably things we're doing here that haven't been tested either, so –

Paul Egerman – Businessman/Software Entrepreneur

Well, yeah, but I argued against those also.

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

That's an equal opportunity argument. Mike –

Paul Egerman – Businessman/Software Entrepreneur

I mean, just to – I'd been consistent on that, but you've got immature standards, high development, high provider use effort, everything's in red on this one and –

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

Okay, I think Mike had something,

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

That's okay I'll pass.

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

Any changes in your remove or keep votes? Okay, so I think there is a sentiment of removing this, not for importance, but for timing, I think mainly. And we know what we'd like – we recognize a good function when we see it and I think the sentiment for people arguing for removal is it's just not there yet, it's an important thing and we need to advance it more. Is it okay if we remove this? Okay, so one, thank you so much for this process, thank you Christine for suggesting it. We have removed a total of nine and kept registries. And I think what I'd like to do, really appreciate people's thoughtfulness in both doing your individual votes and for this discussion.

What I'd like to do is, we'll – George, Michelle and I will work on the remainder that we're keeping, fine-tune anything that language that came up in the discussion and then like to present that back to you in our final call and have you approve that before we present that to the Policy Committee.

Paul Egerman – Businessman/Software Entrepreneur

And Paul, this is the other Paul. What you said sounds good. I'd make the observation that the votes themselves also have value to ONC, so somehow when we submit this information we should submit it and people who feel strongly one way or the other about something, for whatever reason they didn't – they should be able to somehow include their views as like a minority comment or report or something.

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

That's fair, but as you know, this is not only submitted to ONC, I mean, it's already –

Paul Egerman – Businessman/Software Entrepreneur

Oh – the workgroup first, got the Policy Committee first.

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

– it's available to the public. Okay, so I think –

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

So, but is the point – was the point there that when we turn this – when this gets presented to the Policy Committee it's not just going to be what we're ultimately recommending but what we've removed so if someone else is having debates –

Paul Eggerman – Businessman/Software Entrepreneur

Yeah.

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

That's what you're recommending, right?

Paul Eggerman – Businessman/Software Entrepreneur

Well I'm just saying that this is all an important part of like the record, so it should be part of what's in the Policy Committee and whatever gets submitted as a letter. I mean the fact that there are issues where there's not consensus – where there's more consensus or less consensus, I think that's valuable information.

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

I would support that.

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

And I think what I'll do, my thought is to include this in the appendix, so that it's, as you say, part of the record, but the presentation will be the final language of the things we're recommending and telling – reviewing with them what we've decided in our workgroup to remove. And committee members can talk about that if they wish to, but we'll come up with our final recommendations of the ones that we're recommending to go forward. But as we pointed out at the beginning of the discussion, the Policy Committee can change any of that and then ONC and CMS can do whatever they want in the NPRM process and they can do that same thing in the Final Rule.

Paul Eggerman – Businessman/Software Entrepreneur

Sounds good.

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

Well thank you so much, any final comments from the group? Did the process work okay for working on these issues?

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

So Paul, this is Mike. I think this was great, thanks to Christine for her suggesting it, thanks for the way it's been approached and moderated. I think it's really a good part of the process.

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

Okay, now let's open up to public comment please.

Public Comment

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

Operator, can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have one public comment. Peter, go ahead.

Peter Basch, MD, FACP - Medical Director, EHR and HIT Policy and MedStar Million Hearts; Primary Care Physician – MedStar Health

Hi, good morning everyone. This is Peter Basch from MedStar Health. Can you guys hear me?

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

Yes, we can thanks.

Peter Basch, MD, FACP - Medical Director, EHR and HIT Policy and MedStar Million Hearts; Primary Care Physician – MedStar Health

Ah, okay. So good morning and it was really quite illuminating and a pleasure to hear the thoughtful discussion that occurred today, I have a few specific measures I'd like to comment on. But I'd also like to make a general point that the process that went on today, or perhaps started last week and occurred during this meeting, is actually an extremely important change in direction and something that could be a signal to the provider community that I think could counter a lot of the emerging negativity, which is what I unfortunately live with on a regular basis.

Specifically we're told in Stage 1 Final Rule, and we're reminded in the Stage 2 Final Rule, that we should expect, and CMS and ONC kept its promise, that what we see in Stage 1 as menu set, we should expect it in core. And what we see in a particular Stage with a low threshold, we should expect a higher threshold. And that – , that signal I believe has made doctors, even those who are very much in favor of Meaningful Use and what has been done thus far, seem very wary when they've looked at Stage 2 adding some difficult, but I think important measures. Thinking that while this is an inexorable path upwards with more measures, higher thresholds and the fact that this workgroup is considering removing some measures. Or not necessarily advancing a threshold or moving something from menu to core and in fact is recognizing some features such as standards maturity or what the market might be able to do better, I think is very important to do. I want to commend you guys on your work and I think that if indeed the HIT Policy Committee accepts some of this, that this would be a good message to give to providers.

Now, I don't want to overstay my welcome, I understand that as a public commenter you might limit these to only a couple of minutes.

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

Yes, you have one minute left Peter.

Peter Basch, MD, FACP - Medical Director, EHR and HIT Policy and MedStar Million Hearts; Primary Care Physician – MedStar Health

Okay. So the only thing I would make as a specific comment, and I'll be happy to send these in writing, is that there are many measures that you have marked as remove or keep as Stage 2. I would make a request that in some cases, and in fact the source of much of the negativity about these particular measures, has to do with a definition. Either lack of clarity or a definition that's based on unique patients as opposed to unique patients with a particular need, so I think that a lot of what you've discussed, reminders, clinical visit summary, patient education, even view, download, transmit are things that could be made better in Stage 3 if there were fixes to denominator definition. And I'd be happy to submit those specific comments in writing and thank you very much.

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

Well thank you Peter. Yes, please submit them in writing, but I appreciate your opening comments because, and I want to also highlight them to the group, that I think it was a good discussion and the willingness to be responsive to both external and Policy Committee feedback is really important. I think it's just plain really important and the fact that we acted on that feedback, despite the fact that it was hard, is very meaningful. So thank you, thanks for the comments, but also thanks to this group for being so diligent and being responsive to the feedback. Okay, well, our next call is March 4. As I say, we'll be preparing our final slides and clean up the language and respond to the feedback, we received in the ones that we're keeping and we'll review that with you at that time and getting your feedback on changes. Thanks again for doing your voting and for this discussion, really appreciate it.

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

Paul, this is Charlene, when is the presentation to the Policy Committee then?

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

On the 11 – let me see, I think it's the 11th.

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

Yes, the 11th.

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

Thank you.

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

All right, well thank you everyone. Talk to you next time.

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

Thank you Paul thanks everyone.

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

Right. Bye, bye.

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

Thank you everyone.