

Meaningful Use Workgroup
Draft Transcript
March 13, 2012

Operator

Ms. Deering all lines are bridged.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you, Operator. Good morning, this is Mary Jo Deering of the Office of the National Coordinator for Health Information Technology. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. I'll begin by taking the roll. Paul Tang?

Paul Tang – Palo Alto Medical Foundation

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

George Hripcsak?

George Hripcsak – Columbia University NYC

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Michael Barr?

Michael Barr – American College of Physicians

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

Here.

Christine Bechtel – National Partnership for Women & Families

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Neil Calman? Tim Cromwell? Art Davidson?

Arthur Davidson – Denver Public Health Department

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Marty Fattig?

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

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yael Harris? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Greg Pace? Rob Tagalicod? Charlene Underwood?

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

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Amy Zimmerman? Thank you, over to you Paul.

Paul Tang – Palo Alto Medical Foundation

Good, thank you very much, oh did we introduce?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Farzad Mostashari, just observing.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I apologize.

Paul Tang – Palo Alto Medical Foundation

Alrighty, well thank you, welcome. We have a little bit of a later start because we had some technical challenges to get connected, but what we're going to do is show our Workgroup notes in real time for the public. We have an ambitious, but I think reachable goal, sort of like Meaningful Use, of trying to get, we had a very productive call last time, thank you very much. So we got through all of category one minus the comments.

So, in order to maintain our momentum I thought we would march through categories 2 through 5 including the questions that appear in the NPRM and then we'll come back and do category 1 questions. And hopefully we'll get through all of that today. We have two more calls scheduled if we need them. We may need at least one call to tidy things up before we present it back to the full committee. So, we had

left off starting with the engage patients and families and so if we can turn to that, which I believe starts, well we'll see here, it starts on your page 11.

Christine Bechtel – National Partnership for Women & Families

Actually I think it's the bottom of 10.

Paul Tang – Palo Alto Medical Foundation

It's the bottom of 10, okay, bottom of 10. Okay and what we have in front of us and we'll try to read out loud for the public, is a matrix that has several columns and what we're trying to do is we're looking at the final rule from Stage 1, we're looking at what the HIT Policy Committee recommended for Stage 2, we're looking at the NPRM for Stage 2, and we're filling in the comments that we're building in response to the NPRM. As I said, we finished the objectives for category 1 which is improve quality, safety, efficiency and reduce healthcare disparities, and we're just about to begin category 2, which is engage patients and families in their care.

So, the first objective in this section then is to provide the final rule for Stage 1, to provide more than 50% of all patients with an electronic copy of their health information upon request and what we had proposed was to combine this into our view and download kinds of functions that we put together in our proposal for Stage 2 and in a sense, the NPRM recommended the same kind of approach which is to combine this with a future view download and transmit. So, I don't think we have any comments further on this particular objective until we get to the combined objective, any comments on that?

Okay. The same thing essentially applies to the hospital, which is at the top of page 11 for those who are following on the matrix, it's the provide more than 50% of all patients with an electronic copy of their discharge instructions at the time of discharge upon request. And we actually had combined it with the objectives as well.

So, the next section is to provide more than 10% of all unique patients' timely electronic access to the health information subject to EPs discretion to withhold certain information that applies to EPs only. What HITPC recommended was for eligible professionals, more than 10%, view and have the ability to download their longitudinal health information and that that information is available to all patients within 24 hours of an encounter or within four days after the information is available to the EPs, that's particularly to address lab test results.

In the hospital we'd recommend that 10% view and have the ability to download information about hospital admission, and that be made available within 36 hours after the encounter. This was in the NPRM proposed to be replaced with the view, download and transmit functions. I think what we ought to do is just go to that, which is the next row and the proposed NPRM language was the objective is provide patients the ability to view online, download or transmit, I think is the way it should be reading there, their health information within 24 hours of an encounter or within four business days of the information becoming available to the EP, and again this is under EP.

The measure for accomplishing this objective is twofold. One is to have more than 50% of all unique patients seen by the EP during the reporting period are provided timely access, which means within four business days after the information available to the EP, online access to their health information subject to the EPs discretion to withhold certain information. So, half of unique patients have the ability to get access to their information within four business days after the information is available to the EP and a second component of that measure is that more than 10% of unique patients seen during the reporting period view, download or transmit to a third-party their health information. There is also a caveat that this could apply to an authorized representative if the patient so chooses.

So, just to recap that, there are two measures to this objective, one is that half the people seen by the EP during a reporting period have access to their health information and secondly, that more than 10% actually do view, download or transmit their information. So comments about that objective and measurement?

Maybe we can break up the measure into two parts. One is very similar to what we've done in the past which is that half of the patients have timely access to their information. Now, the measure doesn't call for the 24 hours, at least what is written in the matrix. We had said that the information should be available to the patient; I'm talking about EP side first, within 24 hours of an encounter. Josh, do you want to clarify? Have I stated that correctly?

Josh Seidman – Office of the National Coordinator

Yeah, I'm pretty sure that's what's in there. I think it just didn't fit.

Paul Tang – Palo Alto Medical Foundation

Okay. So, one comment is, the timeliness right now doesn't include the 24 hours. So we had said that the information from an encounter should be available to the patients within 24 hours or four days if it's like a lab test result. The proposed rule doesn't have the 24 hours.

Josh Seidman – Office of the National Coordinator

No, I meant to say I think it does.

Paul Tang – Palo Alto Medical Foundation

Oh, it's just not in the matrix? Let's see.

Christine Bechtel – National Partnership for Women & Families

It's on page 93 of the printed, you know, the big...

Josh Seidman – Office of the National Coordinator

Yeah, it is in there.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, both 24 hours and within four business days are in there.

Paul Tang – Palo Alto Medical Foundation

Okay, good. Okay, so that's pretty much the same. Now let me check...

Christine Bechtel – National Partnership for Women & Families

Can I connect to that?

Paul Tang – Palo Alto Medical Foundation

Absolutely.

Christine Bechtel – National Partnership for Women & Families

So, I want to make sure I'm under the right piece here, yeah, view, download and transmit. It does say we believe that four days remains a reasonable timeframe and limits the need for updating. So, I actually think, it says we believe that splitting the timeframes in this manner adds unnecessary complexity to this objective and associated measure, which is the four days for labs, 24 hours for everything else. So it is not in there.

Paul Tang – Palo Alto Medical Foundation

Yeah, in fact I'm reading now from the text as well, this is on page 94, also does not have 24 hours.

W

Page 144 as well?

Paul Tang – Palo Alto Medical Foundation

One forty-four. Now that's hospital, so we're dealing with EPs at the moment.

W

Oh, maybe I...

Christine Bechtel – National Partnership for Women & Families

Yeah and hospital was different, it was 36 hours was what we proposed, because of the nature of hospital care, but under the measure it says we proposed two measures both of which must be satisfied more than 50%, provide a timely access in parenthesis within four business days after the information is available to the EP on-line, blah, blah, blah and then 10% view, download or transmit.

Paul Tang – Palo Alto Medical Foundation

So, we can review our rationale for the 24 hours just to summarize for ourselves and then if anybody either can find it in the text or if ONC or CMS wants to clarify we can consider what the rationale was. So, our rationale was that we'd like to get the information as quickly as possible to the patient. For example, they could have another appointment coming up, they could have a test, they could be wanting to review it with their family members or representatives, so the sooner the better in a sense, and particularly if you wanted to make a change let's say in medications. So, that was our rationale for having it available and we gave it 24 hours because they needed some time to finish. Obviously, the sooner the better, so if you could finish all your medications and your lab tests, or etcetera by the time you leave the office, that should be available to them. Other further discussion of let's say our rationale and then anybody else have any comments on the rationale for the NPRM?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

This is Farzad, I'm not sure if your comments address both parts of the use case that sometimes this is after an encounter where, you know, the issue of kind of closing out the encounter within 24 hours and other times its new information becoming available to the provider, as in the case of the lab tests, which may need time for the provider to check the lab results and have an opportunity to do that. So, in terms of your comments about the 24 hours, I mean, I think the point made in the NPRM is that there is complexity that's introduced by trying to have two separate time periods for those. And, I guess, when you're talking about 24 hours being a reasonable time are you saying for both of those functions?

Paul Tang – Palo Alto Medical Foundation

No, for everything, but things that require time to result, such as test results.

Christine Bechtel – National Partnership for Women & Families

Which I thought was we actually had that bifurcated structure in Stage 1. I don't have enough detail on that spreadsheet to know.

Paul Tang – Palo Alto Medical Foundation

I think what we did was we allowed a longer time. Let's see Stage 1.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

I think it would be worth the Policy Committee commenting on it. The NPRM place's value on simplicity.

Paul Tang – Palo Alto Medical Foundation

So, open for comments on that issue. It's basically to be simpler or be less confusing, it would be simpler or less confusing to have one time metric for what timely means.

Christine Bechtel – National Partnership for Women & Families

I guess the challenge I have with that is then we seem to be going with the least common denominator, you know?

Paul Tang – Palo Alto Medical Foundation

The lowest common denominator.

Christine Bechtel – National Partnership for Women & Families

Yeah, right, so.

Paul Tang – Palo Alto Medical Foundation

Other comments about that? Neil, have you caught up on the question we're asking?

Neil Calman – The Institute for Family Health – President and Cofounder

No, not yet, sorry.

Paul Tang – Palo Alto Medical Foundation

Okay, let me present, since you do this in your professional life, so we're on the measure about when patients would have access to their information, in this case after an encounter for an EP and our original proposal was within 24 hours of the encounter or within four days of new information becoming available. For purposes of simplicity the NPRM suggested that we just have one timeframe, which is within four days after information becomes available to the EP and not have the 24 hours for the rest of that. So we're trying to adjudicate between the simplicity of having one time limit and what we originally thought about trying to be as timely as possible for information that doesn't have a delay.

Neil Calman – The Institute for Family Health – President and Cofounder

...the delay in because we thought that there was information that was going to come in later, right?

Paul Tang – Palo Alto Medical Foundation

Correct like lab tests.

Neil Calman – The Institute for Family Health – President and Cofounder

But a lot of people are moving to sort of instantaneous access at this point. I mean, when it's available to the provider, it's available to the patient. So, I don't know why we're still building in a delay. I mean if it's coming back through the system, it seems to me we ought to facilitate people having access to it. Like it was an early stage development that people said I want seven days to look at this and study it before my patient gets it and I don't know a lot of us are beyond that at this point.

Paul Tang – Palo Alto Medical Foundation

Michael?

Michael Barr – American College of Physicians

I would question a lot of us being beyond that, because the field is not there, Neil, you're advanced; I don't think that's a common thing. I think leaving one standard is very practical, it's easy to understand if they're using it and getting things in there within four days then likely when something becomes available, it will also be available as quickly as possible. So, I don't think that diluting it or actually making it more stringent is going to help folks, especially in light of the second part of this particular measure.

Neil Calman – The Institute for Family Health – President and Cofounder

Some part of the summary, we're not just talking about labs here, we're talking about any summary information. So, when you change prescriptions and you change, you know, and you're sending them for tests and stuff, that kind of stuff should be available to them immediately after the visit, I mean otherwise it's not really useful. What good is having your information about your medication changes four days after they happen?

Paul Tang – Palo Alto Medical Foundation

Christine?

Christine Bechtel – National Partnership for Women & Families

So, I agree, thank you Paul, I agree with Neil, but I also want to point out I think there is a middle ground. There is a provision in here that says subject to the EPs discretion to withhold information. So, if we go with 24 hours and that caveat is in there, I think it would address what Michael was saying as well.

Michael Barr – American College of Physicians

But, it's also trying to make the measurement simple. If I have to try and explain to physicians "okay gotta get it within 48 hours, 4 days or 24 hours with new information" it's like you said get everything within 4 days so people can have it.

Christine Bechtel – National Partnership for Women & Families

I think what I'm saying, just to clarify, is I'm suggesting that the threshold, the timeline be 24 hours period, but there is a caveat that says subject to the EPs discretion to withhold information, which was in Stage 1 and it was designed for things like labs.

Michael Barr – American College of Physicians

But that means then the doctor is going to have to review everything and that's just another layer of complexity we can avoid by just lengthening the period of time and letting things in there and if they are available sooner, great, but it'll be in within 4 days.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven on the phone, some of this is about what people are being legally held responsible for versus, you know, the incentives for the right behavior. I mean, don't get me wrong, I'm all for it, it should be available to patients as soon as it's ready to go, but I don't think it's a good idea to rely on that exemption, Christine, for cases where the doctor is just pressed for time to review it as opposed to, you know, that was really designed for cases where the physician has concerns about the patient reacting to a lab result without the benefit of some counseling. So, you know, my inclination, I think it's going to be hard for us to hang on quite frankly to some of this stuff that we got and I'm inclined not to press this one.

Christine Bechtel – National Partnership for Women & Families

Can I make one other suggestion? I'm trying to find a middle ground here. So, what about having it be within 24 hours of the information being available to the EP? So, it's one timeline, the discretion piece still is there, but if it's not available to the EP within 3 or 4, or 5 days, it doesn't go in there, it's within 24 hours of the information becoming available to the EP. And I just want to reinforce I think...

Paul Tang – Palo Alto Medical Foundation

Let me clarify that 24 hours is by the clock time versus the business day time. So, there is a distinction there.

Paul Tang – Palo Alto Medical Foundation

Can I offer a compromise on your compromise, which is the notion of a business day is a useful one because of weekends and holidays? Four days does seem like a long time, could we have one time period and it be two business days, which seems ample time, in fact we require it before then for example, to have reviewed anything including lab test results. We can even put in for example our comments about the fact that it's very helpful for patients to have information right away, as soon as the encounter, and what I'm thinking about in particular are changes in your treatment plan like medication changes, which you really do want them to have right as they leave the office because it would be horrible to have a difference between the instructions on your bottle and what's in your record. But, as a compromise to get the simplicity we might say two days after being available.

Michael Barr – American College of Physicians

This is Michael, I think that's more reasonable and makes it simple and not have to do different things and I think that's a little bit more coachable and teachable.

Paul Tang – Palo Alto Medical Foundation

Other comments?

George Hripcsak – Columbia University NYC

Twenty-four hours would become two business days also?

Paul Tang – Palo Alto Medical Foundation

Well, so we're trying to act on the rationale behind not having two time periods that the NPRM is proposing.

George Hripcsak – Columbia University NYC

Right, but I'm not sure what the proposal...

Paul Tang – Palo Alto Medical Foundation

The proposal is within two business days after information becoming available.

George Hripcsak – Columbia University NYC

Including the visit itself? In other words does 24 hours go away or not?

Paul Tang – Palo Alto Medical Foundation

It would go away to support simplicity.

George Hripcsak – Columbia University NYC

Okay.

Christine Bechtel – National Partnership for Women & Families

Or, I guess what George is asking is it within two days of an encounter or two days of it becoming available?

Paul Tang – Palo Alto Medical Foundation

We'd just say two days of the information becoming available, because all the other things that are available instantly like...

Christine Bechtel – National Partnership for Women & Families

So, the encounter, I guess I'm thinking and this is a question for the docs in the room, is it a workflow issue in terms of when they update the record, so can they just wait and not give the information? I mean, in my mind it should become available five minutes after I leave the office but that does depend on somebody updating the chart and all of that right?

Michael Barr – American College of Physicians

It's a workflow issue. I heard of a really innovate practice yesterday as doing incredible stuff, but their docs dictate their notes at the end of the visit or enter the notes at the end of the visit or perhaps the next morning, so all of sudden you've just eaten up your business day if you're the first appointment in the morning. So, we have to allow for some flexibility and I think two business days is very reasonable, get everything available and then as soon as something else becomes available that also gets up within two business days.

Paul Tang – Palo Alto Medical Foundation

Okay.

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

If we could say that because the kind of feedback we get is, well what if I have 99 of my 100 results in within two business days and does it count, does it not count? So, some flexibility and understanding I think is going to come in over time.

Paul Tang – Palo Alto Medical Foundation

Well, so that's why the phrase was after the information is available to the EP. So, let's say you get 19 out of 20 results, then the 19, the time clock starts ticking then.

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

Good point.

Michael Barr – American College of Physicians

When it's available.

Paul Tang – Palo Alto Medical Foundation

Yes, when it's available.

Michael Barr – American College of Physicians

If it takes 5 days then in 7 days it's in the record.

Paul Tang – Palo Alto Medical Foundation

Yeah. Okay, so let me try to, because we had a lot of head nodding, let me try to restate the proposal.

Neil Calman – The Institute for Family Health – President and Cofounder

Before you do that Paul can I ask a question? So, if somebody has a number of lab tests ordered, we're saying that those that are available are released, that as they come in they are being released?

Paul Tang – Palo Alto Medical Foundation

Yes.

Neil Calman – The Institute for Family Health – President and Cofounder

Okay.

Paul Tang – Palo Alto Medical Foundation

Okay, so for part one of the measure for the access to the encounter information for EPs is that it would become available to patients on line within two business days after the information is available to the EP. One timeline, shorter than the four days, yet it's reasonable enough for providers to be able to make and I think in part of our comments, which are like a preamble, is that our expectation is that at the end of an encounter you release as much as possible because that's in the best interest of the patient. Sound good? Great. Okay. Yes, David?

David Lansky – Pacific Business Group on Health – President & CEO

I have a technical question about how this would be measured. The language under where it says new measure refers to unique patients get their information in this timely way.

Paul Tang – Palo Alto Medical Foundation

Right.

David Lansky – Pacific Business Group on Health – President & CEO

I don't really know how that's operationalized? Is there an expectation that if I have four visits during a reporting period that happens four times or at least once?

Paul Tang – Palo Alto Medical Foundation

That's a good question. Did we also have unique patients?

David Lansky – Pacific Business Group on Health – President & CEO

In sentence two.

Paul Tang – Palo Alto Medical Foundation

Right. Let me clarify something else that I have clarified and we actually clarified with Rob Anthony on the phone and in the public testimony we had just a week ago, is that when we use the word available, provided, the word is provide, we in our original Stage 1, and I believe CMS, agrees, and also Rob agreed just last week, when you offer lets say a patient portal and the information is available, at least for part one, you have provided the ability to access it online by making that available. It does not mean that the patient has to have gone through and enrolled, etcetera, if they chose not to or they didn't get around to it, etcetera. So, that I believe was our intent for Stage 1, it was our intent for Stage 2 and as Rob Anthony has agreed that that was their intent as well.

Christine Bechtel – National Partnership for Women & Families

I'm still struggling because I think, I would, if people are okay, and maybe they're not, with making the timeframe simple and consistent, you know, for the two days, but I think it needs to be two days of the encounter or the information being available to the EP because that is how Stage 1 was structured and I'm just worried that if we don't say two business days of the encounter, people will delay providing that on-line information and patients are coming out of their appointment, that's when they're at their highest motivation point. So, I just want to make sure that we don't inadvertently create a problem and I'm wondering if it's okay to actually say both.

Paul Tang – Palo Alto Medical Foundation

How about if we explain, because I think the word is being used in a precise way, the way we're describing it, because it's within two days of information being available to the EP. So, clearly if you change a prescription it's instantly available and that should be within the two days.

Christine Bechtel – National Partnership for Women & Families

To Michael's point, it's not necessarily, if you don't update the record right after the encounter. If you wait to the end of the week to, you know, put everything in or whatever or it ends up...

Michael Barr – American College of Physicians

The information is available at the encounter in that case.

Paul Tang – Palo Alto Medical Foundation

Right. So, what we can do to clarify it, the question you're raising is to put in the preamble what we mean. So, all the information exchange that transpires during the encounter that's the clock.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation

And so within two business days of that encounter you would have all that information, changes in medications, changes in treatment plan, any instructions you had, we'll make that clear, but I think the wording that we've proposed is pretty precise and that explanation would be consistent with that.

Christine Bechtel – National Partnership for Women & Families

Okay, as long as it's...it's not precise to me, so as long as there is an explanation.

Paul Tang – Palo Alto Medical Foundation

Okay. Okay so the question that David raised is do we really mean unique patients seen or do we mean encounters basically? Because the only way you'd count it is based on the encounter anyway. Josh or Farzad do you want to say anything? Okay.

Neil Calman – The Institute for Family Health – President and Cofounder

I guess and maybe you went over this already, so are we basically not putting, if we have a portal available that basically does this, but nobody signs up for it and we don't really try to encourage anybody to sign up for it we still have basically met the requirement?

Paul Tang – Palo Alto Medical Foundation

Until you get to component 2, but yes, so that in Stage 1 our desire was to get stuff made available and so that's presumably what ONC and CMS were thinking about to have this second part of this measure, but yes for phase 1 making it available you can qualify for it.

Neil Calman – The Institute for Family Health – President and Cofounder

But then I thought you said that for phase 2 basically it counts if you make it available?

Paul Tang – Palo Alto Medical Foundation

No, for Stage 2 component 1 of the measure we're talking about.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, right.

Paul Tang – Palo Alto Medical Foundation

It would fulfill.

Michael Barr – American College of Physicians

That's only half of the measure.

Neil Calman – The Institute for Family Health – President and Cofounder

No, I got it, yeah.

Paul Tang – Palo Alto Medical Foundation

Okay. So, I think...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

The reason that they're using unique visits, this is Leslie, the unique visit, as I'm re-reading this it looks like we're saying that the reason it's unique patients is because I could be a patient in chronic care and seeing this information multiple times we want to make sure that that unique patient is what's counted in the denominator, right? I mean 10% of my patients, because one could be using it 100 times and one could be using it once.

Paul Tang – Palo Alto Medical Foundation

So, I think...

Neil Calman – The Institute for Family Health – President and Cofounder

Part 1 is visit, I guess. Part 2 is unique individuals.

Paul Tang – Palo Alto Medical Foundation

No, to me that doesn't look right.

Michael Barr – American College of Physicians

Unique patients...

Neil Calman – The Institute for Family Health – President and Cofounder

No, but I'm saying if we're making part 1 visit then part 2 is really individuals because you're trying to sign up individuals for access to their electronic records.

Michael Barr – American College of Physicians

But, wait, wait, I'm confused now, I'll let you clarify, Paul?

Paul Tang – Palo Alto Medical Foundation

Well let me try to clarify it. So, in practice I think it's going to turn out to be the same because you're basically providing access to a patient. But, David raised the issue of well how are you going to calculate it and then EHR vendors have different ways of calculating these things and it can have unintended side-effects. So, it would be clearer, because the intent is every time you have information exchanged that's available to you, that would fit the model of the visit, an encounter. Other comments about that?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

We want to get as many patients as possible enrolled not a patient who represents 10 visits a week.

Paul Tang – Palo Alto Medical Foundation

Enrolled, right. Correct.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Have them count a higher number. We want more people not more encounters.

Paul Tang – Palo Alto Medical Foundation

Okay, so George, so we're proposing, that we can come and revisit this.

Michael Barr – American College of Physicians

I may still be confused, but as written, more than 50% of unique patients seen by the EP get the timely access, get that, right? So it doesn't really matter how many times the patient is seen because I have a process in place that at least 50% of all my patients are going to always have access to that.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

That's an encounter, we're talking about...

