



HIT Policy Committee Interoperability & Health Information Exchange Workgroup Final Transcript April 30, 2015

Presentation

Operator

All lines are now bridged with the public.

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

Thank you. Good afternoon everyone this is Michelle calling from...good afternoon everyone this is Michelle from the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee and the Policy Committee's Interoperability and HIE Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also please note that if you use the public pad that is in the webinar we will share those comments during the public comment period at the end of the meeting, that's a change, so I just want to make sure everyone is aware and with that will turn it over to you Micky.

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

Okay, do we need to do roll?

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

Yes, I do. I am totally off...today.

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

Here.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Didn't I see you...

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

So, Micky is here. Chris Lehmann is not here today. Arien Malec? Barclay Butler? Beth Morrow?

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

I'm here.

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

Hi, Beth. Brian Ahier?

Brian Ahier – Director of Standards & Government Affairs – Medicity

I'm here.

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

Hi, Brian. Carl Dvorak? Chris is not here. David Whitlinger? Hal Baker?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Here.

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

Hi, Hal. Jitin Asnaani? John Blair?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Here.

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

Hi, John.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Hi.

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

Kate Kiefert?

Kate Kiefert – State HIE Coordinator – State of Colorado

I'm here.

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

Hi, Kate.

Kate Kiefert – State HIE Coordinator – State of Colorado

Hi.

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

Kitt Winter?

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

I'm here.

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

Hi, Kitt. Landen Bain? Larry Garber?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I'm here.

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

Hi, Larry. Margaret Donahue?

Margaret Donahue, MD – Director of VLER Health (Veterans HIE), Co-Director of the Office of Interoperability – Veterans Health Administration

I'm here.

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

Hi, Margaret. Melissa Goldstein? Nancy Orvis? Shelly Spiro?

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

I'm here.

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

Hi, Shelly. Tony Gilman? Troy...

Tony Gilman – Chief Executive Officer – Texas Health Services Authority

Here.

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

Hi, Tony. Troy Seagondollar?

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

I'm here.

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

Hi, Troy. Wes Rishel? And Kory from ONC?

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

I'm here.

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

Hi, Kory. Anyone else from ONC on the line? Okay now I'll turn it back to you Micky.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Hold on its Arien, Arien is here.

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

Hi, Arien.

Carl D. Dvorak – President – Epic Systems

As is Carl. Hi Michelle.

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

Hi, Carl. Thank you, Micky.

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

Okay, great, thanks Michelle and excellent again and thank you. So, welcome everyone we're going to be continuing our review of objective of the CMS NRPM, the Stage 3 NPRM. Let's dive right into it because we're going to certainly short on time and I want to get through a bunch of stuff today. Next slide, please.

Chris Lehmann unfortunately is not able to join us here. So, we're going to do...we may not...we're not going to do this exactly in this order but we've got a whirlwind review of send, capture and reconcile. We may want to start review of governance questions that were in the NPRM, if we don't get to those I think we can, you know, do that off line and take comments off line on that but I do have a slide on that just to tee that up if we do end up getting to that.

But what I'd like to do is just do a little bit of intro some of that will be really fast because I'm really just starting to tee up the slides that we'll use for the HIT Policy Committee presentation so this...I'm just, you know, sort of working my way through that so some of this will be really fast.

And then what I would suggest is, you know, we've spent a little bit of time on send and capture which is measure one and measure two but we haven't talked, as a group, on measure three which is the information reconciliation and so I would suggest that we start with that actually since it's relatively new. That was, you know, sort of an off line assignment for people, we got four responses, written responses back from people, and that's what's captured in the slides that you'll see, but, you know, with everyone on the call we can get your inputs on that and see how far we get with that.

Then I'd like to go back and then review where we are on send and capture, and hopefully we'll be able to close out some of the issues that we've been tackling with or wrestling with over the last two meetings. So, let's go to the next slide, please.

So, we do...this is the last meeting, the last formal meeting that we have to review the Meaningful Use Stage 3 NPRM comments. On May 7th Chris and I will be attending with other Workgroup Chairs an Advanced Health Models meeting where we'll be reviewing our recommendations from the Meaningful Use Stage 3, I don't know Kory if there is anything more to say about that but, you know, that's sort of a meeting on May 7th where we'll be...I guess will be the first presentation of our recommendations in anticipation of the Policy Committee presentations that will be coming up the following week on the 12th.

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

Yeah, nothing to add Micky, just wanted to make sure everybody knew that you guys were going on the 7th to have that conversation with all the Workgroups...

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

Okay.

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

Yeah.

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

Right, so I guess it does suggest though that whatever we're going to do really does need to be finalized by that, right, because we're not going to want to make changes between May 7th and May 12th.

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

That would probably be ideal.

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

Right, okay, okay that would just be ideal, excellent, okay, next slide, please. So, here to begin the summary this slide actually we can go through...we can almost blow right past it's really, you know, just starting to tee up the presentation for the Policy Committee and for that Advanced Health Models Committee. There are three measures in objective seven send, receive and incorporate, and reconcile.

Measure one essentially just increases the threshold of the Stage 2 measure whereas measure three increases both the threshold as well as the scope of the Stage 2 measure as we'll discuss and measure two is a genuinely new measure so, you know, we're sort of forging new ground there and you only have to meet two out of three of the measure thresholds. Let's go to the next slide.

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

Micky, can I make just a comment now because...this is Beth?

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

Yes.

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

I realize there is no other place to make the comment but as I was reviewing all the slides I was...there is such interplay between one, two and three, and I worry that by having to meet only two out of three some of the ways that the things are written in one and two sort of anticipate doing all three. So, I just wanted to raise that as a sort of concern. I don’t know if down the road in the future the threshold is going to be applied to all three, but I would hope that.

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

Right, yeah and I don’t know, you know, I guess the way this has worked in the past is that these things that are sort of menuish, you know, now we don’t have any real menu items anymore but things that are menuish end up becoming core.

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

Yeah.

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

So, maybe that’s, you know, kind of a trajectory this would be on as well.

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

I mean it’s a practical approach to scaling up, but hopefully in the future all three can be required. I just wanted to get that on the record.

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

Right, right, right, yeah and I think it does, you know, recognize that two is genuinely new and three is, you know, fairly significant expansion and scope.

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

Yeah.

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

But I think it’s a point well taken. Next slide, please. So, in general I think, you know, where we seem to be headed and I’m anticipating what we’re going to say on three, so, but in general there seems to be, you know, a sense that increasing the measure thresholds for measures one and three makes sense, I mean, both are important, you know, from a quality and safety perspective. These things seem to be gaining traction in the market which are...you know it’s all good, however, we remain concerned about setting thresholds that are unrealistically high.

We certainly don’t want to have to backtrack on the threshold and we certainly want to strike that balance between motivating providers to own the problem but not penalizing them for factors that are genuinely out of their control. So, that’s, you know, sort of the balance that we’re trying to strike here in our recommendations. Next slide, please.

So, here’s where we’re going to get a little bit into the data and I think this will be informative for us as we think about all three of the measures because there is a little bit new and richer data that Kory and I have managed to dredge out with a little bit of back and forth on making sure that the data is reflecting what’s actually in the CMS reporting.

So, the...and I've got a data slide on the next slide, but let's just talk through this for a second. So, the reported...one question obviously as it relates to this question of well, you know, is 50%, 40%, 80% are those reasonable is well what's the experience that we have so far with Stage 2 and can that help inform us in this question of what's reasonable.