Michael Barr – American College of Physicians

No, no, no it's a unique patient, that's something different. The encounters will flow no matter what, but I'm going to make sure at least 50% of the patients I care for have the ability to view, download and transmit. It doesn't matter how many times they come to see me. It could be a well healthy person who never comes to see me who is a unique patient, may see me once, that may still be necessary. So, you're actually reaching, it's not the 50% of encounters you want, it's the unique individuals you want to have access to their care.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

You're right.

Paul Tang – Palo Alto Medical Foundation

So, let me, one of the questions I think and the issues that David raised is some of these folks could try to qualify based on, and only fulfill it, 1 out of 10 visits that had for example.

Michael Barr – American College of Physicians

No, no that's not what this says though. It says for the 50% of the folks, if I have 100 people, 50% of them will have view to download and transmit no matter 1 visit, 100 visits per patient, they're all going to have that ability, right?

Paul Tang – Palo Alto Medical Foundation

Well, it's two parts, it also means timely access.

Michael Barr – American College of Physicians

Yeah, well but I'm going to have to provide to those 50 of my 100 timely access no matter how many times they come in.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

You're right it's...patients, you're right.

Michael Barr – American College of Physicians

Its unique patients. If you do the encounters you might have 10 people generating 100 encounters in which case only 10 are going to get, you know, 5 of them would have to...if 10 of them provide 100 encounters only 5 of them are going to get unique access.

M

Are you convinced?

David Lansky – Pacific Business Group on Health – President & CEO

I just don't know how you'd measure Michael's formulation of it, but if the vendors can measure it and the EPs can measure it I'm happy.

Christine Bechtel – National Partnership for Women & Families

But the unique patient seen by the EP is like a fundamental building block of Meaningful Use so CMS and ONC have been very prescriptive about how you do that...

David Lansky – Pacific Business Group on Health – President & CEO

How do you determine which of the 100 patients had access?

Yael Harris – Health Resources and Services Administration

Well if you set up a portal whether they use it is a whole other thing but you need to establish that.

Christine Bechtel – National Partnership for Women & Families

It's attestation I think.

M/W

Multiple voices.

Michael Barr – American College of Physicians

Yeah, we're going to talk about the second one in a minute.

Paul Tang – Palo Alto Medical Foundation

Well let me ask David's question in a different way. So, for this one person who we're seeing 10 times, one time you got the information up within two business days, the other 9 times you didn't bother?

Michael Barr – American College of Physicians

No, but what I'm saying is this would say you would have to.

Paul Tang – Palo Alto Medical Foundation

But, see there is no way to measure that.

Michael Barr – American College of Physicians

Well there is no way to measure it either way or by encounter either.

Neil Calman – The Institute for Family Health – President and Cofounder

You would have to say on the 50% to qualify it would have to be on every encounter for those 50%, otherwise you end up with...which is what you're basically saying, to qualify you'd have to qualify by providing it on every encounter for the people that are there and that's...

Christine Bechtel – National Partnership for Women & Families

So, can we write that into our preamble? For clarifying?

Michael Barr – American College of Physicians

Now, practically speaking though, let me ask the systems people, if I'm doing it for one patient it's going to be all of them?

Paul Tang – Palo Alto Medical Foundation

No.

Michael Barr – American College of Physicians

Excuse me?

Paul Tang – Palo Alto Medical Foundation

No you cannot meet the timeliness requirement, which I think is the driving piece for component one. So, here's an example of how it's measured. It becomes released to the patient in many systems; at least most of the one's I know, when you "close" when you authenticate the encounter. So, there's an easy measurement between encounter and the time you close and make it available, that's easy. It would be a more complex calculation to say, for the 10 visits how many did they get, you know, I mean the driving part I see for this is getting the information, one on on-line and two in a timely way and the measurement I

think is easier to look at by encounters, because otherwise then you are taking up a proportion of patients and do you get counted as a unique patient if you had 1%, 10%, 100%?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Then there are two things then you are saying really, the unique patient ID it seems everyone agrees to in both measures or areas, but the timeliness is not by unique patient, the timeliness is by encounter.

Paul Tang – Palo Alto Medical Foundation

By an exchange of information.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, how do we word that in a way that says that the timeliness is when...because that is how you'd be measured?

Christine Bechtel – National Partnership for Women & Families

So, right now the measure reads more than 50% of all unique patients seen by the EP during the reporting period are provided with timely online access to their health information subject to EPs discretion to withhold certain information, would we not simply suggest putting timely access to their health information after each encounter?

Paul Tang – Palo Alto Medical Foundation

Well, you're getting back into the...

Christine Bechtel – National Partnership for Women & Families

But, I think that was our intent.

Paul Tang – Palo Alto Medical Foundation

Let me try to rephrase it using an encounter basis, okay?

Michael Barr – American College of Physicians

Okay.

Christine Bechtel – National Partnership for Women & Families

On reading the measure?

Paul Tang – Palo Alto Medical Foundation

Yes, measure one. For more than 50% of encounters, information is made available to the patients...

Michael Barr – American College of Physicians

No, Paul, if a measure looks at all encounters, all encounters, okay, and can get a measure of timeliness from that, as you said a stamp, and then look at how many unique patients does that represents compared to all of the unique patients that the practice has or that an EP has then you have timeliness and you have 50%, you can measure both.

Christine Bechtel – National Partnership for Women & Families

Fifty percent of what?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Patients.

Michael Barr – American College of Physicians

Of unique patients.

George Hripcsak – Columbia University NYC

So, a couple of things, one is if you count encounters then every lab test that comes in is another encounter presumably because it starts at a different time.

Paul Tang – Palo Alto Medical Foundation

...an office visit.

George Hripcsak – Columbia University NYC

But there's other lab tests coming in independent of office visits which are covered by this but not covered by encounters and may come in a week later.

Paul Tang – Palo Alto Medical Foundation

It's generated by the encounter.

George Hripcsak – Columbia University NYC

Okay, but it's a set of timelines it's not one time, in other words its two days from the encounter and then two days from each of the tests coming in, so it gets complicated even if you do encounters is what I'm saying. There's a set of timelines for each encounter. A little worry is that for unique patient does that mean if they missed...if they have a thousand pieces, you know, of data and they miss on one that means they didn't meet the objective for that patient? I'm a little worried about that.

Paul Tang – Palo Alto Medical Foundation

The problem is even worse if you do it by patient.

George Hripcsak – Columbia University NYC

Yeah, yeah, right.

Paul Tang – Palo Alto Medical Foundation

I think if you tee everything off the encounter you can measure this and I'm not sure what we would be missing as far as from a patient point of view. So, let's say one patient came in at 1000 and that's all this doctor did for the entire 3 months, still what you're trying to do is get information to people where you're generating information.

George Hripcsak – Columbia University NYC

The choice of patient or encounter should be according to the ease of measurement.

Paul Tang – Palo Alto Medical Foundation

Yes.

George Hripcsak – Columbia University NYC

I'm not sure that we can figure that out right this second which is easier or more practical. And if you had 50% anyway if there is slight bias in one direction or the other I don't think it matters that much if you're at 50%, you know, like 50% is such a middle range, if there's a couple of patients who have a lot of encounters it's not going to have a big effect on the persons practice. So, I think we should suggest to CMS that they adopt whatever is most measurable for each patient encounter.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Perhaps it's two sentences, guys, maybe it's more than 50% of all unique patients seen by the EP during the EHR, the information is made available in a timely way period. Timely access means within an encounter or within two business days from information available it was released to the patient. So, I think that we're trying to have two concepts in one sentence.

Paul Tang – Palo Alto Medical Foundation

Do you have any idea of how it's working in Stage 1, measurement?

Michael Barr – American College of Physicians

That would be an important piece of information.

Christine Bechtel – National Partnership for Women & Families

Well it's just a menu option and most people deferred, that's the problem, right?

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

It was challenging in Stage 1 because of trying to figure out when having either to put another data field in trying to figure out when the start time, the encounter stuff is straightforward, it's the add on stuff that is really hard and trying to make sure does that show up within the desired timeframe or not? But, I think they took that as a more concrete timeframe not a rolling timeframe. This is a rolling timeframe. So, I think this Stage's 1 problem was it had to be in within this fixed window where now we got a rolling timeframe.

Paul Tang – Palo Alto Medical Foundation

So, if we make it an encounter basis, I'm thinking about George's question, if we make it encountered based then it's an all or nothing for that encounter. So, it's that encounter, you get two business days for everything that was discussed at that encounter to make it available. If lab tests were ordered and they get resulted, all of those things that come in later must meet the two days or this encounter fails in terms of information going to the patient. That seems straightforward and measurable because you have a timestamp for everything, the encounter and the resulting time and the release time.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...necessarily.

Paul Tang – Palo Alto Medical Foundation

Pardon me?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I don't know how easy that would be to do a report on all of that.

Paul Tang – Palo Alto Medical Foundation

I think that all of those things are time stamped automatically, so I'm thinking that...

Yael Harris – Health Resources and Services Administration

I'm wondering if we could add a caveat about establishing a portal, I'm wondering if the 50% are some people, even though it's just easy, are some vendors going to say okay it doesn't establish a portal for every patient and I'm worried about not clarifying that, because we just said, you know, everyone has access to this information and then we're saying 50%, so what if I picked those patients that are low hanging fruit that I doubt are going to come back again and have very few labs, I didn't order lab tests for them, etcetera, and then just give them access to the information.

Paul Tang – Palo Alto Medical Foundation

Well, we're not trying to get all the...

Christine Bechtel – National Partnership for Women & Families

...give away things.

Yael Harris – Health Resources and Services Administration

I mean for the large vendors it's just easy, establish, you know, a patient portal for everyone, but I wonder if there are some that are just going to say, its added work to establish that portal and therefore only establish 50% of the patient a portal for the...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Or there could be some who use Direct and send information directly to the patient and no portal is involved or they use a...player, so dictating a delivery method I don't think, I think that's too prescriptive, dictating the what, which is want 50% of the patients to have access to the information in a timely way, right? Is good. Defining too prescriptively how, then we are mandating more expense than perhaps is necessary to meet the objective. So, there are other ways to do it besides a portal.

Paul Tang – Palo Alto Medical Foundation

Christine?

Christine Bechtel – National Partnership for Women & Families

So, my sense is that, you know, I think everybody is largely trying to do the same thing but we're not sure what kind of loopholes we might inadvertently create. So, I'm going to come back to what I said, which is think we need to be clear and suggest to CMS that they come up with whatever works to achieve the two objectives we're talking about which is timely access, you know, two business days of the encounter or the information available, but also, you know, you want, I think our intent or at least certainly mine, and the way the rule reads is actually 50% of patients.

Let CMS figure out the measure, because I'm a little bit worried that if we suddenly say switch to an encounter-based denominator, what does that do to the rest of the measures? What does it do to the next one coming up? That's not, I think, been part of the Meaningful Use construct yet and I just feel like we're getting way hung up in the weeds. Let's just be clear about what we're trying to achieve or table it until we can figure it out.

George Hripcsak – Columbia University NYC

My opinion is we should just let CMS figure out what's easy to measure and let them do that, but we need to fix the business day thing, so I agree with that, but as far as the denominator, that's what the NPRM is going to be reporting on, I mean the public comment period is going to be reporting on and that's one of the things people have commented on. So, I think we're not going to solve this. I do have a question, the objective says 24 hours here, I'm sorry if I missed that, but I don't think the NPRM doesn't say that, right?

Christine Bechtel – National Partnership for Women & Families

Correct.

George Hripcsak – Columbia University NYC

Okay, good, thank you, great.

Michael Barr – American College of Physicians

Paul, a question?

Paul Tang – Palo Alto Medical Foundation

Yes.

Michael Barr – American College of Physicians

Looking to the new ways people are practicing medicine and the fact that an encounter is not always a physical encounter, and this specifically says when the patient is seen, wonder if we want to offer a comment about whether, you know, electronic communication, structured e-mail, telephone, which also could change a care plan, should also be reflected in terms of the update?

Paul Tang – Palo Alto Medical Foundation

I think there was a definition in the NPRM. Is that right?

Josh Seidman – Office of the National Coordinator

It goes back to Stage 1 it was just defined specifically as an in person encounter.

Yael Harris – Health Resources and Services Administration

Well maybe the word should be consult, consulted...

Michael Barr – American College of Physicians

Well, I mean some of the language we used, at least in our conversations was relevant interaction including an encounter or something, where something was changed. I mean, because if the whole idea is to give up-to-date information to a patient and a family, or authorized representative, you could have a

whole series of conversations with a home health nurse and that would not be reflected in any of this in terms of the requirement update of the record.

Yael Harris – Health Resources and Services Administration

I think we used the word encounter and then define what we mean by encounter, which could include the following.

Paul Tang – Palo Alto Medical Foundation

Yeah, there can be a lot of those.

Yael Harris – Health Resources and Services Administration

The “seen” implies an office based visit.

Paul Tang – Palo Alto Medical Foundation

Correct. Correct. So, let’s try to be specific. So, let’s enumerate some of these encounters. There is obviously the office visit, there is a telephone encounter, there is an on-line encounter, there are home visits. So, just dealing with those let’s think that through. An on-line encounter, well it’s on-line it should be there, I mean, actually it’s automatically there, because that’s how you got it in there. So, that almost is a given.

Michael Barr – American College of Physicians

Well, no if it’s an electronic health record it may not be reflecting whatever communication strategy portal they’re after, otherwise to the patient.

Yael Harris – Health Resources and Services Administration

Secure e-mail is going to capture it.

Michael Barr – American College of Physicians

It’s just like generating a progress note.

Neil Calman – The Institute for Family Health – President and Cofounder

Maybe we should specify what’s happening during it rather than how it happens. So, you know, an interaction with a patient that generates a change in the plan, an order, you know, just sort of specify what we’re talking about, because those are the things that are important, a change in somebody’s therapeutic regimen or an order is really what we’re...

Paul Tang – Palo Alto Medical Foundation

Okay, so how would the computer know this? So, let’s say you want them to measure your glucose twice a day, that’s not going to be in an order, it’s going to be in your notes. How is the computer?

Neil Calman – The Institute for Family Health – President and Cofounder

But it’s a change in the person’s therapeutic regimen.

Paul Tang – Palo Alto Medical Foundation

I understand, but how will the computer know to capture that and know that that is in the denominator or numerator?

Neil Calman – The Institute for Family Health – President and Cofounder

You know what, it’s like, I mean if we get too precise with that stuff, I think we have to call out what we mean.

Paul Tang – Palo Alto Medical Foundation

Well, but one of the things that I think CMS pointed out was that when we’re not very precise, I mean they’re going to have the same problem we are and if we’re not precise in how we specify concepts that they could measure, it just generates, either it leaves ambiguity in the rule or it generates a lot of work for them that we should think about ahead of time.

George Hripcsak – Columbia University NYC

So, here's the, I think this is the definition in the NPRM, it's kind of vague.

Paul Tang – Palo Alto Medical Foundation

Well read it.

George Hripcsak – Columbia University NYC

We define patient encounters, any encounter where a medical treatment is provided and/or evaluation and management services are provided, this includes both individually built events and events that are globally built but are separate encounters under our definition. So, the key thing is an encounter where medical treatment is provided and/or evaluation and management services are provided.

Neil Calman – The Institute for Family Health – President and Cofounder

That doesn't solve the problem we just raised.

Paul Tang – Palo Alto Medical Foundation

No it does, because if you submit a bill...

George Hripcsak – Columbia University NYC

It says includes...restricted to.

Paul Tang – Palo Alto Medical Foundation

Any time you generate a bill obviously your system knows about it and it's countable.

George Hripcsak – Columbia University NYC

But it says includes, it doesn't say restricted to.

Christine Bechtel – National Partnership for Women & Families

Right, because e-visits, some of the things that Michael was referring to.

Paul Tang – Palo Alto Medical Foundation

Well over time...

Neil Calman – The Institute for Family Health – President and Cofounder

So, that eliminates most phone encounters at this point.

George Hripcsak – Columbia University NYC

It doesn't eliminate, because it just says includes, it doesn't say restricted.

Neil Calman – The Institute for Family Health – President and Cofounder

Well then it doesn't solve the problem.

Paul Tang – Palo Alto Medical Foundation

Yeah and the other thing is we are going to the ACO kind of world so there won't be "bills."

Neil Calman – The Institute for Family Health – President and Cofounder

That's why I think we can't really specify the types of interactions. There's going to be video interactions, there's telemedicine interactions, there's all kinds of things. I think you basically want to say what it is we expect to be recorded in the record and that would be a change in therapeutics or orders.

Paul Tang – Palo Alto Medical Foundation

Why don't we just say orders then, because that's a measure and countable.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Or status, a change in health status or...

Paul Tang – Palo Alto Medical Foundation

Well that's not measurable.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

You're not going to have the nurse have the discussion with the patient necessarily. There might not be an order specified for a care plan because there is no drug or diagnostics associated with it, there is simply instructions to the patient. So, we want the patients to be informed, we want them to be instructed about their care, we want them to have the tools to take care of themselves when they're not in the office. How do we?

Paul Tang – Palo Alto Medical Foundation

Okay, let's think of how to measure these things though. An order is measurable at least and most of times it is going to be either for a lab test or a drug and we do want them to enter changes in medications through in order.

Neil Calman – The Institute for Family Health – President and Cofounder

I would be satisfied with that. I mean, I think we have to do something that's doable and measurable and that's the simplest way and if people are doing that they're going to be doing other things as well. I mean we've got to get...

George Hripcsak – Columbia University NYC

What did we end up with?

Paul Tang – Palo Alto Medical Foundation

Okay so it looks like...so encounters and our definition of encounter in this regard is office visits and other encounters where orders are generated. Michael is that good with you?

Michael Barr – American College of Physicians

I think so. I'm also looking at page, whatever page this is...

Paul Tang – Palo Alto Medical Foundation

What page?

Michael Barr – American College of Physicians

Page 44, is this where you were reading from before, George?

George Hripcsak – Columbia University NYC

I read from 40, maybe 44 has...

Michael Barr – American College of Physicians

Forty-four says an office visit is defined as any billable visit, includes concurrent care and transfer of care visits, consultant visits, prolonged physician service without direct face-to-face patient contacts, for example telehealth.

George Hripcsak – Columbia University NYC

So, office visits is probably a subset of encounters?

Paul Tang – Palo Alto Medical Foundation

Correct.

George Hripcsak – Columbia University NYC

Yeah.

Paul Tang – Palo Alto Medical Foundation

Okay. So, our definition for this and we'll see if it holds up in future objectives, but our definition of an encounter are office visits and other contacts with the patient where an order is generated? Okay, so let's move to the next component, so what we now have, so in measure one, we have the concept of it goes by unique patients and we are providing timely access within two business days of information becoming available. In the preamble we describe that all the information discussed in the visit is available at that point. Okay, measure two, and this is a new thing that CMS explained that we're now...

Christine Bechtel – National Partnership for Women & Families

...

Paul Tang – Palo Alto Medical Foundation

I'm sorry...yeah. So, more than 10% of all unique patients seen do actually view, download or transmit their health information. So, I think the only addition here is the transmit. Am I correct?

Christine Bechtel – National Partnership for Women & Families

Yeah, well I think they're actually two differences, one is what the Policy Committee said was 10% view and have the ability to download, so it was really counting view only and so in this way what CMS and ONC are proposing is actually giving a little bit more flexibility, you can count in your 10% not just views, but people who view, or download, or transmit, because they're assuming, I think Leslie mentioned earlier, that you could have it sent to Direct or something like that without the patient actually viewing. So, it actually gives you an ability to count more in the 10% number and then the other difference that I picked up is the authorized representative, which I think is right on. That the people who are authorized to do that, a caregiver, a family caregiver or whatever would also be counted in that measure.

Neil Calman – The Institute for Family Health – President and Cofounder

So, what does it mean for somebody to transmit their health information?

Paul Tang – Palo Alto Medical Foundation

I think that's the Direct thing.

Neil Calman – The Institute for Family Health – President and Cofounder

So, they don't actually get it, but they transmit it to somebody else?

Christine Bechtel – National Partnership for Women & Families

Well they might transmit it to another portal or provider, they could transmit it to their personal health record so that you're not just looking at your, you know, information just from your cardiologist but your having the cardiologist transmit into a personal health record or your primary care doctor something like that.

Neil Calman – The Institute for Family Health – President and Cofounder

I just want to make sure that having health information exchange alone doesn't satisfy this, because basically, if their information is transmitted they're not looking at it or getting it or whatever but it's being exchanged in some other way, could that be interpreted as satisfying this part of the measure?

Christine Bechtel – National Partnership for Women & Families

Well this is the number of patients who have viewed, downloaded or transmitted.

Neil Calman – The Institute for Family Health – President and Cofounder

Right.

Christine Bechtel – National Partnership for Women & Families

Not the number of providers who have done that, you know, without the patient being involved. So, I think...

Neil Calman – The Institute for Family Health – President and Cofounder

I know.

Paul Tang – Palo Alto Medical Foundation

So the objective actually says provide patients the ability to view, download or...

Christine Bechtel – National Partnership for Women & Families

No, no.

Yael Harris – Health Resources and Services Administration

The objective says that the measure is for the doctor to get them to download.

Christine Bechtel – National Partnership for Women & Families

Right, it is the number, the numerator is the number of unique patients or their authorized representatives and the denominator who have in fact viewed, downloaded or transmitted to a third-party the patient's health information.

Neil Calman – The Institute for Family Health – President and Cofounder

So, I'm just being very specific, so if I've authorized my provider on my behalf to do that, does doing that through exchange satisfy this? Because, basically, they haven't viewed it or downloaded it but they've transmitted it through an authorized representative, which is their provider.

Paul Tang – Palo Alto Medical Foundation

If the patient is the one that authorized that, then I think you're right, that it would qualify.

Neil Calman – The Institute for Family Health – President and Cofounder

Which I wouldn't want, because that really is a completely different objective, that the use of exchange and stuff is a totally different objective. For somebody to sign an authorization to have their information transmitted to another provider shouldn't meet this objective because that's not.

Christine Bechtel – National Partnership for Women & Families

But, what if it's in the portal of another, a patient portal of another provider? Right? Because the thing that I worried about in Stage 1 is that we were creating a ton of silos where I've got 7 portals and no way to pull everything together or even have a place to do it. So, download might help me on that, but if it became easier I could...and this does say the patient is the one transmitting, so I would have to logon to I guess a portal or whatever and say send this to Microsoft HealthVault, but I don't think that counts as exchange. Neil, I understand what you're saying and so maybe we would need to...

Neil Calman – The Institute for Family Health – President and Cofounder

I would just like it to clear that that's not...

Christine Bechtel – National Partnership for Women & Families

Right, clarify that the recipient is some sort of patient facing thing. Is that what you're saying? As opposed to?

Paul Tang – Palo Alto Medical Foundation

Well, its patient directed.