So, the reported rates for measures one and three for those who have attested to Stage 2, and that's an important caveat, suggest that the higher thresholds, you know, might be achievable though, you know, we need to recognize that there may be strong selection bias in the results meaning that those who have already attested to Stage 2 are probably the more advanced and sophisticated users to begin with, but, you know, be that as it may, you know, a high percent of providers, and this is, you know, one caveat here and speaks to that selection bias, is first off there is a high percent of providers 76% of the eligible professionals and 35% of qualifying eligible hospitals though they are scheduled to attest to Stage 2 are not or at least so far they haven't and that either could be because they're taking a hardship exemption or they're leveraging the flex rule which allowed them to attest to Stage 1 even though they should be on the Stage 2 schedule or they just haven't attested yet in 2014. So, there is some combination there.

So, the data that we're looking at is, you know, a subset and arguably it's...there is a lot of flexion bias in there in that those are the higher performers who have, you know, sort of been racing through the gates here.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Also...

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

Yes, go ahead?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry, I just want to also add that many of these people may be, you know, sending selfies, you know, which we had talked about excluding.

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

Yeah.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So, the people who actually are truly passing, you know, in honorable, respectable, you know, ways that we expect to meet Meaningful Use Stage 3, you know, may be far lower than the percentages here.

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

Right, right, right that maybe the case Larry although one thing that we did, and I don't want to, you know, go back and circle around too many times on this, but on one of the previous calls, I think it was the last one or the time before, you know, both I think Carl from EPIC and John Blair from MedAllies both reported that they aren't seeing, at least of those who are attesting to Stage 2, aren't seeing a lot of selfies.

Carl D. Dvorak – President – Epic Systems

It was...

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

It's certainly there.

Carl D. Dvorak – President – Epic Systems

Yeah.

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

Sorry?

Carl D. Dvorak – President – Epic Systems

I can attest that it was rare, people thought it would fail audit and it was a late breaking clarification from CMS that it would be allowed but even after that clarification people worried that it would be unclarified later. So, for fear of audit people didn't really do that as much as I think folks worried about it.

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

Right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yes.

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

But, you know, certainly the point I think is still there Larry that, you know, what we're looking at in terms of those of who have attested are...you know there is this selection bias, it's clear that they are, you know, probably performing ahead of the curve and if we would look to...once we're in a position to look at the data for the entire population of eligible providers and eligible hospitals we could expect that the averages would be lower than what we're seeing here.

Also, and this is another thing we'll come back to but it's very interesting and something for us to note is that a very high percent of eligible professionals have actually taken the exclusion from the send measure so when you look at the data for the send measure which was 10% required to be electronically transmitted for the transition of care measure it turns out that 86% of the eligible professionals who attested to Stage 2 so far have actually taken the exclusion on that measure and we'll get back to that in a second because there has been a change in the recommendation of the exclusion, which I think is a good thing as we look at that, but, you know, that was a fairly large number.

So, all of that, you know, also just suggests that those who have attested to Stage 2 are likely better positioned for successful...of the measures than those who haven't so we need to take that as a context as we think about the rates.

So, what do those numbers look like? Among those who have attested the, you know, reported Stage 2 rates generally are below the proposed rates for measure one, so the measure one rate that's being proposed in the NPRM is 50% and right now for the Stage 2, for those who have attested to Stage 2, for eligible professionals the average is 40% and for eligible hospitals it's 36% for the Stage 2 and those distributions are skewed lower because, you know, remember that they only had to meet 10% so, you know, it shouldn't surprise everyone that those are, you know, sort of skewed lower than that so the medians of those distributions are a little bit lower than the means versus, you know, the proposed threshold of 50%.

And then we should also note though that even though the measure three, which is the reconciliation measure, was actually quite higher than...even than 80% in some cases that was only...in Stage 2 it was only for medication reconciliation. Stage 3, the Stage 3 proposal is to not only raise the threshold but it's to expand the scope of it to include medication allergies and problems as well. So, we need to keep that in mind as we look at that data.

So, you know, the other thing I think, in terms of the recommendations, that we want to make clear is that the proposed rule also changes exclusions and in considering this we're considering tradeoffs between thresholds and conclusions and in particular what, you know, we could imagine that you keep a threshold high if you're also allowing exclusions or conversely lower the threshold if you're not allowing conclusions, so, you know...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Micky?

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

Both of things can come into play. Yes?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Micky, this is Arien, just for my reminder, I'm just looking at the measure for Stage 1, what was the exclusion for Stage 2? I know there's a flex rule for people who aren't capable of meeting the measure I'm assuming this isn't the flex rule. What actually is the exclusion for Stage 2?

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

Are you talking about for...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Transitions of care.

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

For which measure?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

For send, for transition of care send.

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

For...well the exclusion in...you mean in the NPRM for Stage 3?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

No, what was the exclusion for Stage 2?

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

Oh it was...yeah, it was if you had fewer than 100.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Fewer than 100 people who had transitions?

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

For EPs, for EPs.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

For EPs.

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

But for hospitals I think there were no exclusions allowed. But for EPs I think it was if you had fewer than 100.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

And is that...

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Right and there were...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Fewer than 100 Medicare or that's fewer than 100 total patients?

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

It was fewer than 100 qualifying transitions of care.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Qualifying transitions of care. So, this would be physicians that never refer out?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well would refer less than 100 in 90 days and that was the kicker, the 90 day thing allowed a lot of eligible providers to use that.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I see, so it was an exclusion that was originally intended for an annualized basis and then when it was changed to 90 days...interesting, okay.

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

Yeah and maybe that's...that must be why that number is so high because I think, you know, it took me by surprise when I first saw it, I had to go back a couple of times.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

And Micky...yeah, Micky, this is John and a lot of consultants out there told the eligible providers that were doing the 90 days first check and see what your numbers are on referrals or consults and actually advised them to utilize that.

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

Right. So, one...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I...

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

Go ahead?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I think that's an important point in your summary back, I think that's a really important point to point out.

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

Yes and we'll actually get to that because one thing...one change that we didn't note in the two previous meetings we have, but as we were looking at this, you know, Kory and I went back and pulled it out, is that they are changing the exclusion to not allow exclusions anymore unless you literally have no transfers, but no transitions of care or referrals otherwise you're required to report on this. So, that, you know, should take care of this.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Well, right, so, but to Arien's point by basically eliminating the ability of this very high percentage of eligible professionals that are taking an exclusion now the threshold is probably going to make it very difficult for the eligible professionals to be able to meet the measure. This is Brian.

So, just to, you know, your...I think that that's worth pointing out in your read out and, you know, obviously we have the...as part of our recommendations around the exclusions and how they relate to thresholds considered all of that and I think this just drives that point home.

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

Because they're on the lower end of the distribution in terms of their ability to get all the workflow and technology in place to be able to accomplish that.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Right.

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

Right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah, I'm not sure about that, I mean, again the consultants out there were saying check your numbers and since it's 90 days you can get that exemption but they were also advising that when the year ended that it would be an annual year and be prepared after those 90 days to start meeting it. So, you know, I don't know.

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

Okay, well we can come back to that, to this question after we go through some of this other stuff. So, let's just go to the next slide please. And I just wanted to just give you...give some summary of the data but just wanted to show you the data here just so you can see it.

And, you know, what we've got is the eligible professionals on top, eligible hospitals on the bottom and I've given you the summary statistics but, you know, just wanted to show this to you just so you can get a sense of it.

As you can see on the top that's where that 76% number comes from which is those who...the EPs who were scheduled for Stage 2 about 223,000 and then only 54,000 of them actually attesting to Stage 2 so far. And again, that could be a combination of they just haven't attested yet or they are using the flex rule or they've taken a hardship exemption we don't have all the data to sort all of that out.

And then as it shows there Arien for measure one it was, you know, fewer than 100 transitions of care, I'll add that it was fewer than 100 transitions of care in 90 days and we can add a little bit more richness to that part of the conversation for the Policy Committee discussion.