Arthur Davidson – Denver Public Health Department

Yeah, I'm a little unclear about this also, it's obvious when you say view and download that it's the patient doing the work and that was our intent when we started down this path, but now we're getting to transmit and we're saying that...I like the idea that, you know, Direct could be a solution, but that's an activity that is happening from the providers point of view that could be counted as toward this effort, is that right?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

What I'm suggesting is that Direct could be a mechanism to send secure e-mail to patients, not just provider to provider and so that would be one way to get that information to the patient where

They don't have to view it on a portal or download it from a blue button they can see it in their preference, which is e-mail.

Arthur Davidson – Denver Public Health Department

Right, but the thing is that the transmission is actually the provider doing the transmission not the patient.

Christine Bechtel – National Partnership for Women & Families

I actually think that's not what the rule says.

Arthur Davidson – Denver Public Health Department

Well, I think we need to...you know, this is a little bit confusing here as we start to tease this out.

Christine Bechtel – National Partnership for Women & Families

It says a patient who views their information on-line downloads it from the Internet or uses the Internet to transmit it to a third-party would count for the purposes of the numerator. So, a patient who uses the Internet to transmit it to a third-party.

Arthur Davidson – Denver Public Health Department

So, how would we count that a patient transmitted it? They have to transmit it from the provider's system is that what we're saying? Because if you do it Direct to my PHR and then I transmit it to another place I have no way to count that from a provider's point of view.

Christine Bechtel – National Partnership for Women & Families

Why not? Why not?

George Hripcsak – Columbia University NYC

So, a couple of things, first of all if they download their information there's no guarantee that they're going to look at it. They could just download it and ignore it. If they look at it, they might not read it, they might just glaze through it, you know, so we can't get too prescriptive. If the meaning of transmit is get it to my PHR like my health vault account and count that towards this, because that would be legitimate, then I think that's okay.

I don't think it means provider to provider transmission where the patient gives like a little bit of an okay and then they never see the stuff; I don't think that's what was intended by this. It's mainly like a health vault probably kind of model where they wanted to see that and it's included, we would have just called that download, we would have included that kind of a transmission in what we meant by download, here they're being more explicit and calling it transmit. So, is there anything we have to say transmit doesn't mean. I have to look at the definition of transmit again, because actually it didn't sound too bad the way you read it. Where was it, it was 96, right?

Michael Barr – American College of Physicians

On page 94 it says transmission can be any means of electronic transmission according to any transport standard, SMTP, FTP, REST, SOAP, etcetera, however, the relocation of physical electronic media for example USB, CD does not qualify as transmission although the movement of the information from on-line to the physical electronic media would be a download.

George Hripcsak – Columbia University NYC

All right, but that is defining transmit, but the part that you read I think is more to the point here.

Paul Tang – Palo Alto Medical Foundation

What page are we on?

George Hripcsak – Columbia University NYC

Ninety-six.

Christine Bechtel – National Partnership for Women & Families

The bottom of 96. So, a patient who uses the Internet to transmit their information to a third-party would count. I mean to the point of counting, you know, how does the computer count? I mean, so in the column that you need a giant magnifying glass to read, it does say that the technology would have a way to track the action or actions that occurred. So, just like CMS has the download button where you can click on the download button and they can count that, you could have the transmit button and click on that and then the computer can count if I viewed it, downloaded or transmitted it.

M/W

Multiple voices.

David Lansky – Pacific Business Group on Health – President & CEO

The certification criteria says that...

Christine Bechtel – National Partnership for Women & Families

Action...

David Lansky – Pacific Business Group on Health – President & CEO

You have to have a log of transmission. So, that is theoretically enabled by the technology. To Neil's earlier point, the nature of who is the authorized representative might be something we want them to clarify, because the language now does not exclude the provider from being the authorized, what was probably implicit is that the authorized person is not the provider, but we could ask them to make it explicit.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But, if the patient does take it, let's say it's a Direct model and the patient received it in their in-box, they have the right to do whatever they want with that with no tracking whatsoever. So, we want to make sure that idea of once I have it its mine does not require a burden of now I've got to track where that gets transmitted and how it gets transmitted.

Christine Bechtel – National Partnership for Women & Families

But, that's not what...

Paul Tang – Palo Alto Medical Foundation

So, Art did you...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

That's I think what...

Arthur Davidson – Denver Public Health Department

Well, I'm still a little confused about it, so if I have the Direct sending it to my PHR, how does the EHR or the provider count what is happening after? Does that transmission itself it? Is that it?

M

Yes. Yes.

Arthur Davidson – Denver Public Health Department

So the patient didn't have to do anything, they just said I signed up for you to send me Direct, that's the 10% of the patients signed up for sending this directly to me. There is no way, there's is no blue button...if there's no patient portal there's no blue button to send data, it's just that you set up a system to transmit via Direct to a vault. The only thing you can count is the number of transmission that went out to the vault; there was no button that said the patient asked me to send that information.

Christine Bechtel – National Partnership for Women & Families

I'm not exactly sure that I understand your question, but let me just point out a couple of things. What the standards and certification rule says is enable a user to provide patients and their authorized representatives with on-line access to do all of the following, A-view and then it defines the data that you

have to have in view. B-download, electronically download, you know, a human readable file, blah, blah, blah, so then it says, you know, ambulatory and inpatient and what you have to do in all the data. And then C-transmit to a third-party, electronically transmit the summary care record created, you know, with the fields above or images available to download in accordance with and then they give two standards and it has to have a patient accessible log, and when you either view, download or transmit to a third-party using those capabilities, then the computer has to record and make available to the patient information about the electronic health information that was affected by the actions, the date and time each action occurred in accordance with a particular standard, the actions that occurred and user identification.

Arthur Davidson – Denver Public Health Department

So, thank you for going through this. So in one part there it says “and” transmit and in another one it said “or” transmit and I think we had that question earlier.

Paul Tang – Palo Alto Medical Foundation

I think they did a typo, so I think it should be “or.”

David Lansky – Pacific Business Group on Health – President & CEO

For certification it says “and.”

Christine Bechtel – National Partnership for Women & Families

For certification it says “and.”

Paul Tang – Palo Alto Medical Foundation

No, no, no for certification it’s “and” but for the objective it should be an “or.”

Christine Bechtel – National Partnership for Women & Families

Right, it’s a typo on the spreadsheet, in the rule it is an “or.”

Paul Tang – Palo Alto Medical Foundation

Well, actually no, in the rule it’s an “and” as well.

Christine Bechtel – National Partnership for Women & Families

In the rule it’s...

George Hripcsak – Columbia University NYC

Wait, the way it’s written, you want “and” transmit in the objective and “or” transmit in the measure, right? You want “and” because you want to say they have ability to do this, and this, and this and you have “or” when you measure it because that’s what you’re going to count.

M/W

Multiple voices.

Arthur Davidson – Denver Public Health Department

If that’s true than what Leslie said earlier about Direct cannot be in itself a solution, if that’s true, because then you need to have a patient portal for view and download, you can’t do Direct as a solution here. We’re setting up a pretty prescriptive approach. If it has to be all three then the patient has to see into the EHR.

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

So, I just want to, we’ve been trying to think that one through, because again, we have customers who don’t have a portal or they have multiple portals and the patient doesn’t want to see a separate record. So, in the market there is an HIE and the intent is that they will send, via Direct or whatever mechanism the summary of care record to the HIE and that will be the place that the patient goes. Our expectation therefore is going to be that, that provider has to contract with the HIE to provide view and download capability and they will actually have to do the counting of the access view and download or whatever it is

capability, so it will be a contractual relationship with the HIE, which is certified, to provide that capability. So, you don't necessarily...at least in thinking it through how it's going to have to work, so it doesn't necessarily mean that every system has to have a portal. They can send that information out via Direct to a shared portal and then, you know, go on from there. So, that's kind of how I'm interpreting it, or an exchange.

George Hripcsak – Columbia University NYC

So, what goes along with the one thing that both Neil and Art are saying that I do worry about is if you can sign up for a subscription and that shouldn't count as view, download or transmit, in other words if at the beginning you meet the doctor, who says "do you want to sign up for this thing where I'll send your information God knows where" they say "yes" that counts in their 10%, because that's really the ability, not the action, that's kind of what you were saying "how do I know they've ever looked at it."

I think if what they're doing is they're sitting at their home, they go on-line and they say to send this thing to some third-party that's going to do my cardiac risk score, but I never look at the data, but I send it to some third-party cardiac risk guy, I think that does count. It's just this idea of subscription that then I never even remember that I signed up for it and it just kind of goes off somewhere in the Internet and that then counts toward view and download, that would not be the intent I think of what we're talking about.

M/W

Multiple voices.

Neil Calman – The Institute for Family Health – President and Cofounder

Or somebody agrees to send it to the HIE but they never sign up for the portal from their HIE, but that's basically met the requirement.

George Hripcsak – Columbia University NYC

And the people who don't allow the HIE part would be meeting a much harder objective, which is to actually have patients look at their data, 10% of their patients look at their data, that's a very hard objective in my opinion.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

It's very hard to get people to come to something, right? How do we right now in business want our data? We're very prescriptive, right? I want it either in my e-mail interface, I might have all my e-mails come to my e-mail in one interface, but I choose how I want to receive it and I think we need to make sure that this kind of flexibility, we're not so prescriptive that we don't allow a patient to determine how they'd like to receive that information. So, I know for one, I want my lab results coming into a secure e-mail; I'm not going to go to a portal.

George Hripcsak – Columbia University NYC

So, that's true and so if they sign up to have all their data sent to their e-mail, I guess that should count and we have no way of knowing does that go to an e-mail that they care about or an e-mail account that they don't care about, it's not our job to figure that out.

Neil Calman – The Institute for Family Health – President and Cofounder

Exactly.

George Hripcsak – Columbia University NYC

So, from a measurement point of view we may have to allow transmission and subscription even though it's not really our intent that it goes to nowhere. You know, it's maybe a loophole where you can game the system a little bit, but...

Neil Calman – The Institute for Family Health – President and Cofounder

You can't tell what they do at the end of the day.

George Hripcsak – Columbia University NYC

Right, even if they download it to go to nowhere.

Michael Barr – American College of Physicians

This is Michael, I would say even for the view, the docs could go ahead and show them what it looks like while they're still in the office, that's a view, and they may choose never to go back to it again. So, I think we're setting up a lot of work for potentially not so much gain. I think the better emphasis would be to focus on building the best ability for view and download and people will come to it if they find value in it. I'm not sure that we're building all this to measure 10%.

Neil Calman – The Institute for Family Health – President and Cofounder

Okay, so just to clarify your other opinion, it is "and" and "or" correctly stated in the NPRM?

Michael Barr – American College of Physicians

Yes.

Neil Calman – The Institute for Family Health – President and Cofounder

The objective is "and" and the measure is "or" which is what you want the objective to be "and" because you want to have all of those capabilities, but you want it to count if they do any one of the three, right? But it's correctly written in the NPRM.

Paul Tang – Palo Alto Medical Foundation

Okay, so let's go back to transmit, have we settled on what counts for transmit? Well, have we settled that transmission is satisfying the objective that we had for patients to get access to the data? I think what you're saying is "yes."

Christine Bechtel – National Partnership for Women & Families

Well, I think that's part of the question that people are raising.

Paul Tang – Palo Alto Medical Foundation

Yeah.

Christine Bechtel – National Partnership for Women & Families

I think people are saying, what I'm hearing is view or download gives some confidence that an individual is actually logging in somewhere, looking at stuff, doing something with it. That the piece about transmit is if you have to do the same thing in order to transmit then fine, but if you can just simply say here is where I want it to go every time, I think where people are struggling is yeah but we really want patients to engage in their health information and should that count toward the 10%? I think the distinction is it is absolutely reasonable to allow somebody to say I want my data to go over here so just cc me, you know, every time my record gets updated. So, I think that fine.

I think whether or not though that counts towards the 10% of patients viewing and/or downloading is the question that we need to wrestle with, because it is what we said previously, which is 10% view and have the opportunity to download, so that's consistent. Whether or not transmit sort of creates another issue is I think the question.

Paul Tang – Palo Alto Medical Foundation

Well, I think the intent is to have people avail themselves of the opportunity. So, part one was make it available, provide the functionality. Part two is saying, you know, have evidence that a certain percent is availing themselves of that opportunity. So, if they do sign up, you know, transmit to a health vault that's availing themselves or transmit to my e-mail service provider, that's availing themselves, so I would think those things count.

Deven McGraw – Center for Democracy & Technology – Director

I would count them too; this is Deven on the phone, especially since the patient usually has to set that up for it to happen.

Michael Barr – American College of Physicians

So, can I ask a question? To make sure I'm clear. So, if we say view, download or transmit, a unique patient, 10% of them, according to the measure two, could choose one of those three and they would all be, so it's not...okay, all right...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I'd like to clarify I disagree with the view in the office. If I turn my laptop around to the patient and say here you go, I would then observe in the chart...

Michael Barr – American College of Physicians

I'm just pointing out what could happen if people wanted to game the system not that I'm suggesting it.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right, I think you'd have to demonstrate that the patient was viewing. So, for instance if I'm an EMR provider I'm logged in as myself.

Michael Barr – American College of Physicians

Right, but if I...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Unless I actually turn it to the patient, the patient logs into their own ID and does it...

Michael Barr – American College of Physicians

Right, would that count?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

They would have to log into their own, yes.

Paul Tang – Palo Alto Medical Foundation

That does count.

Michael Barr – American College of Physicians

Yeah, sure. So, right here's how you sign on, sign on, here's your...that's a view.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes.

Michael Barr – American College of Physicians

Now they can choose to go back there or not.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Michael Barr – American College of Physicians

Now, I want to get into the percentage if you will, but I...

Paul Tang – Palo Alto Medical Foundation

Okay, so we now know what view, download and transmit is. Okay fine, now we can talk about the 10%.

Michael Barr – American College of Physicians

Question, assume we have 100 patients combining these two measures, right? I provide 50% of them access ability to view, download or transmit, oh and transmit, sorry, and then I say 10% have had to do that. So, if 50 of my 100 have access, is it 10% of the 100 in my whole practice which would be 10 or is it 10% of the 50 in which case it would actually be 20% of my total practice?

Paul Tang – Palo Alto Medical Foundation

Well, first of all it's only 10% of the people you've seen.

Michael Barr – American College of Physicians

Seen, right. So, I've seen 100 patients.

Paul Tang – Palo Alto Medical Foundation

Yes.

Christine Bechtel – National Partnership for Women & Families

It's all unique patients, yes.

Michael Barr – American College of Physicians

But, all unique patients, but again if I only provide 50% of them.

Paul Tang – Palo Alto Medical Foundation

I think it's 10% of 100.

Christine Bechtel – National Partnership for Women & Families

Yes.

Michael Barr – American College of Physicians

So, that would mean I'd only have to have 10 people, right?

Paul Tang – Palo Alto Medical Foundation

That's correct.

Michael Barr – American College of Physicians

Which would actually be 20% of the people who I have provided access to.

Paul Tang – Palo Alto Medical Foundation

That's correct.

Michael Barr – American College of Physicians

So, it means...

Paul Tang – Palo Alto Medical Foundation

That's the way it's defined here.

Michael Barr – American College of Physicians

Sorry?

Paul Tang – Palo Alto Medical Foundation

That's the way it's defined here.

Michael Barr – American College of Physicians

Right, so that means 20% of the 50, 10 of the 50 would have to have viewed, downloaded or transmitted.

Paul Tang – Palo Alto Medical Foundation

Correct.

Christine Bechtel – National Partnership for Women & Families

Well yes, but I think, Michael, the 50% is an "at least."

Michael Barr – American College of Physicians

I understand, I'm just trying to make it very concrete as to what we're asking of practices.

Christine Bechtel – National Partnership for Women & Families

Right, but by the same token it is not the case that this says hey you provided access to 80% of your patients and then now suddenly it's 10% of the 80 and that's even...you know, what I'm saying, so it is 10% of all unique patients and if you did it for 50 then yes it's 20% of those, but you may have done it for more than 50.

Paul Tang – Palo Alto Medical Foundation

Okay, so I think the question on the table is 10% the right threshold?

Christine Bechtel – National Partnership for Women & Families

And it's the same as what we proposed, right? I can't remember, yeah.

Paul Tang – Palo Alto Medical Foundation

Correct.

George Hripcsak – Columbia University NYC

The truth is it's very hard, it is very high, but we already went through this and decided 10% once and now it's maybe slightly easier because of transmit.

Paul Tang – Palo Alto Medical Foundation

Yeah the only change is transmit in this instance.

George Hripcsak – Columbia University NYC

Yeah, the only thing we did was make it slightly easier. We didn't make it harder.

Christine Bechtel – National Partnership for Women & Families

Yeah.

George Hripcsak – Columbia University NYC

CMS made it a little easier not a little harder, so. We'll see by the NPRM comments from the public whether it is felt to be...

Michael Barr – American College of Physicians

I can anticipate provider groups saying this is all or none thing. So, if I don't meet this particular measure, where I'm now completely out of my control as to what happens. I know we can say that I can try to encourage people to it do it, you want us to be engaged with the patients, you know, there's some validity to that, but this is all or none. If the clinicians or EPs do not meet this particular one or any of the others we'd be held responsible for the activities of the patient they lose everything. There is no gray area here.

So, I do think you're going to get significant pushback on this responsibility on the patient, I'm sorry on the EPs to have patients do certain things, depending on the patient population, if they are 80-year-old geriatric patients, they may not want to do this and this is a real challenge for some practices starting from health systems can do this, they are having trouble, if you think about all the small practices around the country trying to get their physicians, I'm sorry their patients 10% of them to do this, I afraid that we're going to lose some folks.

Christine Bechtel – National Partnership for Women & Families

Can I raise another issue before we move on?

Paul Tang – Palo Alto Medical Foundation

Sure.

Christine Bechtel – National Partnership for Women & Families

And that is the definition of a patient authorized representative or not definition, but designation. It says any individual, so we defined patient authorized representative as any individual to whom the patient has granted access to their health information, examples would include family members, an advocate for the

patient or another individual that they identify and they would have to affirmatively grant access to these representatives with the exception of minors.

So, I'm wondering if that means that...one of the things that we talked about before that I don't think we included in our recommendations was the notion of designating if you do have a family caregiver and what role you want them to play. So, I'm wondering if this tells us that we actually should think about, I don't know if it's a demographics field or what, but having a caregiver status field because otherwise, how do you know, right?

Paul Tang – Palo Alto Medical Foundation

Care team.

Christine Bechtel – National Partnership for Women & Families

Yeah, well you could include it under the care it team list although that's free text, you'd still have to have a sort of "yes/no is there a family caregiver" so, I mean I don't care where it goes if it's under care team or demographics, but I do think it's probably a good thing to say we need to...

Paul Tang – Palo Alto Medical Foundation

So, I think that's a new addition to what we had proposed, right? And I think you point out...so HIM modules have this because they have to release things to people. I think you're right that we don't have this concept in a coded way that's testable and reportable in the "EHR"...clinician...and then you have all kinds of, you know, it's okay because I brought this person to discuss this issue, it's not the same thing as saying it's okay for this person to learn everything about me, which is what a personal representative would be entitled to, do you see what I mean, there's a lot of power that goes into that. So, that's a formal process, but what you'd ideally like to have is an informed consent about.

Christine Bechtel – National Partnership for Women & Families

So, is it a yes or no?

Paul Tang – Palo Alto Medical Foundation

Well, I think there's a lot of devil in the details that would have to be worked out. One, I don't think current EHRs have this capability and one of the reasons is because, yet HIM modules do, is because in the old fashioned world, I say "I'm giving George the ability to get my records as they exist today with the following exclusions" but in the new fashioned world where you're saying you're granting this person essentially proxy access to your entire record in perpetuity until you cancel it, that's a concept that people are not used to and it seems to me you would want to counsel the patient about what that means.

Christine Bechtel – National Partnership for Women & Families

Right, so I think what I'm asking is, agree with the workflow implications but I do think that this particular notion of a patient authorized representative means that we need to think about getting the EHRs to have the capability to record presence/absence and if presence, what, you know, what are the powers? Now, I don't know how you do all that exactly in practice, but I do think having the ability to record it and get that capability in the EHR is going to be really important in Stage 2 in order to set us up for the future and to comply with the objective.

Paul Tang – Palo Alto Medical Foundation

David?

David Lansky – Pacific Business Group on Health – President & CEO

Glancing at the certification rule it doesn't make clear at all how that authorization is captured. So, it maybe just something we want to mention to CMS that we're opening up a new area that seems very important to the future but it hasn't been fully developed.

Paul Tang – Palo Alto Medical Foundation

Yes.

Deven McGraw – Center for Democracy & Technology – Director

It is and although, this is Deven, I mean at the same time people and their personal use of technology quite often share accounts with family members. I certainly know couples who have the same e-mail address. I'm not sure we need to get into that degree of legal specifics on the one hand, and then in addition, if it counts, you know, for the actual access piece, if, you know, an adult child of an elderly parent accesses it instead of the elderly parent that just makes it even easier for some physicians to meet that criteria. So, you know, in some respects, each individual institution is going to have to broker all of that in terms of additional access by others, but there's absolutely nothing that's going to stop people from sharing their IDs and passwords with whomever they please.

Christine Bechtel – National Partnership for Women & Families

Right and I don't disagree with that, Deven, but I think it is absolutely important and okay to have a patient authorize someone else to look at their health information on-line, that's going to be really important for lots of populations and in particular older adults and those with cognitive disabilities. But, I'm also saying that I think, as David said, it's an important capability to at least begin to record presence or absence. We need to move toward the ability to record a patient designated role, you know, for that caregiver in their care because you can't get to patient and family centered care without that. And I think it actually will be critical over time that that information goes to the hospital and the hospital understands the role of the caregiver things like that. I mean, that's a really fundamental tenant here.

Paul Tang – Palo Alto Medical Foundation

And I think that's valid. I certainly know our EHR allows that, or, you know, patient portal allows that, basically its proxy access.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation

We do have a consent based, an agreement that these are signed that tries to explain what this means, the in perpetuity they can view, but still, okay. So, essentially you're just pointing out something that's already in the proposed rule.

Christine Bechtel – National Partnership for Women & Families

Right, I'm pointing out that there's this piece in the proposed rule that says a patient authorized representative but I don't see, and David in his look didn't see, where do you record that in standards and certifications? Where do you say "yes, I have a family caregiver or no" or access, all that?

Paul Tang – Palo Alto Medical Foundation

So, this part of it is being recorded in the patient portal side of it. There is a separate interest and I think actually David mentioned the care team, that's an appropriate place to put some of the caregivers, looking at it from the clinicians...

David Lansky – Pacific Business Group on Health – President & CEO

In addition you may want to designate whether those caregivers had access to the record.

Paul Tang – Palo Alto Medical Foundation

Correct, that's a good point. So, I think in PHRs, patient portal, there is this notion of giving somebody else their own ID and password to access your information, that's not the same as saying that information is even available to the clinician on the EHR side, but that's what you're pointing out.

Christine Bechtel – National Partnership for Women & Families

Right.

Michael Barr – American College of Physicians

I have another question.

Paul Tang – Palo Alto Medical Foundation

Yes, Michael?

Michael Barr – American College of Physicians

I'm a patient obviously and if I have multiple specialists I'm seeing including my primary care physician, each of them have this requirement as an EP to get 10% of their patients to do what we're asking them to do. I would think maybe the primary care clinician has a little bit better odds of getting the folks to come to see their more consolidated record, but if I am a cardiologist, orthopedic surgeon, otolaryngologist, I mean, let's think about where they are in terms of trying to get 10% of their folks to see all these records.

I mean and then if I'm a patient, how many different places am I going to go to view, download and/or transmit? I don't understand how this is really going to help except for maybe in the primary care and then I still have some concerns about making the doctors responsible for the patient's activities. So don't understand.

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

I'm going to add onto this one too. We have a lot of feedback from providers and they have done the outreach to the consumer and they've recruited and they've given away iPods and, you know, the fact of the matter is they cannot generate in their populations the kind of interest to sign on. They've got a portal, it's accessible, and it's just not happening. Now, maybe by 2014 it will change. But this is a major issue for the people who are reviewing the rule at this point in time. They are willing to document and say, I mean, if we want to think about it, did you educate the patient on the availability of this, they will put it in the record, they'll put it in the discharge, well that's the hospital, but in the note, that the education was given. They'll even take that extra step, but they are very concerned about it.

Michael Barr – American College of Physicians

Medical assistant reviewed the opportunity to do these things before leaving the office on this encounter. I mean that's the kind of stuff I think we could get but I do think that it's a challenge for a variety of reasons both on the provider's side as well as on the patient's side.

Paul Tang – Palo Alto Medical Foundation

Neil?

Neil Calman – The Institute for Family Health – President and Cofounder

So, two things, I definitely hear what Michael's saying about the specialty people, and I think it ties into something Christine said before. Do we really, you know, is our goal that people who have chronic illnesses and are seeing multiple specialists have to log into eight different portals to sort of see their information? So, I think we should think about that and maybe this is something that's more relevant to primary care providers.

To the second comment, I think that people are being disingenuous when they say they've tried hard and can't get 10% of their people on a portal. I mean, we have a low income population. The folks that you probably think are the hardest of all to get on a portal and we're up over 20% after just a little less than two years of not a really intensive effort and people are using it. We've had over 3 million hits from our population in a little less than two years on the portal. And this is a group of people who, you know, people are using the internet for everything. We're talking about a goal from three years from now. I mean, I just think people are being disingenuous if they say that they have a population and that they really...

What really happens is that the providers, and we have this because there's a vast difference between those of our providers who really have incorporated it in their work flow and others who haven't, in their ability to recruit patients to the portal, and what happens is you have people who really haven't incorporated it into their work flow and so you can say "well we have a way to get your information on-line are you interested?" "no" and they, you know, document that they're not interested or whatever but the people who have incorporated it into the work flow have 70 or 80% of their patients on the portal now and that's just remarkable.

So, I think it really has to do with exactly the reason we need this as a requirement, which is that we have to get people to engage folks and become comfortable with interacting with people and having them have access to information through the portal. And if you just let them out of this, I think we're not accomplishing that.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. I agree, first of all it has to be useful, it has to be meaningful. I don't go to many things that I am signed up for because the person that I signed up with is not active or not providing me meaningful things and I think that goes back to your point, Neil, that we want the provider to interact with the patient in new ways. We are trying to drive a new behavior that we think technology can help. And where it's been successful it's dramatically successful. You don't hear Kaiser talk about the fact that they have a patient portal anymore, they talk about how many cardiac deaths they've prevented because they've engaged with the patient in a totally new way.

So, we are asking people to make a leap. We are asking them to try harder. When I was a CIO of a hospital in 2004, we had a sign up every 7 seconds to the patient portal for a sustained period of six weeks. Now it cost me a little bit in advertising and work flow, but there is a desire, if we think about when on-line banking started and how pervasive that it is now. There's a natural uplift that happens that doesn't mean we eliminate it. I really feel strongly that this is something we want to sustain.

Paul Tang – Palo Alto Medical Foundation

Christine?

Christine Bechtel – National Partnership for Women & Families

So, I think the points that Neil and Leslie have made are right and I appreciate, you know, we do hear a lot from physicians that it can be hard, but we have survey data from patients actually that tells us how often they use it and what they want from it and I think that's more important than the anecdotal component, but when we looked at it was 26% of people with EHRs had on-line access in this survey and of those, almost half of them use it three times a year or more, that includes a quarter of it that use it 7 times a year or more, only 20% said they never used it, only 20%, and of the 20% we asked them why, some of it was patient preference where I prefer to communicate with my doctor in person, and other parts of it were all around the functionality, I can't communicate with my doctor, it's only lab results, it was never explained to me how to use it, it's all those kinds of things.

So, I actually think what we know also from this survey is that 2/3 of the people on paper today want on-line access and then 3/4 of the Hispanic adults do. I mean, there's really powerful evidence from survey data that tells us people want this and that they use it. So, I'm thinking 10% not too much of a stretch.

Michael Barr – American College of Physicians

But, Christine, you are actually arguing the same point I am arguing. We're all saying that this is important, relevant and needs to be done. And you're in a system, you're in a system, your surveys we're talking about small practices around the country who will lose entire Meaningful Use incentives if they don't meet this objective. And, so rather...we're already requiring them to view, download and transmit and have lots of other requirements. We're talking about trying to say let's show that you're making a strong effort, but to have them lose something because they can't get 10%, for whatever reason, they'll get more perhaps because if this is built well and has the value, Leslie, that you talked about and value that, Neil, provides to his portal, it won't be necessary to have a threshold, people will come to it. Right now I think this is going to be viewed very negatively only because people will have their perceptions, right or wrong, that it's too challenging and it's all or nothing. This should be more of a carrot than a stick.

Christine Bechtel – National Partnership for Women & Families

So, I do want to just say one thing and then I'll move, because people are pretty clear on my positions on these things I think. But I will say that for every story of a physician who says it's hard I also hear stories of patients who say my physician stood up a portal two years ago and I never knew about it. No wonder it was hard. So, I think that's why I want to point to the survey data that there's more evidence.

Michael Barr – American College of Physicians

Any physician who is going to spend the money to put up a portal is not going to do it in secret.

Christine Bechtel – National Partnership for Women & Families

My own doctor did, I'll tell you that. I can tell you others.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I do also think that there is a flip side we've not discussed to interacting with the patient on-line is good for the primary care doctor and it can save money. You know, of the data, it cost for instance a pass card that I...

Michael Barr – American College of Physicians

We're not arguing this. I'm not arguing or making any of those points at all. I completely agree with you. I was just with an all day ABM Foundation and had innovators come, they're all doing these things, what I'm saying is if you make it a requirement I don't think we need to make it a requirement to have it done, let's make sure these things work the way they're supposed to do, all the things that you're describing so that more patients respond positively to your survey. I think if you make it a 10% threshold, I think you already have a lot of requirements in here. This thing is going to be perceived negatively by the clinician community for the reasons I've stated, it doesn't mean it's not a good idea for us to push it and make sure it's out there and that they're doing it, that's not the argument I'm making.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But, don't you think, Michael?

Michael Barr – American College of Physicians

I don't think this is going to drive the kind of change you all are wanting to see is my point.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay. So, if Meaningful Use 3 gets to a collaborative care model and a coordinated care model, then I have just made a much bigger gap in the stretch that the doctor has to reach because I've never implemented anything that says that my patient...

Michael Barr – American College of Physicians

No, no, no, no, they're going to do that as part of the whole thing, they're not going to do it because of this measure. They're going to do it because it makes sense for the model we're pushing forward in ACOs, medical home, medical neighbors, all those kinds of things.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

All right, thank you.

Paul Tang – Palo Alto Medical Foundation

So, all of the views are now well said. George has a point; we did talk about this already.

Deven McGraw – Center for Democracy & Technology – Director

He did.

Paul Tang – Palo Alto Medical Foundation

That's how we got to this. So, at this point I think I was going to ask for a vote.

Deven McGraw – Center for Democracy & Technology – Director

Well, actually, Paul, it's Deven. One of the things that I'm thinking about is, you know, this is the recommendation that we made as a Policy Committee, although my recollection was that it was not consensus, but we did take a vote on it. So, the fact that we got what we asked for, I think it makes little sense for us to peel that back. But one thing that occurs to me is if CMS is going to get a lot of comments on this, which we know they are, whether it is in fact our job to think through what some ways would be to

address the circumstance that Michael raised, which is if this is the only thing despite best efforts that an EP fails on, should they lose their entire Meaningful Use payment? Is there a hardship exception that we should be looking at rather than tinkering with the percentage?

Paul Tang – Palo Alto Medical Foundation

Now, there is a hardship, the FCC, does that apply to this one?

Christine Bechtel – National Partnership for Women & Families

Yes, it does.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, but that's more for technical infeasibility which clearly all makes sense. But I'm just wondering if there's not a safety net provision that we ought to be looking at here where in fact people have used best efforts, they can't hit 10%, they've hit 5, they meet every other Meaningful Use core criteria and they're going to lose their payment because they have a patient base that just isn't right there. But, you know, that I'd be willing to entertain. I don't know what it would look like.

Paul Tang – Palo Alto Medical Foundation

So how would we stop?

David Lansky – Pacific Business Group on Health – President & CEO

Look several people here have shaken their heads saying I don't think so.

Deven McGraw – Center for Democracy & Technology – Director

All right.

David Lansky – Pacific Business Group on Health – President & CEO

My personal vote is...

Deven McGraw – Center for Democracy & Technology – Director

Well, then I don't think we should go backwards on something that we already voted to approve.

David Lansky – Pacific Business Group on Health – President & CEO

Deven, go ahead.

Deven McGraw – Center for Democracy & Technology – Director

No, that's it. I mean, you know, I'm not physically there. So if my idea sounds like it's falling flatter than a lead balloon, so I am happy to pare it back, but I don't think we should revote on something that we already spent a great deal of time talking about and approved including at the Policy Committee level.

David Lansky – Pacific Business Group on Health – President & CEO

So, we acknowledge its high, some of us acknowledge it's a high bar and we look forward to the NPRM comments is basically where we stand right now.

Paul Tang – Palo Alto Medical Foundation

And CMS will have to...

David Lansky – Pacific Business Group on Health – President & CEO

Yes and they'll have to...

M/W

Multiple voices.

Neil Calman – The Institute for Family Health – President and Cofounder

...types of providers.

Paul Tang – Palo Alto Medical Foundation

The specialist, yeah. That's the fair point. Now in theory, I don't know that we covered it enough. So, open to comments about non-primary care, which of course, well, I mean, in addition to medical specialties there's surgical specialties that often times have an episode basically and we've run into this with some of the other stuff as well. Any special provisions for non-primary care?

Christine Bechtel – National Partnership for Women & Families

Yes, there is an exclusion that says we are proposing that an EP who needs orders...

Paul Tang – Palo Alto Medical Foundation

What page are you on?

Christine Bechtel – National Partnership for Women & Families

Ninety-six. An EP who neither orders nor creates any of the information listed for inclusion as part of these measures can exclude both the first and the second measures. So, you wouldn't have to offer or get use.

George Hripcsak – Columbia University NYC

If you have none of the information you don't have to do it.

Paul Tang – Palo Alto Medical Foundation

Yeah, but everybody has the information.

Christine Bechtel – National Partnership for Women & Families

No, if you generate, if you do not generate the information, it does say that.

Paul Tang – Palo Alto Medical Foundation

But you have to have generated something.

Michael Barr – American College of Physicians

That's not responsive to the question I raised where from a patient I'm seeing multiple doctors each of them generate notes and things, each one of them is going to have a portal for me to go view and each one of them has to satisfy the 10% threshold.

Christine Bechtel – National Partnership for Women & Families

Well, so first of all, I actually think because of the transmit piece, it's easier for them to satisfy the 10% threshold because the point...Stage 1 created a construct where you could have multiple providers and multiple portals specialists, primary care and so on down the line and so the idea behind download and transmit was so that I could aggregate in one place across all of those different access points in the system. I could have all my health information in one place. So, I think in that regard that was what download and transmit was really designed to address so that I could see all that and have a complete picture, right? I mean, that's at the end of the day what we want.

We don't want people to be only going to their primary care, you know, provider site but it doesn't include any of their specialty care. We want them to have the full picture. So, if they download or transmit from their cardiologist, then, good to go it counted for that person.

Yael Harris – Health Resources and Services Administration

Question for the primary care, we think that behavioral health and oral health are part of primary care, so just asking if that should be included in it. If I go for a dental visit just for a cleaning, do I really want that information transferred to me versus if I go for an oral procedure?

Paul Tang – Palo Alto Medical Foundation

So your question is?

Yael Harris – Human Resources and Services Administration

Well, we're saying, you know, that all this information needs to be sent to us. Do I really want an e-mail from the dentist through a secure portal saying dental cleaning completed.

Christine Bechtel – National Partnership for Women & Families

Yes, absolutely, I think, yes, because your dental stuff shouldn't just be your one cleaning, that's not going to be all that's in there unless that's I guess all that you did in that time period.

Yael Harris – Health Resources and Services Administration

But, that's what I mean...

Christine Bechtel – National Partnership for Women & Families

But as a patient yeah I want to be able to pull the stuff together so I can go in if he doesn't do patient or if she doesn't do reminders then I can say "oh, when did I do that last." Why wouldn't I have that? I mean, it's a button that I click, right? If under Meaningful Use if the provider is already maintaining this information, and it really doesn't, you know, take it out of his or her work flow, for me to go in and click download or transmit why wouldn't we want patients to have a full and complete picture whether it's dental, behavioral, primary care or specialty care?

George Hripcsak – Columbia University NYC

It's a very good example, actually, of where things can go a little bit off and that's why we have the comment period. Each group may have something just like that, where the last thing a patient wants to do is...I mean yes they maybe want it available, but they're never going to actually look.

Michael Barr – American College of Physicians

Right.

George Hripcsak – Columbia University NYC

Because they know that the cleaning went okay.

Christine Bechtel – National Partnership for Women & Families

Right.

George Hripcsak – Columbia University NYC

And there maybe something in each...most patients, like I probably wouldn't ask them to transmit my cleaning information.

Christine Bechtel – National Partnership for Women & Families

No, but because they're on the 10% too, this is Michael's point, because they're accountable for 10% of view, download too they're going to say "can I send this somewhere for you" and I'm going to say "why yes."

M/W

Multiple voices.

George Hripcsak – Columbia University NYC

...and there may be other examples like that if you look around all the specialties and that's what the comment period is for, but I don't think we can engineer an exception sitting here now until we see the comments.

Paul Tang – Palo Alto Medical Foundation

So anybody disagree with that sentiment? Clearly they'll have comments coming in it's not that we have additional special ways to adjudicate this.

Neil Calman – The Institute for Family Health – President and Cofounder

This may be one of those places where we just want to comment. We could say recognize that there is an issue here.

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation

We understand that there would be...correct.

George Hripcsak – Columbia University NYC

We need to move over to view and download and transmit.

W

Yes.

Paul Tang – Palo Alto Medical Foundation

Now, we have...

George Hripcsak – Columbia University NYC

...view, download and transmit.

Paul Tang – Palo Alto Medical Foundation

And then we're actually dealing with hospitals.

George Hripcsak – Columbia University NYC

Yes.

Paul Tang – Palo Alto Medical Foundation

All right. So, hospitals it's very similar two measures 50%. Fifty percent for discharge have their information available within 36 hours of discharge and more than 10% have access to that. Now, I forget whether, because we originally had an electronic access to instructions upon discharge and I forgot whether that was dropped.

Christine Bechtel – National Partnership for Women & Families

No it got included in this one.

Paul Tang – Palo Alto Medical Foundation

Okay, but it's no longer at point of discharge. So, we're...

Christine Bechtel – National Partnership for Women & Families

Yeah, right, right.

Paul Tang – Palo Alto Medical Foundation

So, you have access because there's a lot of catch up that goes on in the hospital including getting the doctor's signature, so there's a catch up for the discharge essentially summary but the instructions we thought were very important particularly to prevent readmissions. And what little data we have in terms of preventing it is really to get them seen and get them the changes done in the first week.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Go ahead.

Christine Bechtel – National Partnership for Women & Families

Well, I'm going back to our letter, and I think, and we actually recommended combining the 50% of discharge instructions electronically with this objective and I believe that the reason is, and if you look at the exclusion rates, they're so high, patients didn't know to ask for it, it was upon request. So, it doesn't answer your timeliness issue, which I think is valid but just to provide, I think that was our rationality and we did actually recommend this.

Paul Tang – Palo Alto Medical Foundation

Oh, and the other thing I'm remembering too is it turns out as you leave the hospital, you would love to have something in your hand which tends to be paper so that it can be reviewed with you and you can write notes and etcetera. So, that was the primary rationale.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

The patients instructions are included in the actual provision of the information throughout the NPRM, stated that if you include the patient specific education materials or instructions.

Paul Tang – Palo Alto Medical Foundation

That's not the same thing as the discharge instructions.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

It's in the definition I believe.

Christine Bechtel – National Partnership for Women & Families

It is, yeah.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

For instance on page, shoot.

Christine Bechtel – National Partnership for Women & Families

Discharge instructions for a patient are included in the definition in the standards and cert rule and the definition for this particular measure, but I think Paul's point is that's within 36 hours of discharge not at the moment of discharge.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay. I see.

Christine Bechtel – National Partnership for Women & Families

Where you would get paper.

Paul Tang – Palo Alto Medical Foundation

Okay, so let's essentially look at this. There are the two measures, they're very comparable, it changes to 36 hours instead of what we compromised back to two days, business days, which is appropriate because a lot went on in that admission and it has the 10% who have actually looked at it.

George Hripcsak – Columbia University NYC

Do we want to put two days here?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

No.

Paul Tang – Palo Alto Medical Foundation

No, no we're not changing that, I'm just comparing it to what we just went over. So, any comments about what's proposed here? Presumably, no comment about measure one. Measure two is the same 10%, is that different in a hospital admission case? It's different but I don't know whether 10% is a reasonable threshold.

Christine Bechtel – National Partnership for Women & Families

Yeah, well and I like the transit piece because you can then pull it together in one place and even though, you know, you would hope that a summary care record was sent when you were discharged at least if the patient has everything, I can then give it to my primary care provider or whoever I am kind of going to, but I also know that one of the providers that was not included in Meaningful Use eligibility were the long-term care communities. So, if I have the ability to get that quickly, me or my authorized representative could

actually provide that to nursing home or, you know, whatever the next setting of care might be even though they're not a meaningful user.

Yael Harris – Health Resources and Services Administration

That's what I was concerned about 36 hours. I understand a lot of information was generated during that stay and not all of it's available, but if you were in the emergency room and you're transferred to a hospital, 36 hours later that patient is back in the hospital, if they didn't have that information readily handy, if they didn't have the medications the patient was on, they didn't know what treatments were done, that patient is going to have to be transported back to the hospital because the nursing home isn't going to be able to take care of them, and similarly someone who is discharged after a procedure, I mean those first 48 hours are critical, if they don't have the information to care for them and I know we're saying hopefully they'll get something in paper to take home with them, but if they don't have the information about how to best manage that patient, family or the home health nurse that person's going to be back in the hospital.

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

Just to comment, this is Marty, the way things take place. I mean, we're not going to quit providing the papers we currently provide just because we only have to give it in 36 hours electronically. So, in the real world I don't see that as a problem.

Paul Tang – Palo Alto Medical Foundation

I mean, it's a JCAHO requirement, a Joint Commission requirement so nothing will stop, this is just adding some electronic access.

Yael Harris – Health Resources and Services Administration

But there's a lot of cases where at least in the post acute setting where the transfer of paper isn't provided to the next facility and them saying if that's what we were aiming for 36 hours is not going to meet the need it's going to be too late. I'm just putting it out. I know it's very difficult...I'm not saying that hospitals should be able to generate two hours later, I understand the burden, but if our issue was transferring to other settings following a hospital discharge whether it's home based etcetera, 36 hours is not sufficient information and yes giving the patient the information but this may not be the information that goes to with the patient to another healthcare setting, especially when you're talking about a demented elder for example.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, Yael are you saying...so I there are two issues, one is the care transition that there isn't adequate information for care transition and that should not be addressed by burdening the patient of taking that information with them. So, I mean, I would think that there's an obligation to provide good care transitions and that is a different issue than handing it to the patient and making it their responsibility. I do think the patient should have access within 36 hours to that information, that's a reasonable request and I think doable, and the patient does get that information, and patient instructions with paper when they leave as well. So, I think your point about care transition and coordination is a real one, but don't believe the patient should be burdened by the sole communication of taking that information and sending it on.

Yael Harris – Health Resources and Services Administration

No, but we're saying here that by doing it electronically one of the things we are trying to address, I agree, one of the things we were trying to address was this transfer of information because it was not a burden on the patient to the next setting of care and I just wanted to make it clear, I am not saying anything, but that 36 hours doesn't address that issue.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I agree that's in the care coordination area. I think it's not in this measure.

Paul Tang – Palo Alto Medical Foundation

Okay, just as matter of process, I think it's probably good not to rediscuss what we did when we came up with the recommendation. So when it's essentially what we had recommended, we probably should try to

move on. If there's something compelling then we can raise it like specialist. Okay. The next one is the clinical summary. Okay, so this is sort of the...for the EPs it's sort of the "after visit summary" that occurs after an office visit. Now it's going to an office visit, is that, a problem? Well in terms of other than encounters we've discussed before.

George Hripcsak – Columbia University NYC

The encounters are broader than office visits.

Paul Tang – Palo Alto Medical Foundation

Than an office visit. So, Stage 1...

George Hripcsak – Columbia University NYC

When the person is actually sitting there in your office.

Paul Tang – Palo Alto Medical Foundation

Right. Okay, the Stage 1...

Michael Barr – American College of Physicians

The definition is broader for office visits it included telehealth also, the one I read earlier.

Paul Tang – Palo Alto Medical Foundation

Okay, so Stage 1 was clinical summary for 50% of all office visits within three business days. Our recommendation was, here's we started tightening up the time, clinical summaries to patients for more than 50% of all office visits within 24 hours except for pending information such as lab tests, results and that was four days. The proposed rule says clinical summaries for each office visit the measure being within 24 hours for 50% of office visits. So actually this is by office visit. All right, so in a sense, I think it's mirroring our recommendations except dropping four days, which is interesting.

Christine Bechtel – National Partnership for Women & Families

Right. Because one of the ways that they have said its okay to deliver this is electronically, which would be through the on-line access dimension.

Paul Tang – Palo Alto Medical Foundation

Right.