And then, you know, so as you can see the mean...the average rate for measure one it was about 40% for EPs of those, you know, again, there was only 14% of those who didn't take the exclusions and are reporting. So, you know, strong selection bias there whereas for the hospitals they weren't allowed to take any exclusions so everyone was reporting on that and that was a mean of 36% and remember the proposal is for it to be 50% now.

And then on measure three as you can see for the eligible providers that was where the only exclusion they could have is that they literally had no transitions of care or referrals, 97% ended up reporting and the mean there was 93% and then on the hospital side it was 87% where the proposal here is 80% but for three types of information not just for medication reconciliation which is what's being proposed here, which is what is being displayed here from Stage 2.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

This is Hal Baker; Again, as a practicing doctor I've got real concerns with the extension of the medication reconciliation which is generally a finite number of pills people will swallow with problem list where an infinite number of synonyms can be added to a list and looking at patients in flow in the last couple of weeks I'm noticing the problem lists are often quite a bit longer than the medication list and the amount of work burden this may put on is not insignificant which could lead to some pushback or abandonment.

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

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies
Yeah...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
So, no Hal that's a...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies
This is John...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
That's actually a perfect segue if you're...John if you're going to comment on that I would suggest we jump right to the measure three discussion right now.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies
Okay.

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

Okay, great, yeah, let's just go right to that. If we can flip ahead a few slides. I think there's like two slides for measure one, two slides for measure two and then two slides for...so, this one, okay, so, no, back one please, yes.

So, for measure three just to orient everyone we got four...this was the homework, we got four responses and, you know, thank you for that for those who did respond and then, you know, now obviously we can, you know, take it up with the entire Workgroup here.

So, what I've done with each of these is just give one slide that just gives a description of the measure and what the changes are for Meaningful Use Stage 2 or other important factors and then on the next slide drilled down into each of these with whatever comments we've had either in written form for this one or in the previous two what we've had, you know, from the discussions that we've had.

So, let's, you know, dive into this and we can take up the issue Hal you were just discussing as well as John, you know, the issue that you were going to raise. So, the measure just remember is to reconcile clinical information for 80% of transactions. The change from Meaningful Use Stage 2 are (1) increase to 50% (2) increase the scope. It now applies to any transitions, referrals and any encounter with new patients so that's the...that second piece is the add before it did apply to any transitions, referrals there were no exclusions allowed.

There is a question that they ask...so some of these things are changes that they are saying that this is the recommendation we are making in this NPRM and then some, as you may recall, are questions that they say, we're still...you know we're not suggesting this as a recommendation but we're asking people to comment on it and so those things I've indicated with a question mark there.

So, one question they ask is, you know, should they weigh in on the question of whether it should be automated versus manual.

The other is whether they should allow credentialed MAs to perform this function as they do allow in the CPOE section of the NPRM which is not within our Workgroup's purview but they're asking the question, should they allow the same thing here.

And then the last question they ask is how does this work for specialists and is there any different kind of treatment we should give to specialists as we think about this. So, next slide.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Hold on, this is a math question, is the 50% fifty percent of the 100% or 50% of the 80%?

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

I'm not sure Arien.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

No they're moving from 50 to 80.

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

Yeah, they're moving from 50 to 80.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Oh, thank you, okay, got it.

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

Yes. Next slide, please. Okay, so here's what I've tried to do is summarize what the...sort of the sense of the people who did provide comments, you know, was and so why I don't just...I can just read through...I'll read through one and then why don't we discuss it and certainly, you know, for those who submitted your comments please free to elaborate and then everyone else just jump in.

So, on the first question of increasing the threshold from 50% to 80% there did seem to be general agreement that it should be increased from the 50% but the question was how much and in the four responses we got there was a range of from 60% someone said, you know, raise it from 50 to 60 all the way to 100% and, you know, there was a strong sense from, you know, that person who suggested 100% that, you know, this is really, really important and we should be pushing everyone to do it. So, should I pause here or should I just go down all of these because some of them are inter-related?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

I think you go down and do each one.

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

Okay, just summarize each one now and then we'll just take up the issue in general?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well, I think we ought to comment on each one if people have a comment.

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

Oh, okay, one by one, okay, all right. All right why don't I pause here and see what, you know, some of the comments are and I know Larry I think, I'm just going to call out people, Larry I think you were more on the 60% side or it might have been Hal and then Shelly I think you were on the 100% side of this.

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

Right and this is Shelly, the one...let me explain the 100%, I said 100% if you move it from...this should be a measure that everyone should be doing and then move...instead of doing a process measure where, are you doing medication reconciliation at least do some type of outcomes measure and lower the percentage that was what I was trying to get to.

This should be...every provider should be reconciling these data elements it's just so important at transitions of care that...and if you can't do it you have your system do it or have your pharmacist do it or have somebody else do this for you but it's important that it is done with every patient encounter and it shouldn't be a process measure it should just be part of your practice of your care and then have some type of outcome measure that's a lower percentage was where I was...what I was trying to say.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah, this is...

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

And this is Larry, I'll do the 60% counter point. There are a lot of visits, you know, I'll give an example, we have, you know, people who go to the ENT doctor to have their ears cleaned because maybe they have a perforated drum and so they'll do it for us and they're there for a specific focused procedure, they're not going to be doing a problem list reconciliation, you know, during that transition they may not even have access to the full problem list, you know, and for that matter it's almost debatable whether they, you know, need to be doing medication and allergy reconciliation for that, you know, focused procedure.

So, there are a lot of, you know, specific procedure oriented visits where a lot of this information is irrelevant, you know, someone is going to an optometrist to specifically get a new prescription for their eye glasses, again a full problem list may not be necessary for just doing the refraction. So, you know, that's why 100%, you know, is crazy, no offense, you know, is unreasonable.

And I think there are many times when the data is just not available, I mean, we're still dealing with that issue where, you know, we're having trouble getting the data, various transitions and, you know, how can we expect, you know, people to be doing full reconciliation of all these if the data is not available.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah, this is John a couple of things. I mean, I agree that it ought to be done all the time if you can but we're also seeing percentages that are way, way, way lower and two points. One, what struck me that Carl said last time is that once they start doing this they start doing it all the time.

So, isn't it more important to get more that want to try to tackle it and get on the merry-go-round and then do it all the time than make it so high that they don't even get on the merry-go-round.

So, one, we're far, far away from anything close to 100% and even though it maybe ought to be at 100% it's...I'm really afraid that we will have less that even start to try.

And then the other thing I wanted to comment on is I thought that this was supposed to be a percentage of those, to Larry's comment, that you did have the data, that there was the transition or there was the pull in, the query that you do actually have it so it's there to reconcile and then the percentage is based on that that's there already to reconcile.

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

Hi, this is Troy, I'd like to make a comment.

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

Okay, go ahead Troy I was just going to look up that just as a point of clarification for John's question there about what that denominator really is. I'm looking at it right now, number of transitions of care or referrals during the EHR reporting period for which the eligible professional, blah, blah, blah was the recipient of the transition or referral and then or has never before encountered the patient. And we're going to deal with that one next. But it looks like you're right John that you are...while you're just a recipient of the transition or referral it doesn't say anything about the document itself being something that you have in hand.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Okay.

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

And they're only supposed to send, you know, measure one says, it's...

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

Hi...

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

You know 50% of the time they're supposed to send it and then measure two says 40% of the time you're supposed to get it.

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

Hi, this is Troy, my phone cut out on me unfortunately.

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

Okay, go ahead Troy.

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

Okay, thank you, anyway I agree that I mean this is extremely important and when you do have the data I mean it needs to be done 100% of the time, however, much like what was stated, I mean, the specialists they really don't have the resources a lot of times or even the information available to do the reconciliation.

Now in the Stage 1 and the Stage 2 criteria for medication reconciliation they were given an out and the providers were told that they only had to do it if it was relevant to the reason for the appointment, right, so it had some effect. So, like an optometrist or ophthalmologist who is seeing somebody for eyes isn't necessarily going to reconcile the medications for blood pressure it's just not in their purview, right? So, that was the out. So, how come we don't have that same verbiage for this particular measure?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

And this is Hal I'd like to comment on what Larry said talking about the ophthalmologist or the ENT doctor, in addition to the work on medication reconciliation was to prevent drug interaction and it was preceded by Joint Commission work pushing us towards it so we developed some degree of competencies around it.

Problem list reconciliation is a relatively new effort and unlike medications the patient doesn't necessarily know whether they carry a diagnosis or not and in fact some of the diagnoses are increasingly so specific that an ophthalmologist will not know whether an orthopedic diagnosis is correct or not and the patient won't be able to help with that. So, how does that reconciliation process take place?

This is really a very new competency being inserted and while ideally it would be done every time and every place I'm struggling to understand what the purpose is of having an ophthalmologist reconcile an orthopedist's problem list.

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

Right I agree.

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

Right...

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

...

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

So this particular question of the specialists is down on the...that's a separate category down here but I'm fine that we're getting into it but I just wanted to point out that, you know, of the people who responded most did agree that some specialties with narrow scope shouldn't be required to perform this or at least should be treated differently with respect to this measure although one person, you know, Shelly, I don't know if you were going to say something now...

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

Yes.

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

Did suggest that it should be required 100% of the time for all specialties. So, if you wanted to weigh in?

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

Yes, and again, I think that what we need to do is, you know, I just...these process measures should be practice measures. If it's pertinent, and I agree, if it's pertinent for that patient, but if we're talking about transitions from one setting to another or from one practitioner to the other especially at a new visit that these are some basic pieces that providers have to do now if they don't do a good job nobody is sitting there, from a quality stand-point because it isn't an outcomes measure, saying "you did a rotten job of the reconciliation" you just did it. You did it to your practice. But you could say that you did it that's what the process measure is.

So, if you're going to do something and you're going to look at the medications or you're going to look at the problems whether you reconcile them right or not it doesn't matter for a process measure is what I was saying. So, if you're going to do it because it's part of your process of care with your patient I can't think of any provider that isn't going to see a patient that isn't going to scan their medications to see what they're on or isn't going to look at their diagnosis.

I mean, every person goes into a doctor's office today has to fill out that clipboard of information with all of that on there. What the practitioner's don't look at it? That's what I'm saying, this is being done 100% of the time already.

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

Well...

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

Are they reconciling and are they reconciling it well, that isn't the process measure, the process measure is "did you do it?"

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah, I have a suggestion...

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

Well, Shelly I...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Hold on, I have a suggestion that...because I feel like we're discussing our general unanimity that this should be an outcome measure and we're discussing what the relevant outcome might be and it might just be easier for us to jump to the agreement that we had that this should be an outcome measure and discuss what a relevant outcome might look like before we discuss the more tactical considerations that are kind of downstream of that decision.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Just a suggestion to clarify our discussion.

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

Right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah, I'm not okay with this just becoming an outcome measure, I have no problem with outcome measures, but, you know, half of the time the information is not even there on transitions...

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

Right, right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Let alone reconciliations and, you know, we work with, and I know Micky does and probably others on the phone, with hundreds and hundreds of providers and we wish this was done all the time but, you know, there is a lot of process stuff that still needs to be measured.

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

Right.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Well, I guess...

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

That is...

Carl D. Dvorak – President – Epic Systems

This Carl I'd like to advocate for a process measure as well because first off this doesn't lend itself to a simplistic or even a complicated outcome description I can only imagine the numerator and denominator inclusions and exclusions that would need to be derived to determine an outcome measure for this.

And I think it's one of those things that as a process measure if we force people to do it we're also forcing accountability so the doctor who clicks "yes I did it" when in fact they didn't there is an outcome there secondarily if they're not doing it reasonably well.

So, I think as a process measure it meets the objectives and it creates the habits and also does create the accountability and liability should someone attest if they've done it when in fact they haven't.

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

Right, I think there is a difference of thought here about what reconciliation really entails. Now Shelly from your point-of-view, I mean, I see where you're coming from, but the question is, I mean, what is reconciliation is it the integration of information from an outside record just installing it into your record or is it going through that information and making sure that you don't have duplicates, that it's right, appropriate and true based on what the patient is telling you and what you can abstract out of the record that you can see. They are two totally different aspects.

I mean, integration part piece you could just say "yeah I saw it, I looked it over, I reviewed it and it got incorporated into my record." But to reconcile it, which is to really make sure that it's accurate that's much more difficult especially for, you know, a specialist who doesn't deal with those type of diagnoses or even medications or allergies on a day-to-day basis.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah, this is...

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

And there you go, there is...this is Shelly, there is your outcomes measure right there, did you reconcile it to a certain extent? Did you talk to the patient? Did you...so those are more outcomes measures. Your process measure is an unidentified aspect of what you are considering as medication reconciliation or problem list reconciliation.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

This is Arien, I very much actually agree with that perspective. The outcome that I want from a clinical perspective is that the clinicians who are treating me are doing so with respect to a complete reconciled medication, medication allergy and to some extent problem list and that process should be inclusive not just of the information received in transition but also the information they receive from me or family members who are advocating on my behalf.

What I would mean by an outcome measure is that there is at least some evidence that the clinical practice has, to the respect of what's required to appropriately clinically practice, has done the effort required to gain that up-to-date...those up-to-date lists and again I do think it should be to the respect that's required to reasonably practice if you're prescribing medication that has a level of interaction maybe different from if you are cleaning out the ear drums of a person.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry, I actually...I'm not going to debate about whether that's a process or an outcome measure but to that point about who should be excluded in my comments further down I was suggesting that people who don't prescribe or who prescribe minimal in their practice that perhaps that should be an exclusion from this measure or at least the need to be doing medication and allergy reconciliation.

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

This is Beth it seems to me that part of the challenge here is that the medication and allergy reconciliation might be easier to put at a higher threshold but the problem list is a more challenging ask and even though we want to drive towards 100% for all of them it forces us to be a bit more conservative by having the problem list in as we pick a threshold.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yes, this is Hal again, the difference with the medication list is that you can use the patient not the transition of care document as the source of truth so you interview the patient to find out what they're taking and you may or may not go back to the transition document.

With the problem list the patient can't be the source of the diagnosis because most of them are not knowable to the patient, they're often eponyms and complex terms that don't mean anything to the patient. So it's a fairly significant workload to do it and we do it and I can just say it can be quite an onerous time burden. It really is very hard for anybody but a provider who knows that vocabulary to do.

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

And then with that, this is Troy again, I don't believe that a credentialed medical assistance has the knowledge level to make that discern.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Correct.

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

Okay, on that specific point is there general agreement on that? Just a credentialed medical assistant, it sounds like there were two people who agreed with that, I think that Shelly did as well in her comments, others thought that it was okay for a credentialed medical assistants to do this. Just trying to see if we can tackle some of the specific issues.

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

Well, this is Troy, and like I said, I do not believe that they have it in their knowledge level to be able to make that decision.

Kate Kiefert – State HIE Coordinator – State of Colorado

And this is Kate from a state perspective you might bump into some state scope or policy and licensure issues if it's not consistent across all states.

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

Right.

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

This is Shelly, I just want to bring in one other point on problem although it's not related to who can reconcile the problem, but it's moreover the sense of the problem and what it leads to. If we're going to go to a patient-centric shared plan of care we have to have, especially during transitions and for our chronic care patients that we have to have some type of reconciled problem list. So, maybe that's what...maybe the percentage needs to come lower but we put more criterion there in terms of when you're leading to these...and that's where I was trying to get with better types of measures than just "did I do it."