Christine Bechtel – National Partnership for Women & Families

The one thing, just while I have the mic, that I wanted to flag, I don't have any issue with this right now. I think it's consistent with what we recommended and consistent in what was in Stage 1, but we have heard some providers say that, because, and I think the issue is that because the data set says at a minimum and there's a large list, they feel like it's not as useful to patients as it could be because they are seeing somebody, you know, let's say two or three times a month or maybe once a week and they're kind of getting the same piece of paper over and over again and we are looking for some flexibility. I don't know, I don't have enough understanding of what the real issues are as I flag them for the ONC folks, but I do think this something we probably have to come back to how is this is playing out in practice.

Paul Tang – Palo Alto Medical Foundation

Yes.

Christine Bechtel – National Partnership for Women & Families

And I don't know that this is the cause, but one of the differences that I noticed is that when you look at most of the other standards and certification criteria, four things that list a...like will have a long block of data, is that they will see it should include at a minimum this information where applicable. Now, the where applicable piece is missing from here. So I don't know if that's enough to give folks flexibility and I don't have the right answer today but I do want to flag this as something that we need to get a slightly better handle on how it's going in practice and make sure it's useful for patients.

Paul Tang – Palo Alto Medical Foundation

So one of the things that came up clearly in our hearing, you know, I think it was the October 5th hearing, was that some vendors were measuring the print-outs and that's where we heard the story of essentially forcing patients to take the print-outs and then dropping them off in the parking lot. So, to restate it, it was our intent, it was CMS's intent that providing electronic access regardless of whether they enrolled was sufficient to meet this criteria. So, it does not require the generation of paper.

Christine Bechtel – National Partnership for Women & Families

Correct. Yes.

Paul Tang – Palo Alto Medical Foundation

So, that was one of the misunderstandings there. The four days, I'm trying to read through the text, whether it was lost or not, can someone help me? Is four days no longer there?

W

...three days.

Paul Tang – Palo Alto Medical Foundation

So it's just not in the...

Josh Seidman – Office of the National Coordinator

Actually it said, although we provided three business days to send the clinical summary in Stage 1 we now believe that a faster exchange of information with the patient is not only possible but also encourages better quality of care, however we welcome comments on this timeframe.

Michael Barr – American College of Physicians

...

Paul Tang – Palo Alto Medical Foundation

But, in the numerator then does it include...I don't think...so the numerator is provide clinical summary of the visit within 24 hours, it doesn't include anything else correct?

W

That's right.

Paul Tang – Palo Alto Medical Foundation

Okay. So, presumably, the clinical summary does not then include the...okay, unfortunately the clinical summary does include the lab tests results. So, how does that work?

Michael Barr – American College of Physicians

I think it was combined with the online access and saying it's not necessary on page 78. The common practice for lab results to be delivered by phone, we are proposing other objectives in Meaningful Use that would provide for on-line access to the latest health information.

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation

Okay, so in other words...

Michael Barr – American College of Physicians

So, clinical summaries should be include what's pending and then forward to patients that more information will be soon available.

Paul Tang – Palo Alto Medical Foundation

So the only clarification then was when you specified what is in the clinical summary, the test result does appear in that list and some maybe just specify that it doesn't necessarily mean results that are pending. In practice what happens is you would just update the field and it's just a matter of when people get down to the precise definition.

Christine Bechtel – National Partnership for Women & Families

...this point, stop me if Michael read it out loud, but it does say that the Policy Committee recommended the EP had four business days to make information known to the patient, we concur, that EPs.

Paul Tang – Palo Alto Medical Foundation

Yeah, he just read that.

Christine Bechtel – National Partnership for Women & Families

You did?

Paul Tang – Palo Alto Medical Foundation

Yes.

Christine Bechtel – National Partnership for Women & Families

...all right. So, but they're saying that you don't have to issue it in every instance.

Paul Tang – Palo Alto Medical Foundation

Correct.

Christine Bechtel – National Partnership for Women & Families

That's what you just read?

Paul Tang – Palo Alto Medical Foundation

Correct, they're basically including it in the access piece so the only potential conflict is that it's required as part of the after visit summary and have the results and so there's a little bit of a conflict.

Michael Barr – American College of Physicians

But, Paul, I think when we we're reading off the list on page 79?

Paul Tang – Palo Alto Medical Foundation

Seventy-nine, yeah.

Michael Barr – American College of Physicians

All right, so it says list of diagnostic tests pending, if you want to broaden that to be lab, all those other things it says list of pending, as well as above that the list of results.

Paul Tang – Palo Alto Medical Foundation

Yeah, yeah.

Michael Barr – American College of Physicians

So I think you can interpret it list of results available at the time and then whatever is pending. I think we're okay.

Paul Tang – Palo Alto Medical Foundation

Okay. Good then I think we're okay with this and...

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

...just to clarify a little bit. The feedback we're getting, the operational feedback on this is again, there's this concept of...and I was trying to find it in here, multiple visits if they are grouped together it's really hard for the vendors to like figure out what that means, you know, or there are cases when you're just there for a repeat visit you just don't meet...so there is this concept here, whether, you know, where you

don't necessarily need to give them a new copy of a clinical summary especially if you are printing them out, which tends to be the practice now.

Paul Tang – Palo Alto Medical Foundation

Right, so remember, I think this has been a common misinterpretation that they required something to be handed. In a sense, because they hard wired the measure as print and in fact, it really means that it was made available. So, a patient portal would essentially satisfy for all people who are eligible to sign up for that portal and that basically gets rid of this whole problem, it gets rid of the multiple visit problem, so I think it's just a restatement of what was already the intent of both our recommendations and CMSs. Good, even if we did that clarification alone it would relieve a lot of burden I think and a lot of paper on the parking lots.

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

Yes...

Paul Tang – Palo Alto Medical Foundation

Okay, next one is a menu item, which was patient specific education resources for more than 10%. People did not take us up on that very often, probably because there was some lack of clarity. So, I think there's more clarity being added here. So what we proposed was essentially the same thing.

Michael Barr – American College of Physicians

Where are we?

Paul Tang – Palo Alto Medical Foundation

Top of page 13.

Michael Barr – American College of Physicians

Okay.

Michael Barr – American College of Physicians

The education didn't pop out right away, so it just sort of...

Paul Tang – Palo Alto Medical Foundation

Right.

Michael Barr – American College of Physicians

...certified EHR...

Paul Tang – Palo Alto Medical Foundation

Okay. Now the proposed rule for EPs and I think they're basically the same for both sides, is to have patient specific educational resources that were determined by the EHR using information in the EHR. So, in other words, you can't just pop up another resource in a frame in your EHR and have the clinician do the search or have the patient do the search at home for example and that those would be provided for at least 10% of all office visits or admissions. Comments?

Neil Calman – The Institute for Family Health – President and Cofounder

...certification?

Paul Tang – Palo Alto Medical Foundation

Correct.

Neil Calman – The Institute for Family Health – President and Cofounder

That fact that you use technology to buff it up. So, our piece is that's giving it.

Paul Tang – Palo Alto Medical Foundation

Well, no our piece is also the 10%. So, should 10% of patients have educational resources tailored to them?

Neil Calman – The Institute for Family Health – President and Cofounder

...

Paul Tang – Palo Alto Medical Foundation

Yes.

W

Yes.

Neil Calman – The Institute for Family Health – President and Cofounder

Because if the system is going to recommend educational resources based upon the information that's in the system it's going to recommend it all the time.

Paul Tang – Palo Alto Medical Foundation

Correct.

Neil Calman – The Institute for Family Health – President and Cofounder

The question is we want the provider, the Meaningful Use by the provider is to at least 10% of the time give that to patient right?

Paul Tang – Palo Alto Medical Foundation

Well, it's provided to, it's the same kind of thing. So, if you have access to your after visit summary and it has system tailored information for you, then you qualify.

Yael Harris – Health Resources and Services Administration

Could provided to be that they said something.

Paul Tang – Palo Alto Medical Foundation

They what?

Yael Harris – Health Resources and Services Administration

We didn't say provided to in terms of electronics or provided in terms of paper.

Paul Tang – Palo Alto Medical Foundation

That's correct.

Yael Harris – Health Resources and Services Administration

What is if at the end of the visit I said to you the EHR here says x, y, z and you should...

Paul Tang – Palo Alto Medical Foundation

No, I think you could get a printout that says that or you could be getting it through your patient portal, but the system has to have helped generate something specific for you.

Yael Harris – Health Resources and Services Administration

That you hand them or e-mail them.

Paul Tang – Palo Alto Medical Foundation

Correct. Correct. This is to counteract the way some people fulfilled JCAHO requirements of just printing it on the back of every discharge summary. We thought about...

Yael Harris – Health Resources and Services Administration

...under hospitals it says just unique patients admitted to the hospital. Do we want also ER admissions? We have that for ER, I'm sorry EDs. We have that for cause but we don't have EDs for other hospitals, other...

Paul Tang – Palo Alto Medical Foundation

Wait a minute, it does have ED is included here.

M

Eligible hospitals or...

Yael Harris – Health Resources and Services Administration

No cause and patient or ED but not eligible hospitals.

M

Eligible hospitals or cause inpatient or emergency room.

Yael Harris – Health Resources and Services Administration

Okay. I interpreted it to be just the ED for cause. Okay.

Paul Tang – Palo Alto Medical Foundation

Yes.

Michael Barr – American College of Physicians

Paul a question?

Paul Tang – Palo Alto Medical Foundation

Yes?

Michael Barr – American College of Physicians

On the educational materials itself, I think this is a great issue, I'm not arguing at all just clarifying what actually would count. If the EHR says, oh, you have a patient with asthma and this patient with asthma hasn't had education on something, and it recommends an asthma education module, which actually resides outside the EHR, so it's another tool set somewhere else, somebody else provided, but it's coming as a recommendation from the certified electronic health record technology, I'm assuming that would count. So, then everything has to be embedded within the certified technology.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Correct, in fact the standards, the recommendation from the ONC side of this reflects the use of the specific technology that identifies patient specific education materials which is pretty prevalent in the industry. So, it's not an issue.

Michael Barr – American College of Physicians

Okay. I'm just...because an information prescription to go...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Exactly.

Michael Barr – American College of Physicians

Right, it can go somewhere else to find this information, it might come out of the EHR, so that helps, thank you.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Paul Tang – Palo Alto Medical Foundation

Well, but it doesn't say that you have to go search some other...oh, okay. There can't be a human intervention that says "hey go find this stuff."

Michael Barr – American College of Physicians

No, no the EHR says you populated the EHR with specific references and resources that either come from the vendor or that you've identified and put in there and based upon the patient context a recommendation comes up, but the recommendation might be to a resource that's not embedded in your EHR.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Correct.

Michael Barr – American College of Physicians

Okay, that's fine.

Paul Tang – Palo Alto Medical Foundation

Okay, it has to be integrated though, it's not like you can go look this stuff up.

Michael Barr – American College of Physicians

No, no, no, let me concrete. Okay, asthma education program put out by, you know, the national association, but the recommendation is coming from the electronic health record.

Paul Tang – Palo Alto Medical Foundation

So, to be in the spirit you would...

Neil Calman – The Institute for Family Health – President and Cofounder

I want to give it to the patient.

Paul Tang – Palo Alto Medical Foundation

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

What do I need to do? Do I click on the link and go out there and then print that separately?

Michael Barr – American College of Physicians

I send the patient the link to go view this or I have another computer in the room where they go to another room and they do the education there with a nurse or something like that, but it's...

Paul Tang – Palo Alto Medical Foundation

As long as there's no human intervention to get to the specific information.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So what happens in real life is the context is passed, which is the allergy, the weight, the age, the problem list, chief complaint or principle diagnosis it's all within the standards wherever you are in the EMR the work flow would help to determine what's brought up. So, for instance if I am in the drug ordering section of the EMR and I click on the info button standard the context passes that I first want to see drug stuff first and then I want to go on. So, if the context is passed inside the EMR to other modules.

Neil Calman – The Institute for Family Health – President and Cofounder

But the question that we're raising is, if what comes up says there's great information on diabetes at this link and I hand that to the patient, have I satisfied this criteria or not?

M

According to this, no. This is page 102.

Neil Calman – The Institute for Family Health – President and Cofounder

Right and I think that's our intent is that it should be no, because that's not really transmitting the information.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But you also have to record what you've given a patient right? So that's not enough, you're going to have to be able to see what's been prescribed. I think they've identified it quite well in the ONC side of this.

Paul Tang – Palo Alto Medical Foundation

Do you have a handy page for that?

Christine Bechtel – National Partnership for Women & Families

Which...patient education?

Paul Tang – Palo Alto Medical Foundation

The certification.

Christine Bechtel – National Partnership for Women & Families

It's around 100.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think...yeah.

Christine Bechtel – National Partnership for Women & Families

Patient education resources, yes...what was the question?

Michael Barr – American College of Physicians

I don't see where it's excluded in this language.

Christine Bechtel – National Partnership for Women & Families

What was the question?

Paul Tang – Palo Alto Medical Foundation

The 100?

George Hripcsak – Columbia University NYC

We're looking for the page...

Michael Barr – American College of Physicians

On page 102.

M

...have to be identified by certified technology, if the resources are not identified by the technology and provided to the patient it would not count...

Michael Barr – American College of Physicians

Well, so we're saying that it would be identified. The question is if it sends the patient outside, so to the National Allergy and Asthma Association whatever for asthma if we're using that or the American Diabetic Association and you gave an information prescription say there's a great program here or some commercial vendors that now offer some really great videos and education, I mean that's not going to be within my electronic health record, but the recommendation to send the patient would be.

Paul Tang – Palo Alto Medical Foundation

Correct. So, as long as the EHR generated using clinical information about you, specific information for you.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Correct.

Paul Tang – Palo Alto Medical Foundation

Okay? So no issues with this one? Okay. Next one is a new one compared to Stage 1. We had recommended secure online messaging from patients to their providers or healthcare team for a countable number and we've picked the number 25. The proposed rule suggested a percentage that a secure message was sent using the messaging function of the certified EHR by more than 10% of unique patients seen during the EHR reporting period. This might be the most stringent of the new kind of measure saying you have to rely, you the provider, have to rely on the patients to take an action.

Christine Bechtel – National Partnership for Women & Families

And the reporting period is two years, right?

Paul Tang – Palo Alto Medical Foundation

Its 1 year.

Christine Bechtel – National Partnership for Women & Families

Its 1 year?

Paul Tang – Palo Alto Medical Foundation

Well, it's 90 days for the first one, but its 1 year...

Christine Bechtel – National Partnership for Women & Families

Right, but for Stage 2 it's 1 year.

Paul Tang – Palo Alto Medical Foundation

Yes.

Christine Bechtel – National Partnership for Women & Families

Okay.

Michael Barr – American College of Physicians

This is the same issue on the other one. I think it's a great objective to have secure communication between patients and providers, and practices, again the same objections and concerns I raised earlier I would raised for this one.

Paul Tang – Palo Alto Medical Foundation

So, I can provide...

George Hripcsak – Columbia University NYC

We didn't vote on this one.

Christine Bechtel – National Partnership for Women & Families

We did, we just said 25.

Paul Tang – Palo Alto Medical Foundation

We said 25.

Christine Bechtel – National Partnership for Women & Families

That 10%...

Paul Tang – Palo Alto Medical Foundation

I can provide a little bit of a data point. Now, we've been at this for a long time so we have almost 3/4 of the patients on-line with us and with that kind of...we get about 30% of our patients sending a message

within a year. So, 10%, which may be too high, because it takes a lot to get that amount of messages generated.

Arthur Davidson – Denver Public Health Department

I think that's a bit high, especially for many of the health centers where you know, the tool they use might be a smart phone but that's not really the tool that we're thinking most people will be using to communicate with their providers. You know, we're talking about the internet having access to e-mail, computers at home. I just think this is a little bit beyond what we could expect for those more challenged populations.

Michael Barr – American College of Physicians

This is Michael, I mean, I would almost, when I first read it I thought it was the other way around that the provider should be sending secure messages to patients and I think that actually would stimulate the responses, but in this case, and maybe that's the way they'll get at this objective if it remains, but I think to require it as written, same objections, same concerns.

Yael Harris – Health Resources and Services Administration

I would agree with Michael in terms of if the patient were sending notes to the provider there is an obligation on the provider's part to respond within a certain period of time, so why would the...you know, if the patient doesn't hear back within 48 hours why would they continue to use secure, you know, and 10% is a very high expectation. So it's almost the burden should be on the provider if we want to have this in place.

Michael Barr – American College of Physicians

To initiate...

Yael Harris – Health Resources and Services Administration

To initiate the conversation in which case then the patient knows okay the provider is engaged, he or she is active on using the secure messaging.

Christine Bechtel – National Partnership for Women & Families

I guess I had the same concern you did, Yael, around responsiveness only because that's been my own experience and I think it's not unique to me where actually the provider did initiate a secure message and delivery of lab results, there was an abnormal lab in there that I didn't understand and she didn't explain. So I sent a secure message back and said "oh what is this." Nothing, another one, nothing. So, I guess I have two thoughts on this. One is, I'd rather think about the denominator first. I'm not sure that 10% of all patients, you know, I wonder if it should be connected to a percent threshold of those who are in fact using or signed up for the portal. I don't know if that is possible to do, but it is...in which case I would argue that it would be probably a higher threshold than 10% if it's a smaller denominator.

Yael Harris – Health Resources and Services Administration

...populations.

Christine Bechtel – National Partnership for Women & Families

Right, but I think either sort of an issue getting to that right population and then I would love to put a responsiveness frame around it, at least sending a signal.

Yael Harris – Health Resources and Services Administration

Like your e-mail was received and will be reviewed in this time period.

Christine Bechtel – National Partnership for Women & Families

Yeah in some kind of time period, right? And they actually do respond. I mean, even just a reporting of the average response of times would be great. That doesn't force them to do it in a time, but it gets their eyes on how long does it take them on average to respond.

Paul Tang – Palo Alto Medical Foundation

So, let's parse this up into various components. So, the first one is, one that there's a fairly widespread sentiment that 10% of your patients is a bit high for 2014. So the counter proposal that Christine raised was to change the denominator, which actually can address that a lot because you've essentially selected for folks who already decide this is the mode I want to communicate.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation

So, her proposal is that we change the denominator to the unique patients who are already enrolled in the online access.

George Hripcsak – Columbia University NYC

It creates a disincentive to enroll patients on your portal.

Christine Bechtel – National Partnership for Women & Families

That's what I am worried about.

Paul Tang – Palo Alto Medical Foundation

...her reaction, there...

Christine Bechtel – National Partnership for Women & Families

I'm trying to think of...

Paul Tang – Palo Alto Medical Foundation

Now you can't get lower than 50. No wait that's wrong.

Christine Bechtel – National Partnership for Women & Families

Where you have, you're supposed to make the function, the portal or whatever functionality, the on-line access functionality available to at least 50% of your patients. So maybe the ONC was smarter than we're giving credit for by keeping the threshold relatively low, because you know you're going to have to focus on that and it gets back to Michael counting or saying it's basically 20% of your patients who are signed up would be sending a secure message.

Neil Calman – The Institute for Family Health – President and Cofounder

We'll make it 5%.

George Hripcsak – Columbia University NYC

Then 10% of the minimum 50 and don't punish people who do better.

Christine Bechtel – National Partnership for Women & Families

Right.

Yael Harris – Health Resources and Services Administration

If you have 100 patients in a period, 50 of those have to have access and then we're saying 20% of those or which would be basically 10.

Christine Bechtel – National Partnership for Women & Families

Right, which is exactly what I was saying...

Yael Harris – Health Resources and Services Administration

Exactly.

Paul Tang – Palo Alto Medical Foundation

So, we're saying...

M

...

Paul Tang – Palo Alto Medical Foundation

Yes, so throughout the United States, are there sufficient numbers who would like to engage and communicate with their health provider such that 5% of them would have an issue to communicate within a period of one year.

Christine Bechtel – National Partnership for Women & Families

Yes. I mean, I think our survey data says absolutely unequivocally and it's more than that.

Yael Harris – Health Resources and Services Administration

I'm worried about...you know, it's going to take a while for them, Paul's been at it years, to get comfortable with using this modality.

Paul Tang – Palo Alto Medical Foundation

No we've been at it for over a decade, but, so I mean with good results, but I wouldn't generalize that throughout the country for example.

Yael Harris – Health Resources and Services Administration

You're also in an innovative part of the country, exactly.

Paul Tang – Palo Alto Medical Foundation

Right.

Christine Bechtel – National Partnership for Women & Families

But, I mean, we're also, I guess I'm just trying to think through, so if I initiate a message, that says you know, let's say I do a reminder for follow-up care on secure messaging, right, so we're then killing two birds with one stone and I'm saying "hey I wanted to let you know, blah, blah, blah" it's hard for me to imagine that you're not going to get a lot of people responding to that and at least saying "thanks I will call you" right? So, as I'm thinking this through, whether it's, you know, if it's even 20% of your online patients, it doesn't seem to me to be that challenging.

Neil Calman – The Institute for Family Health – President and Cofounder

I think just following up on that, I think providers have a hard job when you hold them accountable for something that the patient is supposed to do and I think, following up on what you said, maybe what the requirement is that we should call out that the providers need to use secure messaging and that the secure messaging functionality has to have an ability for people to respond and then we definitely should raise the issues of response time. But, I don't think you can call out a requirement that patients need to do something. In this case, I think you've accomplished that if you ask the providers to do it. I mean, I think there's other places where it makes sense, but I think here it doesn't necessarily make sense. And if you do, use messaging and it has a reply function you're going to get replies.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, you're suggesting that this measure should be on the provider?

Neil Calman – The Institute for Family Health – President and Cofounder

Yes.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Ten percent of the total population or 10% of those patients on-line, that they engaged on-line?

Christine Bechtel – National Partnership for Women & Families

Well, if it's 10% of the total I think it's going to end up being 20% of your on-line patients.

Paul Tang – Palo Alto Medical Foundation

We don't want to get into pushing people...like this whole AVS and getting a printout and having them on the parking lot. I'm not sure if forcing people to message folks for no good reason is good. I mean, patients actually are going to message folks...

Michael Barr – American College of Physicians

Yeah, if you're requiring somebody to send them a message you're requiring them to respond essentially.

Christine Bechtel – National Partnership for Women & Families

...

Michael Barr – American College of Physicians

...patients 10% of them.

Yael Harris – Health Resources and Services Administration

... to initiate the contact to say this is a communication modality I am willing to use.

Paul Tang – Palo Alto Medical Foundation

So, in a sense a patient's actually considered SPAM from the doctor as well, from the doctor practice as well, because every time you do send a message, I mean, it's really no good unless you send an e-mail notification that you now have a message and when they go back and the doctor is not providing something substantive they consider that SPAM.

Michael Barr – American College of Physicians

Right, but it says here to communicate with patients on relevant health information, we're just saying flip it over, instead of making the requirement of the doctors to convince 10% of their patients to send them information, we're saying why don't we say doctors or EPs you should be starting or initiating the conversation with 10% of your folks. It could be relevant information. It wouldn't be SPAM and if they don't reply they don't reply, but if they do then I'm hearing a call for some sort of policy about responsiveness if you do get a reply. And this actually could be a very positive thing. It's more of a let's start trying something guys as opposed to holding them accountable for something they really might not see a clear way of influencing.