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yeah, Shelly, this is Hal, I agree with what you're talking about and love the shared list my worry and the reason I'm expressing concern here is that this may drive people from the program, they may say the time burden is so significant here I'm going to make the business decision to drop out of Meaningful Use because problem list reconciliation just is a bridge too far and that's my concern.

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

And Hal I agree with you and that's why I say, make the percentage lower but make the process that you're doing more explicit as to the validity of the process and what it actually does in terms of an outcome. So, don't make those real high percentage but let the people who are really going that extra route and taking care of the chronic care patients can do this for the betterment of the patient.

Carl D. Dvorak – President – Epic Systems

Shelly, this is Carl, may I ask a question?

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

Sure.

Carl D. Dvorak – President – Epic Systems

The programmer in me, you know, has to sit down with folks and design out how do we code the report that measures the outcome and, you know, that has to be done on discrete data and specifics. When you say an outcome measure for this, what kind of...how would you describe the material aspects or the measure? What would we count? What would a numerator be? What would a denominator be? What inclusion? What exclusion? Things like that, how would you describe an outcome measure for this as different from a process method, did I just simply attest that I did it?

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

Well, this is certainly not my area of expertise in terms of creating outcomes measures and I think that there are quality folks you can talk to Kevin Larsen I'm sure that he can explain the difference between the two measures.

But the outcomes measures are more based off of explaining the measure in a way that you performed the different functions that lead to an actual event. So, as an example, you're medication reconciliation led to the creation of a shared care plan.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah, but that's pretty hard to do for I think in MU here.

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

Yeah, I agree.

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

Well that was in the intent of MU 3 was to go to outcomes measures and not necessarily process measures but we never got to that point.

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

Right, right.

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

But you can certainly talk to NQF and NCQA, you know, the quality folks, Dr. Larsen those are folks who have really, you know, pushed for some of the outcomes measures. This is Shelly.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well, I've been on the Clinical Performance Measure Committee for NCQA for eight years and I mean it's...what Carl is asking is I think germane here it's not...and the other piece is the...some of these thresholds that we think ought to be very high unfortunately are not in the clinical care setting. So, now that we have the ability here to start to measure that and to move it forward...and I feel we certainly need to keep the process measures in here.

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

So it sounds like...Shelly it sounds like you're...just as we're talking about this that you're concern about wanting this done every time is something that's shared by everyone so I don't think that seems to be an issue with anyone. But the question is if we're going to back off from that, you know, how do we think about, you know, backing off from that.

So, if we...I've also heard just in the conversation that problems seem to be different in nature than medications and medication allergies and perhaps we ought to recommend, you know, treating those separately and a little bit later I think they do get into something that asks the question of, you know, should all of these be treated equally. So, I'm hearing that as well. Is that something that everyone agrees with?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yes.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yes.

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

Yeah and I think it's in that third one actually, increasing the scope to now include medication allergies and they ask, and it says, you know, most...the people who did respond said that medications and medication allergies makes sense, problems may be optional, maybe it's a different threshold, you know, we don't have to go...come back as a recommendation and say, we think this should be 63% and those should be 85%, you know, we can make the general recommendation that you really should treat those differently and have perhaps a lower threshold for problems.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Medications and medication allergies make sense if you're prescribing.

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

Yes.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I want to go back to the issue of process versus outcome because it may be that I'm using the wrong terminology. I'm wondering what folks who are advocating for a process measure are advocating for? Are they advocating for "I used the reconciliation function of the EHR" or are they advocating for more of an attestation "that I did indeed reconcile the medications?"

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well, I mean I'm advocating for they used the function. I mean, they actually do a true reconciliation. Now there may not be reporting yet out of the system but at least you can audit that and they may be attesting but that's what I'm recommending.

Carl D. Dvorak – President – Epic Systems

Yeah, the way these work in practice is you have to make a determination as to whether visiting the functionality is sufficient to imply they took the action or if in some cases it's rationale not to make any changes to the medication list. You may make the determination you'd like them to attest or mark as reviewed that's been a common thing that people have had to do for some limiting for these measures to differentiate having it flowing past them on a screen versus having them said "yes I actually did reconciliation even though there were no changes."

In many cases we can take it on faith that if they did make adjustments to the medication list then we can presume it's reconciled because the likelihood of doctors making changes to the medication list while still leaving it in an unreconciled state is unlikely although I'll tell you some auditors and compliance officers don't feel that's appropriate it's often done.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

And again, just to maybe understand before having an opinion, the way this measure is worded is that it's specific to transition if there is a routine process by which a clinician reconciles the medication list independent of whether a transition occurred or not as long as that transition information was available during the reconciliation process would that count or not count relative to a process measure?

Carl D. Dvorak – President – Epic Systems

I think it depends Arien.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah.

Carl D. Dvorak – President – Epic Systems

I think different people would have different interpretations. Clearly the classic medication reconciliation is on an intake typically to an ED or to an inpatient environment. Ongoing activity at your primary care doctor's office it's a little bit harder to tell without making them push the "I marked it as reviewed" button all the time.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

That's right and that's what I'm getting at is that I would be concerned about a process that requires somebody to manually go through some step every time a transition occurs only with respect to the transition information as opposed to going through some routine ordinary process to check and update the medication list and check and update the medication allergy list with respect to all of the information that is available whether that's through a transition or through a patient reported information and, you know, I think with respect to this definition, not with respect to the JACHO definition or the Joint Commission definition, but with respect to this definition if we have an opinion about what should and shouldn't count I think it's incumbent on us to make that statement.

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

This is Shelly I have one suggestion and I don't know if you want to take this but maybe keep the higher measure for chronic care management and if you can come up with some definition of...there are several definitions out there that CMS is using in terms of chronic care management and apply that to maybe a higher percentage, I don't know if you want to get that complex, and leave the lower one to everything else.

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

Yeah, I think that the challenge...I think that...I certainly understand the goal there and it seems like, you know, everyone would certainly be in agreement that it's precisely in those cases that you want to make sure that it's happening and all the concerns that I think people have been expressing are about the cases where people aren't dealing with that which is when they're...which is when it's going to be a significant workflow burden.

I guess I would be concerned about, you know, bringing yet another parameter in that we have to define that's going to start making this more complex as, you know, the providers and the programmers start to think about how do I classify something as chronic care management and treat it differently than patients who would fall outside of that category.

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

That's why I didn't recommend...this is Shelly, that's why I didn't recommend it in the comments, because...

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

Yeah, yeah, yeah, yeah.

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

But again it's getting back to what is important to our patients and we're not doing that.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well, but it's also...it's also retraining the providers and their staff on how to do their day-to-day business. So, they're not used...I mean, half the time they didn't get information before in transition and it's just starting to change and so you have those that are getting these documents in now that will look at them and, you know, we're trying to train them now to routinely always do a medication reconciliation and it's starting to happen but by adding that to this, this new workflow, this new process that they're now moving into that gets them to go further. We're changing how they're working now.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry, along that same line I think that, you know, we shouldn't be constraining, you know, and defining who has to be doing these reconciliations, you know, an MA or anybody else for that matter, because I think that's part of the...that's the state's responsibility of licensure to determine, you know, who can appropriately be doing it and what training is taking place within specific offices or who is qualified to do it and I don't think it's our federal responsibility to be saying that an MA can or can't be doing medication reconciliation for instance.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

But Larry, I agree with...Hal Baker again, I agree with medications but problem list reconciliation while an MA may attest that they've done it and checked the box it has been done it's probably outside of the scope of their knowledge given how many diagnoses are out there.

I'm going to suggest that problems be removed from this because the complexity of trying to figure out how to measure it and it being a relatively new idea of reconciling problem list we don't really have a standard around it and whereas medication reconciliation had been done for a decade before this the medical director's information system society talks a lot about the problem of problem list clutter and since we know the problem lists are typically cluttered reconciling them is going to be quite burdensome and may have unintended consequences.

Carl D. Dvorak – President – Epic Systems

And Hal I'll just add on to that, in our experience we've exchanged something like 80 million records in the last 12 months, as you start to do more and more interoperable work the problem list starts to hear echoes of the past.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yes.

Carl D. Dvorak – President – Epic Systems

And as a clinician further evolves their understanding of a patient's condition they will start to see old statements of that problem show up on the problem list and have to push it back down into the resolved or subsequently updated category.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Again, this is Arien, I just want to re-push, and apology if I'm pushing inappropriately feel free to push me back, but I want to re-push on this issue about let's just look at medication and medication intolerance or adverse effects reconciliation. Is the intent, and again let's push away Joint Commission definition and Joint Commission auditors for another second, is there a perspective that we have that this literally means on every transition reconciling the information from transition or to the extent that there was a reconcile and update function in the electronic health record that the physician or delegated person used that if it had information from transitions that this should or shouldn't count?

Just to be transparent I'm of the opinion that it should. But, I'm trying to push on this notion of a process measure, what is the process measure and what actually is it measuring?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Hal, I would think that the goal is to have the problem list, excuse me the medication list and the allergy list reflect the knowledge coming from the transferring place so that decision support alerts that prevent duplication medications or allergy interactions can be behind the scenes to prevent harm...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Right.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

That one seems of much greater precedence. Duplicate problems or problem list omissions are perhaps less dangerous and less prone to decision support.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Agreed but I guess I'm asking if there is a workflow by which routinely in every encounter a physician or delegated person goes through and updates the medication list should that count or should it be relative to the transition and reconciling the information in the transition.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well this measure is looking at transitions so it's saying that if you do have a new document from a transition that you are going to compare and reconcile the medication list in your current system and the new document.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I get that, I guess I'm asking, you know, does the EHR functionality need to necessarily then recapitulate the process measure?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

No, it just needs to say that it was done.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah, okay, that's my opinion as well that it needs to get done in a context where information from transition is available and presented, and that the clinician or appropriate delegee, delegate, delegee has updated the medication list or...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Right.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Adverse effect list, yes.

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

Right or saying that it doesn't need to be updated.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Or saying it doesn't need to be updated, correct.

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

Yes, right. So, I mean, it sounds like we all agree that it should be done 100% of the time. We also agree that sometimes it can't be, we have the situation of what prescribers, we have the situation of information not available and, you know, a variety of things that we also have the issue of problems being different in nature than medication and medication allergies.

Hal had suggested that we recommend...so we'd already agreed that problems should be treated separately, completely separately, Hal has suggested that we recommend dropping problems, what do people feel about that? How far do we want to go on that?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

I agree with that.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

It really depends. I mean, so this is Arien, I think it really depends. In primary care practices is it practicing good medicine to, again, not update the problem list clearly blindly incorporating problems from other places that may be zombie problems is bad clinical process, but in certain settings of care it seems to be appropriate and good practice to make sure that the clinician is creating an up-to-date problem list, incorporating it...

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

Yeah, this is Shelly, I totally agree.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah. I mean, I think its good practice and it ought to be done but to the point before it's nowhere...I mean, it's really apples and oranges between medication...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Sure.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

And problem at this juncture so I think it's...I mean a lot of this is to push it as far as we can without scaring too many off.

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

Yes.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

And I think the medication is definitely there whether it goes over 50 and how high it goes I'm not sure, but I agree with the idea to hold off on problem list for now just because the maturation and the other things that have been mentioned.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Yeah, this is Larry, I agree with that as well. I mean, there is probably pretty good evidence that medication and allergy reconciliation, you know, reduce adverse events, drug events and improve outcomes. There is probably very little literature that, you know, reconciling the problem list, you know, directly resulting in improved outcomes.

I mean, granted I and probably my patients live and die by the problem list that I keep but I don't think there's evidence in the literature to support that. So, I think...

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

Yeah this is...

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

We should remove it.

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

This is Shelly and this is one of the reasons why I mentioned indication for the medications because this is what's actually needed for when we do the care plan process because if you're going to come up with the goals of therapy for the patient you have to have that information in order to move forward with engaging the patient in their care.

So, there are certain patients that really need this and that's why I say we should have some type of measure, I don't mind lowering it but it has to be there for those chronic care conditions or where an eCare plan is actually going to be used.

Kate Kiefert – State HIE Coordinator – State of Colorado

So, this is Kate...

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

This is Hal...

Kate Kiefert – State HIE Coordinator – State of Colorado

And just from an operational perspective and from someone who used to coach doctors on where they should put things I think the biggest issue that I hear is that if they're going to have to do this problem list reconciliation they're going to get this information across they're going to see some really, for lack of a better way to say it, crappy problem lists because there's a lot of providers out there who put everything but the kitchen sink into those problem lists and so, you know, part of it might be advancing better documentation processes but should they be putting the care plan within the problem list or should they be putting it somewhere else. So, I think you're going to come across a lot of operational and workflow issues but it's not to say it shouldn't be done.

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

Well, this is Beth and...

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

And...

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

Yeah, this is Troy, I've got a question for the providers in the room. How many of you would feel comfortable removing a diagnosis that another provider had entered into a patient's medical record?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I do it all the time.

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

Do you?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I have to.

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

Okay...

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Me too, I mean, this is...I mean, we have to...I'm in a multiple specialty group practice, I'm a primary care physician and we do have some etiquette about, you know, how to do that but...

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

Okay.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Yes we remove them when they've resolved or if they're incorrect we transition them to correct diagnosis.

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

Okay.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah and that...and this is John and that's hard enough in a multispecialty group when you have all that now we're talking about transitions between groups and what does stay and what doesn't and I'm sure there was an effort and a policy put in place for the multispecialty group to have to navigate that.

So, it really...I mean, we're getting into some pretty new territory, you know, again, I think on the medication side it's easier. The problem...I mean, as we're starting to see this with the documents moving about, again, the whole point of these long lists and how you manage that I just...I think it's premature to do that at this stage on the problem list.

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

Right.

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

Well, this is Beth...

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

I see it as being more problematic if you're a consultant, you know, you're seeing the primary providers and the patient is here for an orthopedic consultation and now you're going to send them back. Would you have...would you feel comfortable as an orthopedist reconciling that list and remove some things that the patient...that you feel are inappropriate.

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

Right.

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

Yeah, this is Beth...

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

So...

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

This gets to the issue I was raising about sort of how all three of these measures work together and to some degree what we’re really hoping for might be addressed by measure two if it were required and receive and incorporate does happen and the summary of care record includes the problem list and the provider looks at it as compared to getting to the reconciliation it might achieve much of what we’re really hoping for.

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

Right.

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

I don’t know if by having the reconciliation aspect it’s sort of actually creating the outcome measure or just creating sort of a false process measure.

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

Right, right. So, Beth actually that’s where I was going to go to, this is Micky, that how would people feel about...so to take Hal’s point and I think, and Beth’s point too, that problems are different in nature both because they’re complex and really messy I think as Kitt or Kate was saying, and they aren’t self...and they aren’t easily reported by patients or in a way that would lend itself to reconciliation.

Furthermore...so that means that unless problems are delivered in some coherent fashion it’s going to be very, very difficult to do it and then if we look at the two other measures we’re only at 50%, asking 50% on the push and 40% on the receive and incorporate, and asking for 80% reconciliation that seems to be, you know, sort of not working together.