Neil Calman – The Institute for Family Health – President and Cofounder

Also, that's the way get patients to use messaging is for you to use messaging.

Christine Bechtel – National Partnership for Women & Families

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

Rather than to tell people in the office by the way you can message me, you know, but when they receive a message that's really, you know, and it says if you want to reply "reply here" that is the best way I think to engage people in messaging functionality. So, I think it serves that purpose as well.

Yael Harris – Health Resources and Services Administration

And then the relevant information thing gets away from the whole SPAM, they're not sending mass e-mails saying by the way I am on-line, they're sending relevant information, I don't know how you define relevant information.

Michael Barr – American College of Physicians

But I would actually, I'm sorry, Paul, but I would was thinking it doesn't have to be necessarily, unless we specify clinical information too, relevant information to a patient might be "hey, here's your appointment time, I set up your consultants, your cardiologist is going to see you on this date, let me know if that's a problem" so it could be really, really direct information about something, it doesn't have to be necessarily I will say from the EP perhaps, it could be from the team, the practice team.

Christine Bechtel – National Partnership for Women & Families

So, information directly related to the patient's care or condition.

George Hripcsak – Columbia University NYC

Right, not generalize.

Yael Harris – Health Resources and Services Administration

Exactly.

Christine Bechtel – National Partnership for Women & Families

Not generalized “hey let me give you the latest” you know, pamphlet.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

There are already...marketing SPAM under HIPAA. So, we have some preventions under that, so this will be more likely relevant.

Paul Tang – Palo Alto Medical Foundation

So, when we get down to where we're going to...we have a high risk of unintended consequences, it's probably good to go back up and figure out what's the problem we were trying to solve and I think the problem we were trying to solve was to make on-line communication an option for patients, and we're measuring sort of different things, but the real problem we're trying to make your physician practice accessible on-line. Are there other ways to do that without forcing one or the other to take actions which has the potential unintended consequence of people doing things without really needing to? Because the commuter can't measure that.

Christine Bechtel – National Partnership for Women & Families

Paul, I think maybe this is what you're saying, but, you know, I think it's a little more refined in that when we did research with patients, different from the survey research that I've talked about the two problems they've identified as most challenging for them were communication and coordination. So, this is not just about sort of make the practice available. They do want that ability to communicate and have an interaction. It's what Neil talked about, you know, probably two years ago about, you know, opening up the communication outside the confines of that 5 minute phone call or 7 minute office visit. I think that communication component is really the driver here.

Paul Tang – Palo Alto Medical Foundation

Correct. So, is there another way to measure that rather than forcing one or the other party to do something at some volume?

Neil Calman – The Institute for Family Health – President and Cofounder

The only way is the certification part of it which is to force the systems to allow it. But if you're not going to force them...if the systems allow it but you don't stimulate something on either the provider or the patient side to do it, you're kind are saying, we're kind of back at that issue of how do people know that it's really a functionality that they can use?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

What if we say that, because I think it was George's point on killing a couple birds with one stone, that the communication can include clinical results and other things that might be normally found in the portal, right? So we're just encouraging that secure e-mail could have a need to solve many problems for them.

Paul Tang – Palo Alto Medical Foundation

So, here's two examples that are common. One, is that most systems do send lab results, a notification of a lab result via a message to the patient, that's very useful, in fact that's the number one appreciated thing. So, in some sense, if that satisfies this requirement, you know, we have turned it around, you know, it's practiced initiated, then that's good and actually that is a good as well...

The other one that would be common, which would make this very easy to fulfill is flu vac reminders. It happens every year to almost every, now a days, virtually anybody is eligible and encouraged to get these things.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Mammograms.

Paul Tang – Palo Alto Medical Foundation

So those are two examples where if those count and we turn it around, we turn it around to physician initiated messages and those are very clearly, you know, clinically relevant, useful and appreciated that would make this a good tool and it would do the primary objective, which is to start this communication on-line.

George Hripcsak – Columbia University NYC

I'm kind of thinking, I mean what I would prefer is 25 number and the patient has to send it to you because now we're getting into preventative care reminders to the patient's e-mail, we already have that objective.

Paul Tang – Palo Alto Medical Foundation

But, there's nothing wrong with doing a good thing.

George Hripcsak – Columbia University NYC

Yeah, but I mean as far as counting something, then I don't need this objective.

Paul Tang – Palo Alto Medical Foundation

Right.

George Hripcsak – Columbia University NYC

I mean is it a certification that the patient can send me secure e-mail...

Christine Bechtel – National Partnership for Women & Families

Let me ask a question.

Neil Calman – The Institute for Family Health – President and Cofounder

Is it necessarily stimulating, I'm not objecting to it, I'm just thinking out loud, sending a flu reminder isn't exactly getting patients engaged in using messages, because that's kind of a one-way blast.

Christine Bechtel – National Partnership for Women & Families

I agree.

Neil Calman – The Institute for Family Health – President and Cofounder

As opposed to sending somebody a lab result that says if you have a question about this lab result, you know, just message me back by clicking here or something like that. Then you are kind of getting people engaged in the messaging function.

Michael Barr – American College of Physicians

Well, but Neil, the flu vaccine could be respond, these are the times open, respond let us know when you'd like to come in.

Neil Calman – The Institute for Family Health – President and Cofounder

You can do that too.

Michael Barr – American College of Physicians

I mean, if we micromanage the messages other than saying their relevant...

Christine Bechtel – National Partnership for Women & Families

So, I have a question, though.

Neil Calman – The Institute for Family Health – President and Cofounder

All right, I think we're...

Christine Bechtel – National Partnership for Women & Families

My question is this, in order to send or receive a secure message I have to log onto my portal, right?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

No.

Christine Bechtel – National Partnership for Women & Families

No?

Paul Tang – Palo Alto Medical Foundation

No.

M

Yes you do.

Christine Bechtel – National Partnership for Women & Families

A secure message, yeah, it's not coming through my G-Mail account.

Paul Tang – Palo Alto Medical Foundation

Correct.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I don't necessarily have to log onto a portal. I have to log onto a secure facility. So they're very different things, right? So, I could get a message that says you've got mail. I look on it and I see my secure message, its part of the mail system, its part of an SMTP provided mail system, it's not requiring me to log onto a portal.

Christine Bechtel – National Partnership for Women & Families

Well, I think what I am asking if by doing this what does it do to the view criteria which is completely separate and intended to be separate, but if in practice, the way that this is playing out is that most clinicians are implementing some...you know, that their mail system is, you know bundled, with their view on-line access system whether it's a portal or whatever, then by virtue of me logging onto read this one message, is that going to double count in my view my help information criteria.

Michael Barr – American College of Physicians

But what if it did?

Christine Bechtel – National Partnership for Women & Families

Because that's not viewing my health information, that's viewing a message, so that's what I want to know.

Michael Barr – American College of Physicians

But it's part of your health information. I'm saying, like using Paul's idea, I mean, why stop good things, I mean I'm not saying we should require it go through the portal, because I agree with Leslie most of them probably won't, but if it pulls somebody to the portal and they view it "oh, by the way there's my last clinical summary" and all this stuff what's bad with that?

Christine Bechtel – National Partnership for Women & Families

I'm not saying its bad for them to go to the portal, I think that's great.

Michael Barr – American College of Physicians

Why should it not count?

Christine Bechtel – National Partnership for Women & Families

Because, if I only go and view the message, and I do not then go to the screen that allows the viewing of my health information, which is completely different, the intent of these two criteria were different otherwise we'd of made them one.

Michael Barr – American College of Physicians

Well, but the intent is to get folks to their portal for one of those. If I'm now being held responsible for 10% of my unique patients coming there, that's a very valid way for me to get them there. Why would that not count as view of the portal?

Christine Bechtel – National Partnership for Women & Families

I understand.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think the goal is communication. I think you can say I can use an e-mail function to meet the delivery of results, but I also want to use these things that will engage in a new opportunity for communication.

Christine Bechtel – National Partnership for Women & Families

Okay.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So the question is how do we write these in a way that engages in new types of communication? Is that, I've received the results and in that button I say click here that ask my physician a question? Is it something that I think to Christine point is they have two measures for a reason, what was it about this measure that's unique? Paul says it's because really we're trying to get people to engage in a dialogue.

Christine Bechtel – National Partnership for Women & Families

Right, but I'm also saying that if in fact we're fine with the fact that I just got a blast about the flu vaccine being available and I'm going to go log on. I have to log on in most cases to see that and that counts under view and download then I think the view and download use metric should be triple what it is. I mean, really that's not meaningful.

Michael Barr – American College of Physicians

Why don't we see what happens before we start tripling things.

Christine Bechtel – National Partnership for Women & Families

If you force me to go on-line to read a message about flu vaccine that is absolutely not our intent around the use of that online view, download, transmit function to manage my health information that's all I'm saying. So, that makes that 10% an absolute...

Michael Barr – American College of Physicians

Well, Christine, let me ask you this, if I'm an EP and I send a message saying, your lab results are now available to you.

Christine Bechtel – National Partnership for Women & Families

Great.

Michael Barr – American College of Physicians

Let me know if you have any questions, click here, it takes them to the portal, they download their labs. You going to tell me that doesn't count?

Christine Bechtel – National Partnership for Women & Families

No, I'm not telling you that at all Michael.

Michael Barr – American College of Physicians

Or the e-mail says go to my portal...

Christine Bechtel – National Partnership for Women & Families

But, this is my point about it being a lay-up. This is exactly my point. I absolutely think that...

Michael Barr – American College of Physicians

Why is it making it easy to do the right thing a lay-up, I mean we're trying to get the practices to do all these wonderful things?

Christine Bechtel – National Partnership for Women & Families

So, if I can finish my sentence, I think that it's difficult for me to listen to both sides of the argument, you know, on the one hand, it's going to be so hard for physicians to get patients to log on and yet, if the content of the secure messaging, because remember we're changing the objective. This is no longer the patient sending a secure message, this is now the clinician sending a message out and if the content of that message isn't particularly meaningful in some ways, even though it's great and it's right, you know, than I think if that counts as a view or view/download, then I am having a hard time understanding how at the same time we can say that that 10% threshold is just too hard and when in fact I think it ought to be much higher if we can figure out these ways to make the easy thing to do, the right thing to do or vice versa I should flip that, but you get my point.

Michael Barr – American College of Physicians

We're not arguing about whether it's the right thing to do or not, if you're arguing with thresholds I would say we don't have any evidence to suggest what number is right, so we're trying to take a stab at it. I think if you don't count it and try and let folks do the right thing and get credit for it, and you try and micromanage all the things you're going to get a lot of disenfranchised folks.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

This is Farzad; I think we may be talking about two different things. What I hear Michael expressing is making it so that the implement that providers and vendors who want to implement can implement an approach that can meet multiple objectives in which they can align with each other and it can simplify the work. So, if I set up a portal, then I can satisfy the access to patient records after a visit requirement. I can also satisfy the view and download requirement and perhaps if I couple that with secure messaging I can also implement a portal that adds value on top of value and combines, and directs so a combined implementation.

What I hear Christine saying is that the intent that even while you can implement one approach to achieve multiple objectives, those are still distinct objectives that you still have to be able to meet. So, if the requirement and the definition for view is that you view these certain defined elements within the record viewing a message would not qualify, but I don't think Michael's disagreeing with that.

Michael Barr – American College of Physicians

No.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

He's saying...

Michael Barr – American College of Physicians

No, I'm saying you're going to blast through any 10% threshold if you do it this way. So let's get it going in stock but I don't know that requiring it up front before you know what actually is going to happen is the right way to go. You set a threshold at 30, 40, 50% people are not going to see what we're talking about, they're going to see the numbers and they're going to ignore it.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, the argument would be then that if there was push back on the earlier things of the 50% of the 10% of things, that kind of goes away when you include messaging. So, the idea that all of these things would stay in because we've made it easy is that your point Michael?

Michael Barr – American College of Physicians

My point is that I think I can make a more convincing argument to the EPs if we allow some of this to happen, one solution to have multiple things, because it's going to drive the kind of things we want to see out there. But if you start saying okay, well if we're going to do that we have to raise the threshold even higher we just undercut the whole case we're trying to...

Christine Bechtel – National Partnership for Women & Families

Michael that has been the case all along, that has always been the case and it's one of the ways that we have really tried to achieve parsimony. I started with a very specific question and Farzad did a very good job of articulating it, which is what counts? If I log in and view the message does that count as the view or if it is that I log in and view my actual health information, because the intents are different, and it's not clear to me. That was my simple question.

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

Can, I say something? I mean the reality of what the vendors can count.

Christine Bechtel – National Partnership for Women & Families

Right.

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

Is they can't tell if you looked at your record or not, now they can tell if you sent a message, but they can tell that you've accessed it, so, you know...

Christine Bechtel – National Partnership for Women & Families

So, there is no way to log that?

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

That's what they count.

Paul Tang – Palo Alto Medical Foundation

Okay, divide it into three. There's three different components...what we're trying to do, the big picture is to have body contact with your on-line health record and to get engaged in your health and we have identified three components to that. One is to view information in your health record, another is to receive relevant reminders, and the third is to establish an ability to have on-line communication with your health team. So, those happen to be in three different objectives and that's okay. So, to get synergy out of those things, to stimulate conversation by using labs, those are all good things, that's what we're trying to get.

So now let's talk about the criteria, which I think we can solve. So the first criteria is view and actually I think you can look at what link they've looked at. So, we can capture that they've looked somewhere in their health record, that satisfies component one. Two is relevant reminders. We know that, too and that is something that is of use to them. And the third is the communication. Now the important part about secure patient message is that you're able to communicate. So, just getting a lab test doesn't necessarily get you the ability to communicate and have somebody respond. So we do want to measure that ability. You may stimulate, and that's just the 10% thing, by the conversation by sending out your commentary on this person's lab test results with the ability to reply. So I think we can address each one of the things and each one of the things are measurable without having to necessarily start, you know, raising the ante on all the thresholds.

George Hripcsak – Columbia University NYC

So, Paul, thanks for dividing it up that way. I think the essence of this one is communication.

Paul Tang – Palo Alto Medical Foundation

Correct.

George Hripcsak – Columbia University NYC

Communication is bidirectional and you can spur it by sending a message but the essential part is the patient sending a message back. And we started down this route because 10% sounded high, that's why we said 25, count 25 instead of 10% in the first place, but the essence was the patient's doing something. So I kind of like temporarily the idea we can count the providers sending the message and that's good enough for now, but after listening to all this I'm not so sure that's such a great idea to go that route to solve the problem. I'd rather solve it by looking at threshold is 10% reasonable, is it 5%, 2% or 25 counts or whatever, but make sure the patient is sending something in because that's the essence of this that differentiates it different from everything else.

If we just have the provider sending something we're never going to be able to tell was it really communication or is it a preventive, is it really just an automated snippet of the medical record being sent out, because that's what they're going to do, they're going to create little things that send stupid things out to all the patients to meet the objective.

Paul Tang – Palo Alto Medical Foundation

Right.

George Hripcsak – Columbia University NYC

So, I think it's really, the essence of sending it back and is 10% too much by Stage 2, which I think I was leaning towards, which is why we said 25 in the first place.

Paul Tang – Palo Alto Medical Foundation

Okay. So, to restate, I think we've gone from patient initiated, to provider initiated, and George's last suggestion...

George Hripcsak – Columbia University NYC

I'm suggesting going back.

Paul Tang – Palo Alto Medical Foundation

I know, last suggestion is to go back to provider initiated.

George Hripcsak – Columbia University NYC

Patient initiated.

Paul Tang – Palo Alto Medical Foundation

I mean patient initiated, but we have to come up with a scenario that makes a lot of sense which is sending out your lab tests results which everybody appreciates with the ability to send information back.

George Hripcsak – Columbia University NYC

That would be fine.

Paul Tang – Palo Alto Medical Foundation

And that would be fine and often times a provider will send a little message about the test results and that's what would stimulate a response back. So...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...response to the labs?

George Hripcsak – Columbia University NYC

The response is what's counted actually.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Paul Tang – Palo Alto Medical Foundation

The patient initiated message is what counts.

George Hripcsak – Columbia University NYC

Oh, wait, wait...

Paul Tang – Palo Alto Medical Foundation

The patient's initiation is what counts, how you do that, we just gave an example of a lab test results, that's your business.

Yael Harris – Health Resources and Services Administration

Do you want to specify, an example, I mean I'm afraid that a lot of doctors will be "oh I can't meet this because."

Paul Tang – Palo Alto Medical Foundation

Well, we can put that in, I hate to prescribe, but we can put in the preamble the kind of things we're imagining that would be useful to patients, we already know they appreciate, and could lead to a response so that it's not relying on the patient to do something that they don't even know has a value. Does that make sense? So in other words it's going back to keeping it the patient initiated. Now the discussion is at what level, at what percent.

Michael Barr – American College of Physicians

So, Paul, if an EP sends out a message in the middle scenario and gets a response, that response is now going to count.

Paul Tang – Palo Alto Medical Foundation

Yes. The patient did something to send a message to you.

Michael Barr – American College of Physicians

Okay, so it could be in response to something we did to generate that. So, I think that's how it has to be framed if it comes out this way.

Yael Harris – Health Resources and Services Administration

That's the way I think we should frame it because I think a lot of doctors are not going to understand, they're going to say "oh, my patients don't send me e-mails" patients don't even know how to reach the doctor or they got a handout as they were walking out of the office and they were thinking about everything else versus we need to say, an example would be the physician initiated lab results.

Paul Tang – Palo Alto Medical Foundation

Correct.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And a patient response.

Yael Harris – Health Resources and Services Administration

And what we're counting is the patient's response.

Christine Bechtel – National Partnership for Women & Families

And then the third component that Yael raised that I also reinforced was about measuring the timeliness of the physician's response.

Paul Tang – Palo Alto Medical Foundation

So, that's a separate one. I don't want to lose this.

George Hripcsak – Columbia University NYC

...on how good it is.

Yael Harris – Health Resources and Services Administration

But it does have merit, because let's say you initiate it next year...and you never responded, next year no patients are going to respond to your e-mails, because...

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

The other side of it is I got scenarios where the patient's don't look at their e-mail either, you know, for two months, so I'm not sure you can go in that direction.

Paul Tang – Palo Alto Medical Foundation

So, that's a separate discussion, it could be Stage 2, it could be Stage 3, but at any rate let's deal with what we have, we're very close. So, is it 10% or some different number?

George Hripcsak – Columbia University NYC

I think low. I vote low.

Paul Tang – Palo Alto Medical Foundation

So, one vote for lower. Do you want to give a number?

Christine Bechtel – National Partnership for Women & Families

I vote for the same.

Paul Tang – Palo Alto Medical Foundation

What's your number George?

George Hripcsak – Columbia University NYC

It's either 2 or 5, I'm still deciding.

Christine Bechtel – National Partnership for Women & Families

Oh, my gosh.

George Hripcsak – Columbia University NYC

Well I was at 25 counts, is really where I was, so.

M

You were at what?

George Hripcsak – Columbia University NYC

Count 25 is where I started, right?

Paul Tang – Palo Alto Medical Foundation

Well, it's where the committee started. So, our proposal was 25.

Yael Harris – Health Resources and Services Administration

Twenty-five patients.

Paul Tang – Palo Alto Medical Foundation

It's 25 messages actually.

George Hripcsak – Columbia University NYC

It was really a certification.

Paul Tang – Palo Alto Medical Foundation

Twenty-five patients. So, yeah right it was a certification and once you have it people are not going to say, oh sorry got my 25. They weren't going to stop it. That was the rationale behind that.

George Hripcsak – Columbia University NYC

I mean 5% is easy to justify, because you can say well that's 10% of 50% and that's how we got 5% as opposed to an arbitrary number, but I guess we're all okay.

Paul Tang – Palo Alto Medical Foundation

Five. Okay.

George Hripcsak – Columbia University NYC

A 5 on the table.

Paul Tang – Palo Alto Medical Foundation

So there is motion on the table, I mean a discussion point on the table for 5%.

Christine Bechtel – National Partnership for Women & Families

What's the denominator?

Paul Tang – Palo Alto Medical Foundation

What's the denominator?

George Hripcsak – Columbia University NYC

All patients.

Paul Tang – Palo Alto Medical Foundation

Total? Actually this is 10% of unique patients seen during the reporting period.

George Hripcsak – Columbia University NYC

Right, so I'm lowering it.

Paul Tang – Palo Alto Medical Foundation

No, you said all patients.

George Hripcsak – Columbia University NYC

No, no, no I meant the same denominator.

Paul Tang – Palo Alto Medical Foundation

The same denominator, okay, sorry.

George Hripcsak – Columbia University NYC

Not all.

Paul Tang – Palo Alto Medical Foundation

So, we have a discussion between 10% of patients seen during the reporting period having initiated a message or 5%?

Michael Barr – American College of Physicians

Can I ask a question...it's too confusing but to go back, could we use those responses to go to the portal and view, download as we we're talking about earlier trying to get the folks engaged in more ways than just the response can we count that?

Christine Bechtel – National Partnership for Women & Families

Yes. I mean, I guess the thing is yes in theory. Whether or not we know as Charlene was saying, but Paul thinks we do, what piece of the portal they go in and look at whether it's just the message function or

they're actually looking at their health information, because the objective does say their health information. That's what I think I'm not so clear on, but in theory, yes.

Michael Barr – American College of Physicians

The reason why I'm asking is because I'm trying to figure out in applying this logic, how are we going to educate and stimulate EPs to do this and the more you can bundle and say if you send a message and patient replies, you can bring them to the portal, they see their message and you invite them to go examine their portal and...

Paul Tang – Palo Alto Medical Foundation

That's actually the body contact thing.

Michael Barr – American College of Physicians

What Paul?

Paul Tang – Palo Alto Medical Foundation

I think logging is a big win.

Michael Barr – American College of Physicians

Right.

Paul Tang – Palo Alto Medical Foundation

Logging is a big win.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Can I push back a little bit, I'm sorry, but I am rethinking what Christine said about SPAM too and what behavior are we trying to do, we're trying to encourage physicians to talk to their patients more, not patients to e-mail the doctor, right? I think we do want the patient to respond to the physician but don't we want the provider to start a totally new way to interact with their patients? So is it back to the...I guess I'm thinking of the 10% back to provider measure because it is meaningful, dialogue is being stimulated by the doctor.

Michael Barr – American College of Physicians

You mean initiated by an EP.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But, I defer to the group. I don't want to get SPAM and I don't want to get...but I would really love my doctor to say Leslie, I want to talk to you about your lab results.

Michael Barr – American College of Physicians

See, my reservation as stated previously about the threshold requiring view, download and this one in terms of the patient's activity, if it remains I think the way it's going to likely play out is we'll encourage clinicians to go ahead and send meaningful messages to patients, initiate a response.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay.