So, how would people feel about saying that we should keep medications and medication allergies high and, you know, I don’t know if it’s 80% or, you know, in that range, if we look at the data from just medication reconciliation where no exclusions were allowed they...it was high, it was like 90% both for EPs and EHs where the threshold was lower at that time.

So, we keep medication and medication allergies high but we drop problems, we suggest that problem, that the problem threshold be dropped very, very low and I don’t know what very, very low is, you know, is it 10% or something like that in recognition that sometime you’re going to be able to do it, sometimes you’re going to be able to do it, sometimes you’re going to get the data electronically but we’re not in the situation where workflow conventions, interoperability is in a place that would really enable people to be able to get close to 80% on problems without imposing huge workflow burdens.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Micky the only...this is Hal again...

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

I think that...

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

The only thing I would add would be to what Shelly is talking about is that there are other tools in healthcare such as medical home certification or the new wellness visits covered under Medicare that can push problem reconciliation discussions and the care plan, it’s just that HIT policy may not be the right tool to push that betterment of practice.

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

Right, right, right, no, and that's a fair point and it may be that the reason that we may not want to eliminate it entirely is, remember, you know, this is the last stage and, you know, Meaningful Use has said that...I mean CMS has said that, you know, they certainly reserve the right to increase thresholds, I guess I'm a little bit worried about taking it off entirely because, you know, then how does it get back in. I suppose they can but it seems like it's easier from a process perspective and rulemaking that if it's at 10% now that in the future as those things start to kick in and people start to...we get more coherence around this and some of those things start to kick in that they could increase the threshold appropriately.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah, Micky this is Arien...

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

I agree with that. I think it must stay on the table for consideration in the future, it's got to be on the radar because like Shelly pointed out, I mean, I agree it is important to reconcile it but only in the situation where you can do it with accuracy, you don't want to just do it, you know, willy-nilly.

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

Right.

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

So, I think it's a great idea.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So, this is Larry, I agree if we have problems in the, you know, 5-10% range I'd be okay with that and I'd be okay with the 80% for medications and allergies if we have an exclusion in there for people who, you know, prescribe less than 100 prescriptions or something like that, you know, during the measurement period.

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

Right, okay it seems like there's general agreement on that too to have some exclusions for specialties, scope of practice things like that, okay.

Are there any...I actually think we got to, you know, a pretty good place in terms of, you know, a recommendation that we formulate and that actually says something.

Is anyone feeling uncomfortable with where we are because I want to move back now to the measures one and two?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

No that all makes sense.

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

Okay, great.

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

Well, before you leave this slide though are you going to get to...

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

Yes?

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

The new patient issue?

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

Okay, sure, yeah, why don’t we look at that one. So, on that one from the comments that we got back all seem to agree that it should apply to all referrals and transitions of care. Now there is I think...Kory I was just looking at the rule while we were talking here. I think that the measure three for whatever reason does bring in the fewer than 100 exclusion if I’m not mistaken and we may want to recommend that they not have that.

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

Yes it does for the transitions Micky you’re right.

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

Right. So...and I think that’s different right? In Stage 2 I think there were no exclusions allowed if I’m not mistaken.

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

I’d have to double check that.

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

Yeah.

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

Well in this...this is Beth, in this forth bullet and there’s the comment from the homework that people didn’t feel that new patients should be added, but I sort of had the opposite feeling that new patients when it comes to receiving and capturing information from likely more than one other record as you receive this new patient to truly understand what the patient needs you do need to reconcile and identify whether they are problems with their medications.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

This is Hal, if you’re going to be involved with them in an ongoing basis because a lot of that work will happen after the first visit because as a new patient you very infrequently can get the records before because the sender doesn’t know to send them to you until you request and I think there are other reasons why we do it. We have all done it for years, but the complexity of having Carl and his partner’s code this would be a lot.

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

Right.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah, new patients has an interesting issue in acute and ED care makes maybe more sense in sort of a medical home environment or in areas where you're seeing patients over and over again but there are environments where it's really hard to determine who is a new patient and who is not.

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

So, it's just too complex to achieve, I don't think we want to say that it doesn't...it would not create benefit but...

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Absolutely.

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

It's just not feasible.

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

Okay, yeah, maybe that's how we should frame it then that it's more just the practical aspect of the workflow as well as the technology, you know, being able to count that appropriately and again it's not that it's not benefit clinically it's just that from a measurement perspective, you know, how much benefit are we adding there and how much more motivation are we adding there by something that's going to be very complex to implement.

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

Okay.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

It can't be done concurrently with a visit.

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

Right. So, let's back up, we have about 10 minutes before we have to go to the public comment, so if we can back up a few slides to bring us back to a galaxy far, far away.

Measure one, if we just come to that for a second here. Okay, so measure one you may recall we had the sending electronic summary of care for 50%, these are the different exclusions that we had talked about. So, why don't we go to the next slide to go into these in a little bit greater detail here.

So, I think we've got...we agreed that the threshold should be increased now remember it's 10% now, we agreed that it should be increased, the proposal is 50%, we've seen data that the EPs and EHs who did attest and who are, you know, arguably the ringers, you know, in the Meaningful Use universe are at roughly 40% right now. Now recognizing that this is two years away that we're talking about here.

So, there's, you know, one question we want to tackle with which is what's the appropriate threshold if we, you know, if we think that we want to go higher. Last time we had talked about maybe 50% is too high, we may want to revisit that question.

In terms of the...one other thing I wanted to mention on this slide is that first off I think that we had come to...we had agreed that requiring electronic transport that does not specify the use of a particular standards makes sense because there are other modes of doing that. It does suggest perhaps allowing a higher threshold because it will theoretically be easier to accomplish from that dimension. I just want to point out here sort of the tradeoff that we have between some of the decisions we made about exclusions and different ways that one could do things and what threshold we end up coming to.

We did agree, I think, that we should not allow the inclusion of patient self-referrals, again for the same reason that we were talking about the new encounters in measure three it's just a very cumbersome workflow for relatively little benefit on the measurement side or as we think about what the motivation side might be. That suggests allowing...

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

I...

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

Perhaps a lower threshold. Sorry, did someone have a comment?

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

Yes, just Beth, I think we should say relatively little benefit to patients and if we can't say that then, you know, we shouldn't make this recommendation, because that's what we really care about and I thought we had decided that really the benefit to patients comes on the other side, the retrieval capture with respect to these self-referral spaces.

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

Right, right.

Brian Ahier – Director of Standards & Government Affairs – Medicity

So, this is Brian, one thing that I was thinking as we were looking at where we are today with Stage 2 and when we look at the challenges around achieving Stage 2 and now the increased thresholds for Stage 3, might it not be good to have separate thresholds for eligible hospitals and critical access hospitals as we have for eligible professionals, because it certainly seems that a higher number of eligible professionals are taking exclusions as well as not even participating in the program than we're seeing with eligible hospitals and, you know, maybe it's anecdotal but there is an awful lot of concern among eligible professionals about transitions of care and whether or not they'll even attest at all and so maybe if we lower the threshold for eligible professionals would help in that case.

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

So, it does...as we discussed before the rule does suggest getting rid of the exclusion for fewer than 100 so we should see fewer...we should see, you know, we'll say a higher percent who are doing it but your point is that we may just lose people. So, of those who stay in they're going to have to do it but there could be people who would just leave because they think this is too high a bar. What do people think about having different thresholds for hospitals versus EPs?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Well...

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I mean, this is Larry, I don't have a problem with, you know, keeping the thresholds the same but I do think that you need to put that exclusion back in there if you have less than 100 referrals.

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

Well, except...but then we come back to the problem that, you know, that 86% of people were taking the exclusion.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah it's only because you defined it for 90 days, you should prorate it right, so...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

That's right.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

A quarter is 25 referral.