Michael Barr – American College of Physicians

And that response will then drive them either to a portal or some other place, you know, where that exists and this way you're getting the intended aims, it's not the way I would prefer, but I think we'll get there if we do it this way.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay.

Christine Bechtel – National Partnership for Women & Families

So, for me I think that's part of why, given the synergy with view, download, with patient reminders, with, you know, reminding people when lab results do come in or any other piece of information that wasn't provided within whatever the time period, two business days or whatever, there are so many ways I think we can use secure messaging and that it reinforces everything else that I think 10% is a better threshold. And I also do think the patient initiated side, one of the things it does or sort of preserve, was one of original intents was to use it for information reconciliation, so I don't know if that, you know, it helps in way to kind of use that feature. Anyway, so I'm voting for 10%.

Paul Tang – Palo Alto Medical Foundation

Okay.

George Hripcsak – Columbia University NYC

Ten percent of all patients?

Christine Bechtel – National Partnership for Women & Families

Ten percent...I am supporting the criteria that CMS and ONC have proposed.

Paul Tang – Palo Alto Medical Foundation

So, any further discussion, and I think we're just going just vote on 5 or 10?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

As written or...

Paul Tang – Palo Alto Medical Foundation

We're voting on...

M

As written.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

As written, okay.

Christine Bechtel – National Partnership for Women & Families

...

Paul Tang – Palo Alto Medical Foundation

Okay. So we can vote on, well let's do it by the 5 or 10 I think it's a little bit easier logistically. So, the proposal on the table is either to adopt it as written 10% of the unique patients seen during the reporting period or 5% of unique patients seen during the reporting period. So, all those in favor of 10? So, one, two, three. All those in favor of five? One, two, three, four, five, six. Okay, so the 5's have it. Okay, so I think everybody's in agreement and the spirit and we're trying to make sure that people fulfill this objective.

Okay we have one more before lunch to finish off this category 2, which it's basically, we had proposed as a new requirement for Stage 2 that both EHRs have the facility to and that the providers record patient preference for communication for at least 20% of the unique patients seen during the reporting period. The NPRM did not have that, but was seeking a comment about this. And I forgot what the NPRM said is the rationale.

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

I think it was because to be able to do these other capabilities by definition you have to provide this capability.

Paul Tang – Palo Alto Medical Foundation

Okay.

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

Just a comment on that. From the vendor community, we really like this provision for both EPs and for hospitals, because we felt that started to give us a good base for our denominator if we're going to go to this electronic communication. So, you have to communicate to the patient, you collect it as part of your process, you engage the patient, you start to have a denominator of those people who are using electronic means. Then we can really start to measure some of the other stuff because we've got a good denominator. So, there was a lot of support from the vendor communities to do this actually both across hospitals as well as practices.

Paul Tang – Palo Alto Medical Foundation

From the provider, our experience, we like it too, because it becomes more efficient. So, we're doing what the patient wants and we're not doing it double. Because, when you get...so let's say a drug recall, a flu vac, when we did the H1N1 we had to week by week put out broadcast message of who is the next high risk population and when we knew that they preferred electronic communication that was the way it was done, that was the way they wanted to get it and we didn't have to separately also mail it out to them. So, it turns out that if you do it multiple times it actually looks like it's a bad thing for the patient. So, if you know it's not only efficient, but it's appreciated, that was at least our experience and part of the rationale.

And, like...says, you know, if we know then we can start doing these other interactions knowing they want that. We actually worked with a company and it turned out on their survey it was something like 2/3 of them wanted electronic communication to be the primary way we communicated with them. So, knowing that is just really helpful.

Arthur Davidson – Denver Public Health Department

So, just our experience at Denver Health has been that, you know, there are some programs that are not using e-mail and the preference is to use text messaging. So, you know, I think that gets a little back to the last point is how do you achieve this bidirectionality, because the patients are text messaging back their patient reported outcome. So, it says tell me your blood sugar and they enter back their blood sugar for the day or their home blood pressure reading, or how many steps they took. So, there are different ways to have this bidirectional communication and there are different modalities by which that can happen.

Neil Calman – The Institute for Family Health – President and Cofounder

There's lot of nonsecure communication going on between the patient and providers in spite of our best efforts, otherwise, there's lots of people, you know, that send me messages on regular e-mail, you know, about the most personal stuff. And I mean, there's no way to stop initiated messages like that, really. Your system has no idea what the content of the messages are, but whether they're text messages which I get or e-mails through a regular e-mail system, I mean things are coming in all different ways.

Paul Tang – Palo Alto Medical Foundation

Are you still online Deven?

Deven McGraw – Center for Democracy & Technology – Director

Yes and I would completely agree with that, I mean, but here's the thing, when you're talking about HIPAA applying to most of these transactions, we don't have, you know, right now a provider doesn't have an option of sending an unsecure communication to a patient. I mean, you know, the patients certainly can do whatever they want to with data, but I don't see how a provider does. Now, I have heard someone from the Office of Civil Rights say that if a patient wants you to e-mail them at an unsecure address or a work address, and, you know, they understand there's security risks in that but they're willing to take those risks, then a provider could do that, but that's never been written in any official guidance and it was just an offhand antidote that was overheard at a conference.

Paul Tang – Palo Alto Medical Foundation

And I think ONC...

George Hripcsak – Columbia University NYC

...actually doing it.

Paul Tang – Palo Alto Medical Foundation

I think ONC is even having a mobile health security, what is it an event or a...

Deven McGraw – Center for Democracy & Technology – Director

It's a round table.

Paul Tang – Palo Alto Medical Foundation

It's a round table?

Deven McGraw – Center for Democracy & Technology – Director

Yes, it's this Friday.

Paul Tang – Palo Alto Medical Foundation

It's to develop public sentiment, is that what the goal is? And then you'll come out with some, or are you going to propose rules or guidance, or something?

Josh Seidman – Office of the National Coordinator

Yes.

Paul Tang – Palo Alto Medical Foundation

Okay. Then how are people feeling about this?

Christine Bechtel – National Partnership for Women & Families

I think it's great.

Paul Tang – Palo Alto Medical Foundation

To restate it.

Christine Bechtel – National Partnership for Women & Families

Well, I mean I like the intent. I think the piece that stood out to me was that there aren't any standards around it, and there aren't any defined fields, right? So would not we want to say you need, I think to Charlene's point, you need to record what my preference is, you may want to do, I mean in an ideal world, probably not right now, you would say okay, for billing I want it by mail. For follow-up appointments I want it this way, right? You know what I mean? You'd be actually able to designate at a granular level and then the computer system, you know, with little work on the provider's part would be able to help comply with those. So to set that groundwork I think we at least need to say, you know, there needs to be a field that probably designates options, e-mail, text, portal or whatever and then I wonder also about should we have kind of priority one or priority two, I don't know, but some way to get around that.

Neil Calman – The Institute for Family Health – President and Cofounder

I think this is much more complicated and if you don't get down to that granular level of what people want communicated in what ways it becomes useless. Because, you know, what if you have in your system that somebody wants to be communicated with through secure messaging but the next thing you get from them, you know, is something in your e-mail system or, you know, the labs they want sent to a portal and, you know, they want their appointments phoned to them, but they want, you know, a mailed reminder for their flu shot so they can hang it on their bulletin board. I mean, I think people are, you know, and if you add billing and stuff into this I think it's a complete mess to just have one field for it, because people definitely are going to want their bills sent differently, potentially sent differently than their flu shot reminders.

Christine Bechtel – National Partnership for Women & Families

Was there any reason we can't have the capability to have multiple fields for different purposes in Stage 2?

Neil Calman – The Institute for Family Health – President and Cofounder

I mean to me this is pretty simple. I mean, you know, but I turn to Charlene to say how simple is it?

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

I mean, most of these systems have a patient registration and preference process, but I'm sure they vary all over the place, they probably have all different levels of capabilities and again, depending on the kind of data they have.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Today it's recorded largely because a patient is asked whether they can be phoned, can they leave a message on the home recording device, can they leave it on their cell phone. So that information is being captured because in order to comply with HIPAA if I'm going to leave you a message I have to show that you demonstrated that's okay even if it's available to your kids when they listen to the messages at night. Although, I guess those days are over. But, I do think there are ways to gather it today because we're seeing it required in other areas.

Paul Tang – Palo Alto Medical Foundation

And in a sense, that also proves that provider, I mean you still have to have common sense, you know, there are certain messages you are going to leave on a phone and there's certain that you really need to get in touch with them just like the, because I was going to raise, well not everybody looks at their messages sent electronically, but if you've gotten this product of consent, like may I leave messages on the phone? Then it's the provider's discretion saying is this something, one, that should be left on the phone and two, the urgency is not such that I really actually should talk to them. I mean, you just have to rely on professionals.

Neil Calman – The Institute for Family Health – President and Cofounder

Well, that's the question is whether or not we're actually...when somebody specifies a preference whether you're required therefore to use that preference.

Paul Tang – Palo Alto Medical Foundation

Well, it's just like phone. I mean, the fact that they said...

Neil Calman – The Institute for Family Health – President and Cofounder

Well, that's a different field. I mean if you're saying to somebody how do you want to be communicated with, you know, it ends up you've called them on phone three times to tell them about an abnormal lab result but you didn't use your secure portal, you know, have you now like, you know, are you now responsible for not having gotten them the information the way they said they wanted it? I mean, I'm just thinking...there's a different between permission and requirement here. And I'm just thinking once somebody specifies that are we then, you know, required to send their flu shot that way and their Pneumovax reminders and all the other things because that's what the person said that's the way I want it.

Christine Bechtel – National Partnership for Women & Families

Well, but this is preference it doesn't say requirements. Yeah, I mean it says preferences.

Neil Calman – The Institute for Family Health – President and Cofounder

Well, it's the patient's preference, it might be my requirement. I mean I just want to make sure, you know, that it's interpreted as that way and that it's still the provider's discretion to basically use their judgment to send messages however they think is appropriate.

Christine Bechtel – National Partnership for Women & Families

Sure.

Yael Harris – Health Resources and Services Administration

If your recording preferences and then you have to use those preferences...I mean that's a very good point.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But, it does say that we're building to something and it does give signals for phase three, right? We do expect that you're going to know how your patient wants to be communicated with because in the future we want to do care coordination and collaborative care. So, I think just like all the things we've done through Meaningful Use first phase is data collection, the second phase is action and third phase is outcome, so right now we want to make sure that there's something there that records the preference of the patient's communication. I think there is a minimal; I mean I'd like to see it bigger.

Yael Harris – Health Resources and Services Administration

But, right now it's just basically capturing the information and moving it to something more in the next stage.

Neil Calman – The Institute for Family Health – President and Cofounder

Well, if we're going to build it, we should be build it right the first time. So, if we think there is some granularity that's needed we should build the granularity in now not say well now we'll do one field, but in Stage 3 we'll require 6 different fields for how they want their labs and how they want their, you know, reminders and how they want whatever. I mean, we should figure that...I think...and I'm not suggesting we do this right at the table. But, if we're going to do the granularity we should build it once and build it right.

Paul Tang – Palo Alto Medical Foundation

So we might say something like...I mean, as examples it could be like, nonurgent clinical information and administrative information. So, the granularity we're suggesting is that there are multiple types of messages and there are multiple means of communication and then leave that to the industry/Standards Committee. Over time hopefully there will be standards, but...

Yael Harris – Health Resources and Services Administration

That still goes back to the fact that there are no standards.

Paul Tang – Palo Alto Medical Foundation

Correct, but I mean, people come up...so even if you gave us, the provider, the capability of saying there are multiple messages types and there are multiple modes of communication, and we fill in our fields, that's fine, we can deal with that.

Neil Calman – The Institute for Family Health – President and Cofounder

So, I would think that health maintenance and general reminders, and things like that are things people would consider less secure. Lab messaging and, you know, results and other things like that might be in a different category.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So administrative or health.

Neil Calman – The Institute for Family Health – President and Cofounder

And then administrative and billing information might be a third category, but I mean, we should think this through a little bit more than...

Paul Tang – Palo Alto Medical Foundation

Yeah. So, multiple categories, multiple media. Okay.

Christine Bechtel – National Partnership for Women & Families

So, but this is one we would want to re-elevate given...

Paul Tang – Palo Alto Medical Foundation

Correct.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation

So is there consensus about us reconfirming our recommendations about the importance of this and we include multiple message types and multiple media.

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation

Good. Okay.

Christine Bechtel – National Partnership for Women & Families

The outlier would be because it's not in the NPRM we can't recommend it for hospitals, right?

Paul Tang – Palo Alto Medical Foundation

Now, what does this mean when it says seeking comment? I think it gives them the ability, right?

Christine Bechtel – National Partnership for Women & Families

We could? Okay. All right.

Paul Tang – Palo Alto Medical Foundation

Yeah. So, that was the signal, right? Open for lunch.

Josh Seidman – Office of the National Coordinator

...

Paul Tang – Palo Alto Medical Foundation

Okay.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

It's even better business for hospitals.

Paul Tang – Palo Alto Medical Foundation

Actually, wait a minute did we recommend? We didn't recommend for hospitals.

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

...

Paul Tang – Palo Alto Medical Foundation

But a hospital, you are a captive audience there, so, what?

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

I think hospitals need to find out, you know.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Well 40% of my hospitals...if the hospitals represent 40% of the commercial lab business for instance, you know, I'd want to know the preference of communication...If I have to send ongoing, not only provide patient education materials and patient instructions, but I also need to send reminders that are based on care reminders to help avoid rehospitalization, I would like to know what communication media, because I would encourage electronic communication, it's less expensive for me as a hospital. So, I do think this applies to whether you're an EP or a hospital. Why wouldn't a hospital do this?

Paul Tang – Palo Alto Medical Foundation

Because they don't have a relationship outside of the admission.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Well, they're going to be held accountable for readmission.

Paul Tang – Palo Alto Medical Foundation

Yeah, but not they are, the provider.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

The hospital will be held accountable for readmission, at risk for the readmission. The hospital will be held accountable for the transitions of care and more so, there's long-term care to other settings. So, I think this is a good place to say we're going to start collecting that data, because there is an intent that you will communicate with a patient after this discharge.

Paul Tang – Palo Alto Medical Foundation

So, why didn't we include hospitals the first time around?

George Hripcsak – Columbia University NYC

...I don't remember.

Paul Tang – Palo Alto Medical Foundation

...so, do people want to include hospitals in this proposal?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I do.

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

Yes.

W

...

Paul Tang – Palo Alto Medical Foundation

Okay. Okay. Okay, so it took a little longer than planned, but hopefully this was the harder of the remaining categories. I think we'll still keep with the game plan of trying to get the objectives as we have them and then come back for the questions just so we make progress. Okay, lunch, how about if we go until 1:00 o'clock. I think the fact I didn't give you a break...yeah, yeah. Okay, so be back at 1:00 please. Thank you.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Operator would you like to open the lines please?

Operator

Lines are open, thank you.

Paul Tang – Palo Alto Medical Foundation

Okay, wonderful, welcome back. Hopefully you had some time off for lunch and we hope to finish off the rest of the categories and then come back and do some of the questions we didn't have a chance to do in categories one and two. Some of the questions will come up for categories three and four, care coordination and population public health. What we can do is we'll go back to questions maybe after we finished the objectives. So, the first objective actually was eliminated because instead of testing, they're going to go onto incorporating sustained use. Now, if someone can remind me what they did with Stage 1 folks, doesn't it change in 2013 or something like that?

W

It's deleted in 2013.

M

Basically it was agreed that there was not a very robust objective that it was actually not included for Stage 1 in 2013.

Paul Tang – Palo Alto Medical Foundation

So, in a sense, it was something that in practice didn't live up to the expectations that we had. Probably the biggest driving force for it in the first place was just to work it into certification so that EHRs could exchange. Then the idea came about of well maybe you ought to test it as it exists and that probably is where we stopped the intent but so many people went through a lot of trouble to do even more than perhaps was intended and so CMS and ONC are proposing to just drop it even from those qualifying for Stage 1 but beginning in 2013 because the final rule doesn't come out until the latter part of this year. Everybody got that? Okay. Any questions there?

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation

Christine?

Christine Bechtel – National Partnership for Women & Families

So, while the NPRM does say they are proposing to eliminate it the NPRM also discusses four options, elimination is only one of them and I think we need to talk about the four because my concern is there is no on ramp to exchange if you take an exchange you're completely out of Stage 1.

Paul Tang – Palo Alto Medical Foundation

So, do we have...can someone quickly find that in the text?

Christine Bechtel – National Partnership for Women & Families

It's page 31.

Paul Tang – Palo Alto Medical Foundation

Thirty-one.

Christine Bechtel – National Partnership for Women & Families

The four options are one, removal, two would be require that the test be successful, three eliminate the objective but require that providers select either the Stage 1 medication reconciliation objective or the Stage 1 summary of care at transitions and referrals from the menu set, so make one of those, you know, they have to pick one, or four require one case of actual electronic transmission of a summary of care document for a real patient to another provider of care at transition or referral, or to a patient authorized entity.

Josh Seidman – Office of the National Coordinator

Just a note, on number three, there was potential for alignment for what was done with public health in Stage 1 where there were no core measures but that you had to choose something from that. In Stage 1 since the care coordination had just that one as the core there wouldn't be anything that they would necessarily have to do.

Paul Tang – Palo Alto Medical Foundation

Okay, Christine, do you want to discuss all four or do you have one of the options that you thought was appealing in some way?

Christine Bechtel – National Partnership for Women & Families

Well my...I think my preference would be either the third or the fourth option, so one case of an actual transmission or I actually think number three is interesting, but the summary of care at transitions from the menu set being the more important I think, because I'm not sure how medication reconciliation really

facilitates the kind of exchange that we're building towards in Stage 2. So, if they did the summary of care at transitions then they would have to do, if I remember correctly, 50% transmit a care summary which could be on paper and of that, I believe, 10% have to be electronic, is that, Claudia is shaking her head, but let's go back and look.

W

...

Christine Bechtel – National Partnership for Women & Families

Oh, well that's a problem.

W

...

Josh Seidman – Office of the National Coordinator

I think that's right.

Christine Bechtel – National Partnership for Women & Families

Let's go find it.

Josh Seidman – Office of the National Coordinator

Just to clarify when the number three proposal was not that there would be, you're right medication reconciliation doesn't necessarily require exchange, the idea was to propose one in the care coordination domain. So, it's certainly a care coordination objective.

Christine Bechtel – National Partnership for Women & Families

Oh, okay.

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

I just wanted to add a comment relative to the measures. This was one and recognizing that, you know, whether the test was successful or not, there's a lot of work on part of both the vendors and the providers to get ready to do this, so in kind of soliciting some feedback, providers are so busy that unless they have to focus on it they don't. So, it really...having the test there was a huge step in helping them get ready for Stage 2, you know, working through that, so anything external and driven by external. So, they kind of...of course these might've been Stage 1 attestors who already did the work and don't want people to get by more easily later, but on the other hand they felt there was a lot of value in driving the alignment toward gathering the necessary data to populate the CCD, making that a focus such that the exchange could happen. So, that's really not trivial on the part of organizations to get even to the test.

Christine Bechtel – National Partnership for Women & Families

So, Charlene if they had to do one case of an actual electronic transmission of a summary of care document that would essentially be the same as a successful test?

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

Yes.

Christine Bechtel – National Partnership for Women & Families

And assuming that Direct is a little more available now, it may not be as complex?

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

I mean, they've got the infrastructure in place, you know, and most of the products now are supporting it so we're getting there.

David Lansky – Pacific Business Group on Health – President & CEO

...advocate that we comment in favor of.

Paul Tang – Palo Alto Medical Foundation

And that one is one transmission of a summary of care document?

M

I concur.

Paul Tang – Palo Alto Medical Foundation

We have a rising tide for that.

Christine Bechtel – National Partnership for Women & Families

...

Paul Tang – Palo Alto Medical Foundation

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

It makes sense.

Paul Tang – Palo Alto Medical Foundation

Okay, so it makes sense because of what Charlene just said, which is you're getting both ready technically and you're getting in the mood to try to understand what it takes to do that and you'll know better what to ask of your vendors and your partners to do the actual transmission in a sustained way.

Neil Calman – The Institute for Family Health – President and Cofounder

And care transmissions is one of the things we've highlighted as being one of the most critical aspects. So, I think calling that out is really good.

Paul Tang – Palo Alto Medical Foundation

And it does address one of the biggest complexities and wasted efforts was just having to understand what test meant.

Neil Calman – The Institute for Family Health – President and Cofounder

Right.

Paul Tang – Palo Alto Medical Foundation

So, instead we're going to something that is preparatory. Would people recommend that this be an either or? So, would you recommend it being a core or you would substitute for the test for example?

Christine Bechtel – National Partnership for Women & Families

Well what would the difference be?

Neil Calman – The Institute for Family Health – President and Cofounder

Are you talking about for Stage 1 or for Stage 2?

Paul Tang – Palo Alto Medical Foundation

For Stage 1.

Neil Calman – The Institute for Family Health – President and Cofounder

For Stage 1?

Paul Tang – Palo Alto Medical Foundation

Yeah, because they're recommending by 2013 that people who can qualify for Stage 1 without even doing any kind of exchange, test or otherwise.

Christine Bechtel – National Partnership for Women & Families

So CMS has clearly said that they don't think that a test idea was effective?

Paul Tang – Palo Alto Medical Foundation

Right.

Christine Bechtel – National Partnership for Women & Families

And I'm not sure that I see the difference between a successful test and number four, which is one actual electronic transmission.

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

Yeah, I'd agree. It seems like you have to do one electronic transmission and...

Paul Tang – Palo Alto Medical Foundation

Well, but you have to succeed this time.

Christine Bechtel – National Partnership for Women & Families

Oh, you know, the difference may be on a real patient versus, you know...

Paul Tang – Palo Alto Medical Foundation

Right.

M/W

Multiple voices.

Christine Bechtel – National Partnership for Women & Families

Which I actually think is more meaningful and I think it's a better connection too. So, I, like David would be...

Arthur Davidson – Denver Public Health Department

But this is our recommendation for Stage 1.

Paul Tang – Palo Alto Medical Foundation

This is for Stage 1. So, one...Josh do you know whether this is even allowed? Because this would be more strenuous than what currently exists. Would that be allowed? Let's ask the question that way I guess.

Josh Seidman – Office of the National Coordinator

Well we are seeking comments on these four.

Paul Tang – Palo Alto Medical Foundation

Okay.

Josh Seidman – Office of the National Coordinator

Four options.

Christine Bechtel – National Partnership for Women & Families

...permissible.

Paul Tang – Palo Alto Medical Foundation

Okay. Are people comfortable with that then? So, we're recommending back that we agree with eliminating the test which was just not that useful in practice and substituting something more substantive and valuable in moving toward Stage 2, which is going to have to be a sustained kind of exchange anyway. Okay, so that's option...so agree with eliminating the test and recommend option four.

George Hripcsak – Columbia University NYC

But, it doesn't go under Stage 2?

Paul Tang – Palo Alto Medical Foundation

It goes under Stage 1 and 2.