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

Okay, yeah and do we think that that's really...do we think that's really the issue and what allowed so many to take exclusion because it was 100 for 90 days.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

I definitely think so that would be...

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

You do, okay.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yes.

Carl D. Dvorak – President – Epic Systems

It made our report writers heads spin. I don't know if you know how many 90 day reporting period exist in a year and anybody...473 or 4 based on leap year I guess is...simpler is better on these things if we can manage it.

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

Right.

Carl D. Dvorak – President – Epic Systems

It's probably good for everyone and saves...

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Yeah, I...

Carl D. Dvorak – President – Epic Systems

Healthcare resources for patients that need care and less on programmers writing silly reports that don't add value.

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

Okay, so it sounds like...

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

This is...

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

Now just to be clear the rule suggest that there be no exclusions so it sounds like what we're saying then is that we can keep the thresholds the same as long as we bring back the 100 and we say that...and then we just point out that the reason that there seems to be such a high exclusion rate last year or last time was because it was applied to the 90 days.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Right.

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

But we...right...

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Or in the combination is also the fact that there, you know, weren't necessarily people who were there to be receiving the data.

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

Right, right.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

And that...

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

This is Shelly...

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

And we also need to recognize that...sorry, just one other point that we are saying that electronic transport can now be done in a variety of ways so that ought to make it easier as well. Sorry, go ahead Shelly.

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

Yeah, this is Shelly, I think we're going to go down another slippery slope with this as the primary care providers and especially the physicians are going to be needing to be in the loop because of reimbursement models and value-based payment models that if we don't push this particular process of keeping those physicians in the loop on transitions of care that they're going to be left out of that payment model.

I just think it's a slippery slope not to say, you know, for me I'm going to say one way or the other it's okay but there are going to be some changes in the payment model that physicians are going to want to be in the loop because that's their revenue stream and if you they're not going to be pushed into that then there is the possibility that they're not going to...

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

Right, but Shelly, isn't that what pushes them and not Meaningful Use? I mean Meaningful Use doesn't push them.

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

Well, Meaningful Use is...

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

But it is...

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

Is an enabler, yes it's an enabler to push them.

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

Right, so this is saying they need to do it but...

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

You don't...

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

And it's saying that, you know, they need to do it some significant fraction of time I don't know if we're up at 40, 50% and then those things that you're talking about it seems to me are the things that really are going to motivate them to want to do it even more.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah...

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

Beth...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

As we discussed last time the intent here is to jump start an ecosystem and at the end of the day if that ecosystem isn't adding value or if there is no way to generate value because you're improving care then Meaningful Use isn't going to do it, but the intent and function of Meaningful Use is to give a little, enough of a push but not so much that you're trying to dictate practice patterns.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Right.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

And the other thing is that there is, you know, a lot of eligible professionals that are not part of the standard ACO picture, you know, dentists are eligible professionals and, you know, we have to kind of have them fit into these, you know, models and exclusions as well.

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

Right. So, given all of this do people now want to revisit the question of 50%? Do we feel that 50% is too high? It's feeling to me frankly from the tone that we're coming around to thinking that maybe 50% isn't too high as long as you bring back the exclusions and we have some of the flexibility that we've talked about here with electronic transport and taking Shelly's point that, you know, we do want to be motivating people and creating enough of that ecosystem as Arien points out.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I still think...this is Larry, I still think 50% is too high...

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

Okay.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

And unrealistic for two years from now...

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

Right. Given that it's at 40% right now what do people think?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

And that's really just for the very best.

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

Yes. So, should we, you know, say that we think 50% is too high but 40% appears reasonable? Given that's where we are right now but that is for the ringers.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

It's Hal here, if we got to 25% wouldn't we have enough flow that it be established and then it would either grow on its own accord or stagnant there because it's not meaningful.

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

It might be, I guess I'm thinking that it seems a little bit awkward to be recommending a threshold that is below what at least the people who have attested in Stage 2 are at right now like significantly below.

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

I agree.

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

Fifteen percentage points below.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Were zeros added in for people who took the exclusions or the...

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

No, no, no, so, you know, that's a fair point that's what I mean, you know, it is the ringers we recognize that but 25% or suggesting 15 percentage points below where they are.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

What if we compromise at 30%.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Thirty-three point three.

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

Right.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Sold.

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

That's the...

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

All right, 30%, any strong objections to 30%?

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

Thirty percent without the exclusion or 30% with the exclusion?

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

Sorry?

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

Thirty percent with the exclusion or without the exclusion?

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

I think we're talking about...the thresholds here are with the exclusion, we're saying we want the exclusion for fewer than 100.

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

This is Beth, I go for the higher rate with the exclusion and feel like so much of the whole program depends on this particular...

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

Right.

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

Functionality.

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

The higher meaning 30 or the higher...

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

Fifty.

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

Oh, you’re saying 50.

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

Yeah with the exclusion.

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

Yeah, I agree, I mean if there is going to be an exclusion it needs to hit the higher level.

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

Right.

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

If there’s no exclusion then yeah I’m for the 30%.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Okay, exclusions drop down to 100 per 365 days. So, it’s basically 25 per a 90 day period so that’s a significant drop.

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

It is but remember at that level 86% were able to take it. So, you know, if we get to a point where 25% are able to take it, you know, we’ve still accomplished a lot it seems. All right, so I’m sensing that a few people want 50 with the exclusion, some people want to go all the way down. What do people feel about 40 with the exclusion?

Carl D. Dvorak – President – Epic Systems

You could sell this to the highest bidder Micky...

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

Okay, yeah.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

...process.

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

It is okay, I think...why don’t we take this away and we’ll sort of...I think the way we can frame this is that there are these kinds of tradeoffs this is the range that we came in. Again, I don’t think we have to recommend to them a precise number.

Carl D. Dvorak – President – Epic Systems

We'll each e-mail you our number and then you can average them how's that?

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

Perfect. Okay, now are we completely out of time I think we aren't we?

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

I think so.

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

I'm asking for Michelle, yeah, okay that's Kory saying...okay, so why don't...so there is something in here on governance that I would appreciate and we can send a follow-up e-mail to get your comments on that. These are...now that's not a...there is not a proposal that's being made by CMS with respect to how governance should play into the incentive program in general but they are asking the question how HIE governance should play.

I put a slide in there with some straw thoughts, those were Micky Tripathi's personal straw thoughts for people to react to, by no means representing that any of that has been, you know, vetted as a Workgroup conclusion. So, I'd ask if you could take a look at that and provide any comments back. Again, we can send a chase e-mail out to just get your comments on that.

And then also on the measure two you'll see a similar framework like we've gone through here for measure one and measure three where I've laid out one description that breaks out the different exclusions and things that we've talked about and then a slide that talks about where I think we were in terms of agreement and whether there might be some open areas for us to consider. So, get your input on that as well.

And then, you know, given that we have a little bit of time maybe if we can...I might be able to have a turnaround of the comments that I have to give people an off line chance to make a final pass at the written recommendation document that we'll have, you know, by mid next week recognizing that we have to have this done by May 7th for that Advanced Health Models meeting. Okay?

Great, well, thank you, I think we did make a lot of progress. There are just, you know, so many variables here and so many things that effect each other which I think makes it very complex and very difficult to sort of go through in a linear type of process so I appreciate everyone's patience and everyone's engagement in this and look forward to putting together all the pieces into something that reflects where the Workgroup discussion was. So, let me turn it over to Michelle and ask for the public comment.

Public Comment

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

Caitlin, can you please open the lines?

Caitlin Chastain – Junior Project Manager – Altarum Institute

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

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

We have no public comment.

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

Okay, great, well thanks everyone.

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

Thank you, have a great day.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thanks a lot.

Carl D. Dvorak – President – Epic Systems

Thanks Micky.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Thanks, take care everybody.