Christine Bechtel – National Partnership for Women & Families

Right, there's another tab on the spreadsheet that is proposed changes to Stage 1, that's another tab, a different tab. Paul, the only question I have is what would a patient authorized entity be? And Josh, I don't know if that is some term...if that's a term of art from CMS and ONC? It says a transmission to another provider of care at transition or referral or to a patient authorized entity. Do you have any sense of what the patient authorized entity would be and should we therefore, if we don't know what that is simply say another provider of care, which is what, you know, what it says but eliminating the other patient authorized...I'm just am not sure what that would be and I don't want it to end up being a loophole.

Josh Seidman – Office of the National Coordinator

Yeah, I don't know. It also might confuse things with the discussion...that is something that happened this morning.

Paul Tang – Palo Alto Medical Foundation

So eliminate that clause?

Christine Bechtel – National Partnership for Women & Families

Yeah, just that little "or."

Paul Tang – Palo Alto Medical Foundation

Okay. Okay.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation

It's on page 31. Okay, very good.

Michael Barr – American College of Physicians

On that point could there be another health information exchange outside the normal region in which case you wouldn't want to eliminate it, that would be another entity but it wouldn't be a provider. So, I'm a snowbird, I live in New York, I fly to Florida, I want the doctor to transmit my information to the Florida HIE. So, maybe they're not connected in New York. That would be, I guess a patient authorized entity perhaps?

Josh Seidman – Office of the National Coordinator

I honestly just don't know.

Michael Barr – American College of Physicians

Okay. I think before we eliminate it we ought to seek clarification to what the intent was.

Christine Bechtel – National Partnership for Women & Families

Yeah, I think that makes sense and maybe we can say in our narrative, if this is an information exchange that seems okay, but it if is a family caregiver, that is not the intent of this piece because that's covered somewhere else or I don't know who else it would be, but.

Paul Tang – Palo Alto Medical Foundation

Okay and let's answer the question. So, we are basically substituting the test with this requirement for Stage 1 beginning 2013, I think that's what I heard the proposal to be. And what do we say about Stage 2? It would just be the same?

Christine Bechtel – National Partnership for Women & Families

No, Stage 2 is a totally different proposal, different criteria.

Paul Tang – Palo Alto Medical Foundation

Okay, okay, so this is only basically a substitution. So, instead of just dropping we're proposing a substitution.

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation

Okay. The next was a menu item and it's the medication reconciliation for more than half of the transitions of care. So, that's what Stage 1 was. Stage 2 what we had proposed was to keep the same specification but just move it to core. And what is proposed in the NPRM is an increase in the percentage, instead of 50% going to 65% and I believe that's it. Correct? So, this is just a change in percentage.

Christine Bechtel – National Partnership for Women & Families

It's a core.

Paul Tang – Palo Alto Medical Foundation

It is a core and raises the percentage from 50% to 65%.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Does there need to be anytime about timeliness?

Paul Tang – Palo Alto Medical Foundation

It is at the point you received the patient. So let's see if it says that. It says who receives... So any comments about the increased percentage? So we'll just accept the 65%?

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

A lot of the comments we were getting back was relative to definition of transition. So, first encounter, admission, referred, but a little unclear, you know, someone who had seen a specialist in coming back. So, you know, do you need a reconciliation then a post discharge visit? So, there was more clarity around what is defined as a transition of care.

Paul Tang – Palo Alto Medical Foundation

Okay. So, I think one thing they did do in the... was talk about okay this applies to the recipient, so that's helpful clarification. The others I think they did specify transitions, which is settings or providers really, it's the primary to specialist. Now, what I didn't hear is the specialist back, is that another transition?

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

Yes.

Paul Tang – Palo Alto Medical Foundation

So we're all agreed on the recipient at the time of transition from another provider or setting? Now let's answer Charlene's question about on the way back. On the one hand there certainly could be a medication change on the way back that you'd have to reconcile. Is that another requirement we're putting onto, in this case it would be the PCP?

Christine Bechtel – National Partnership for Women & Families

Paul, can you restate that?

Paul Tang – Palo Alto Medical Foundation

So, we've been thinking of transition as going... well at least EP to EP would be going from PCP being referred to a specialist and so, being received by the specialist to do a medication reconciliation, when you come back to the PCP that's another transition actually. We didn't really think about it that way.

Christine Bechtel – National Partnership for Women & Families

Right, so it's closing the loop.

Neil Calman – The Institute for Family Health – President and Co-founder

The proposed measure says 65% of transitions of care in which the patient is transitioned into the care of the EP or...

Paul Tang – Palo Alto Medical Foundation

Okay, so what you're pointing out is they're established with the PCP already, they're not being transitioned back.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation

That seems fair, if we can clarify that definition.

Christine Bechtel – National Partnership for Women & Families

Yes, that helps.

Paul Tang – Palo Alto Medical Foundation

And of course it's in the PCPs best interest to make adjustments and medications that have been added, but to add another requirement and another counting may just be overly burdensome.

Michael Barr – American College of Physicians

The challenge I see with that is that once you're established with a primary care clinician, you're always there. So, it's not like you're ever going to be transitioning back into it. So, the definition of transition is they're in a different setting for a period in time in theory whether that's a hospital with specialists having oncology episode of care and then coming back for...so it's hard to even use the definition you just came up with. I think, I mean, whenever there's a medication change there should be a medication reconciliation. If there's a medication change in relation to where the patient was before they came to where they are, a medication reconciliation has to happen. So, I don't know.

M

We could go around and around...

Christine Bechtel – National Partnership for Women & Families

...

Paul Tang – Palo Alto Medical Foundation

So, what the medication reconciliation is supposed to uncover is the medication change that you just made.

M/W

Multiple voices.

Paul Tang – Palo Alto Medical Foundation

Yeah, a little bit of a catch-22 here.

Michael Barr – American College of Physicians

Oh, no...but I don't think just...

Paul Tang – Palo Alto Medical Foundation

Okay, so let's think about logistically what we would have to do is be able to count these things. Well, if you're going to another specialist and not in your EHR there is no other way to get the medication on your

list and we're projecting in Stage 3 to have accurate problems in medications for example. So, this would support the accuracy. So, if you're doing a medication reconciliation for every transition, you're supporting having an accurate medication list.

Neil Calman – The Institute for Family Health – President and Cofounder

How does the system know whether you've been somewhere else? That's really the...when you're counting part.

Paul Tang – Palo Alto Medical Foundation

That's right.

Neil Calman – The Institute for Family Health – President and Cofounder

Right. It doesn't. So, like if a patient of mine comes back from the hospital I have that conversation and I record it in the text part of my note, but the hospital record is not part of my system and so there's no way for the system to know that I was required to do a medication reconciliation at that visit.

Paul Tang – Palo Alto Medical Foundation

So, for people familiar with the certification rule, how is that spec'd out? And, both in functionality as well as a counting measure? So, while they're looking that up, that's one issue, but how are we philosophically on transition to the extent that we can identify them, I suppose they have to have a medication reconciliation.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, I was just going to ask, before you made the distinction between somebody who had an existing PCP or somebody who is coming from the hospital for the first time to a PCP, I don't really think there is a distinction there, is there?

Paul Tang – Palo Alto Medical Foundation

No, we were trying to leverage your definition of established, if you're already established, that was our out for the return home, but Michael pointed out that's irrelevant, a transition is a transition.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, exactly.

Paul Tang – Palo Alto Medical Foundation

We're trying to maintain the accuracy of the medication list in this case.

Christine Bechtel – National Partnership for Women & Families

So, Paul, I think, and this is certainly the case for Stage 1, because we're not, the measure itself hasn't changed only the threshold, but to the extent that it is helpful, the certification criteria say clinical information reconciliation, enable a user to electronically reconcile the data elements that represent a patient's active medications, problem and medication allergy list as follows; for each list type, number one, electronically display the data elements from two or more sources in a manner that allows the user to view the data elements and their attributes, which must include at a minimum the source and last modification date, and then the ability to merge and remove individual data elements and the ability to review and validate the accuracy of the final set of data elements.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...the order?

Paul Tang – Palo Alto Medical Foundation

The order, but how do you know this if they're not in your system? That sounds perfectly fine if they were in your system.

Christine Bechtel – National Partnership for Women & Families

I mean, yeah, so I think, but this not a change from Stage 1, so I think we have to figure out how is this happening today and I think...

Paul Tang – Palo Alto Medical Foundation

Well, I'm not sure it's happening because most people elect not to do it and probably one of the reasons is its pretty hard to measure. So, can we improve on...so let's go back to intent. The ultimate intent is to make sure we have an accurate medication list for this patient. So, that's what we've got to do. How do we do that? So, let's say a future world when all is connected, you may be able to reconcile what's being dispensed to this patient against what you have, that would be a medication reconciliation, right?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, PBM connectivity might be one of the considerations that we have beyond just an HIE for demonstrating connectivity, because then if I have my PBM connected, the idea of medication reconciliation is not overwhelming. The idea of medication reconciliation right now is a paper bag filled with drugs that you carry.

Neil Calman – The Institute for Family Health – President and Cofounder

I think this is a different objective. I think the objective here is using the electronic health record to do a medication reconciliation, it is not the HIE objective; it's not that you have to get the information electronically for a test or whatever it is, because ultimately the medication reconciliation is a conversation with the patient. The only person that knows whether they're taking their medication is the patient and what they're actually taking, you can consolidate all the electronic information you want in the world, even which prescriptions got filled and where they were filled and when they were filled, when they were changed, it doesn't make any difference at the end of the day the only way to actually determine what the medications are is by having a conversation with the patient.

So, I read this objective is how do you use the electronic health record to support reconciling what medication somebody is actually taken with that conversation and the ability to get other information from other sources is actually sort of a supplement to that but I don't think should be part of this requirement, because I think what we'll do is we'll lose the core meaning of this requirement because of all the exchange craziness that's going to go, you know, whether or not you get information from pharmacies and from hospitals and wherever.

Arthur Davidson – Denver Public Health Department

So, I agree with you, Neil and I'm wondering whether, since we're having this trouble is that we can't define when there is a transition of care. We don't necessarily capture that in the electronic medical record. So, maybe one of the things that we could do, since we need that information, which would then trigger to say it's time for you to do a medication reconciliation, because that's the thing we want to happen, is should there be a question asked during the triage phase? Have you transitioned or have you seen anybody else in care, we say "yes or no" and then you go to that workflow that says, okay I'm doing medication reconciliation and I'm also collecting the denominator for the number of transitions.

Neil Calman – The Institute for Family Health – President and Cofounder

That's a really great idea. I would support that idea, because that would really drive home the value of this and a lot of times that information is not captured that people have gone other places and that they've gotten other medications.

Paul Tang – Palo Alto Medical Foundation

So, let me just point out that both of those suggestions are one, increased documentation and two are checkbox kinds of documentation, that's just a fact, it's not saying one way or another, but other people's reactions? And we can't formulate it, yeah.

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

This is Marty, one of the big things that happens of course in the hospital is reconciling what the patient came in on with the changes that were made during their inpatient stay so we can get accurate

information to their primary care provider, but in actuality the best medication reconciliation we do is when home health goes in and sees what's in the medicine cabinet and it really reconciles it.

Paul Tang – Palo Alto Medical Foundation

Any other comments?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, the reconciliation that computing helps us with is I have this list and that list and I compare them, that's what computing does. So reconciliation that you're talking about is patient reported medications against what I have in the computer, which is a consult, not a reconciliation of computing. So, I think it is really important to get this nailed, what is the objective that we're trying to achieve and how does HIT help meet that objective?

Paul Tang – Palo Alto Medical Foundation

Well, I think as Neil and Art pointed out reconciliation is a human process. Data can be made available to facilitate or supplement, I think is what Neil said, that process and because it is a human process I'm not sure there is another way besides a checkbox.

Neil Calman – The Institute for Family Health – President and Cofounder

But, the EHR, it's not as simple as a checkbox, because the EHR has to have the ability for you to enter, you know, time-limited medications, somebody completing an antibiotic prescription for eight more days when they come back to your office, but something that is going to end, changes in dosages, you know, there's all kinds of things that go on in that reconciliation process. Changes in medication schedules, so it's more than just checking, you know, checking a box, but I hear what you're saying, if it's the same you check the box, but a lot of time it is not.

Paul Tang – Palo Alto Medical Foundation

Well, no the process of even doing this adjudication of the dosage, that's the activity. So, the only way you can indicate that you did that activity is to check the box. I think what we're asking for in the EHR is the facility to have a, oh a change and indicate what I'm doing, is I'm reconciling. Do you see what I'm saying? If you just have a medication list and you add medications nobody will ever know, but the process of doing the reconciliation is something that should be supported by EHR but unfortunately the act, the fact that you did this human process is probably still checked. Christine?

Christine Bechtel – National Partnership for Women & Families

So, maybe I'm just catching up with CMS's thinking and now I get the implications for exchange here, so it sounds like in order to meet this criteria successfully you would actually have to have another electronic source of that information, whether it's coming from the hospital or a PBM, or something like that, because if they define it as the ability to compare two lists electronically, you're going to have to have another list from somewhere else, it may not be a complete one, but I don't see how you could have...

Paul Tang – Palo Alto Medical Foundation

But the list could be in the patient's summary that somebody is carrying...

Neil Calman – The Institute for Family Health – President and Cofounder

It could be a plastic bag full of medications.

Christine Bechtel – National Partnership for Women & Families

Right, well, no, I understand what it could be like in real life medicine, but in Meaningful Use what I'm reading is that it actually could be two lists in the computer and that's why...you don't think so?

Paul Tang – Palo Alto Medical Foundation

No, I don't think so.

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

Actually there were a few questions about that from our customers, I mean, we would have calls, I mean, because they have, they're converting from a paper system to an automated system and they'd have their paper list and does that count as two lists? You know, and we do the Surescripts, so we do all those piece too, but it was a big issue.

Christine Bechtel – National Partnership for Women & Families

So, it might be helpful to look at CMS's fact sheet on this, because as an existing criteria, I mean, they have detailed sort of spec sheets and that may shed some light, I just don't have Internet access at this moment.

Paul Tang – Palo Alto Medical Foundation

Any clarification from ONC on this point? Either how it's measured? Is it measured as a checkbox? My guess is it's measured as a checkbox. I think the spirit of the discussion is the EHR should support this process by being able to compare lists one way or another. So, there is a list of what you're on and there's a list of what I used to think you're on and one can be populated by human entry from a paper or whatever, ideally over time it'll be done through other exchange mechanisms, but there is a facility where I can record my actions, you know, this is what I used to think you're on, now this is what I think you're on for the following reasons, and that the measure itself actually is the process of reconciliation, which unless someone can think of another idea, is a checkbox that says I've done this process.

Michael Barr – American College of Physicians

Paul, maybe I'm a little confused, but we're not requiring that it be electronic reconciliation as you're describing, okay because that's not what it says.

Paul Tang – Palo Alto Medical Foundation

Correct.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, we're not saying that.

Michael Barr – American College of Physicians

Okay.

Paul Tang – Palo Alto Medical Foundation

Because we can't at this point.

Michael Barr – American College of Physicians

...

Neil Calman – The Institute for Family Health – President and Cofounder

Right.

Paul Tang – Palo Alto Medical Foundation

Now, so the process has occurred more than 65% of the time for a transition we acknowledge again that the transition is something that is human detectable and the big computer in the sky could be known, but right now it's really a human judgment that a transaction has occurred.

Christine Bechtel – National Partnership for Women & Families

Yeah, so are you going to record it?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

How could you do it? There is no other way to do it.

Neil Calman – The Institute for Family Health – President and Cofounder

So, basically what you're asking is then as part of the process of every encounter somebody asks have you have seen another provider in the interim and has there been any change in your medications?

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

Don't they ask that anyway?

Neil Calman – The Institute for Family Health – President and Cofounder

Well they should ask it anyway.

Yael Harris – Human Resources and Services Administration

...change in health status, whatever, that's just part of the questions they should be asking.

Paul Tang – Palo Alto Medical Foundation

Yeah.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, I'm agreeing with you, I'm just saying we should recognize the fact that we're calling out that people have to enter and record that information which is not currently entered electronically, you know, as part of the record in a checkbox kind of format.

Paul Tang – Palo Alto Medical Foundation

Well ours does and yours does too, but I mean, so the act actually...it's still a good practice at every encounter.

Neil Calman – The Institute for Family Health – President and Cofounder

Right.

Paul Tang – Palo Alto Medical Foundation

Because what you're doing is like you pointed out, you're trying to figure out what the patient is taking, that's what's most helpful. Okay, so I think we're leaving it the same and what we're doing is we're clarifying making sure that the certification criteria described, and it maybe already described, but most people didn't care, because they didn't use this as a menu, so make sure that is described so that the EHR is able to facilitate this process of medication reconciliation, what you think the patient is on and what has happened since then.

Christine Bechtel – National Partnership for Women & Families

I think the criteria does that.

Paul Tang – Palo Alto Medical Foundation

It may.

Christine Bechtel – National Partnership for Women & Families

Because it talks about merging and reconciliation.

Paul Tang – Palo Alto Medical Foundation

Okay, so if we just confirm that it meets that intent.

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

Just a comment, I think we will probably get some pushback on the 65, that's a kind of, you know, it's a complicated process, there are some process issues with some of the specialists, they see a patient later down and they order 5, so it gets a little complicated to actually operationalize it, not so much as a function, you know, it's the culture of the steps and that type of...

Paul Tang – Palo Alto Medical Foundation

I have to agree with that and I think that's one of the reasons we had this discussion before and said do we go up and we said "no." So, maybe we should have that discussion again. So, in some sense even though whatever you're going to do you want to do for everybody, 65 looks a lot more scary than 30,

because you think you can get there, it's almost like an organizational activation process. So, I guess I share some of that sentiment. Other people, about the feel of 65 versus 50?

Yael Harris – Health Resources and Services Administration

I've got another issue to bring that might affect the percentages, which is are we only talking about EPs and EHs or are we talking about any transitions, because there's plenty of, you know, a psych hospital for example is not an EP, but if they're coming from a psych hospital back to the primary care doctor, do we want to reconcile medications?

Paul Tang – Palo Alto Medical Foundation

I think it was written as any, at least in, well...

Yael Harris – Health Resources and Services Administration

It's not clear there.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, it's not really.

Paul Tang – Palo Alto Medical Foundation

I think in the...it was talking about...

Christine Bechtel – National Partnership for Women & Families

You're right.

M/W

Multiple voices.

Michael Barr – American College of Physicians

The example on 104.

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

We don't know what our denominator is.

Michael Barr – American College of Physicians

So, the example site a hospital, ambulatory, primary care practice, ambulatory specialty care practice, long-term care, home health, rehab facility.

Paul Tang – Palo Alto Medical Foundation

Right. I remember reading that...but the measure actually doesn't include those words.

Neil Calman – The Institute for Family Health – President and Cofounder

No, not really.

Paul Tang – Palo Alto Medical Foundation

It's all left to human honesty and judgment.

Michael Barr – American College of Physicians

Well that's my point if we're going to include that...

Yael Harris – Health Resources and Services Administration

It does say 65%, I mean are we saying that is just transfers from hospital back to EP, is 65% versus any kind of transfer?

Michael Barr – American College of Physicians

The way this would suggest would be any transition, not just EP to hospital or hospital to EP. In which case then the checkbox is this a transition or not becomes a way, honestly to...

Yael Harris – Health Resources and Services Administration

It's almost like you need to have that in the certification criteria to ask them that too, is there a transition.

Paul Tang – Palo Alto Medical Foundation

Right, right. In some sense some of the sentiment is it's really one, hard to measure and two it relies on humans so it may be counterproductive to push something to a scary level.

Michael Barr – American College of Physicians

Because then you're going to game it, you just won't check that this is transition and you'll undermine the intent.

Paul Tang – Palo Alto Medical Foundation

Yeah. How do people feel about that sort of rationale? I see a couple of nods.

Yael Harris – Health Resources and Services Administration

Are we saying we're lowering the percent?

Paul Tang – Palo Alto Medical Foundation

Well, we're suggesting that we'd like not to go to 65 then we talk about what percent, because we might even go back on word, it's at 50.

Michael Barr – American College of Physicians

Do we have any data from Stage 1 yet?

Paul Tang – Palo Alto Medical Foundation

Well that's not used...

Christine Bechtel – National Partnership for Women & Families

But, they do talk about it in the rule and they actually give that, the two reasons for upping the threshold are, one is that the performance of both EPs and hospitals was well above the Stage 1 threshold and two; they believe that they are seeking to promote information exchange. So, that's the rationale given in the rule for going from 50 to 65.

Paul Tang – Palo Alto Medical Foundation

So, just as Rob Anthony constantly informed us the small numbers and early adopter doesn't necessarily predict what the rest of the country is going to do...

Christine Bechtel – National Partnership for Women & Families

I'm just telling you what's in there.

Paul Tang – Palo Alto Medical Foundation

Yeah, I know, I know.

Christine Bechtel – National Partnership for Women & Families

Don't shoot the messenger.

Paul Tang – Palo Alto Medical Foundation

And then the other is we're pushing back for a different reason.

Christine Bechtel – National Partnership for Women & Families

I think I'm having a little bit of trouble.

Josh Seidman – Office of the National Coordinator

The objectives that were in the core, all of the people who have attested, the data that we have is for all of the people who have attested. The measures that were menu we have a test for those who selected that one and the ones where there weren't a lot of people selecting it, we obviously have less data on.

Christine Bechtel – National Partnership for Women & Families

I'm struggling a little bit because I'm not sure there's a huge difference between 50% and 65% and so I'm really thinking more about signaling, but I'm also not sure I completely understand how this objective works and I'm not sure any of us do and so without that knowledge, at least looking at some of the CMS fact sheets and really what this thing is, it's difficult for me to kind of weigh in.

Paul Tang – Palo Alto Medical Foundation

From human behavior activation philosophy it's sort of more give them confidence that they can do something to move them along and so almost for the same reason that was stated in the NPRM, they were trying to encourage exchange, I guess what we're arguing is actually by making it less scary they actually work better in terms of activating folks, that's the rationale we are trying to use for the same goal.

Christine Bechtel – National Partnership for Women & Families

And you're making a core.

Paul Tang – Palo Alto Medical Foundation

And we're your making it core. So, all of a sudden we're going to hear from a lot of folks.

Yael Harris – Health Resources and Services Administration

I get a lot of feedback already on this.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think that 50% or 65% is to me...I think 50% is great, 65% is better, but it is something that in the care setting people would say they do 100% of the time at every transition of care, there's not...you can't ask the hospital administrator if they're not doing intake and doing medication reconciliation with that patient in the ED and at admit, and in the preadmission department, they're not and I can't speak as much to the sole practitioner or the family practice doctor but I think this is one area if you asked they'd say of course we do.

Neil Calman – The Institute for Family Health – President and Cofounder

Well the inpatient side it's probably not even right to call it reconciliation because basically what they're getting is a history of the what medications the people are on and they're not trying to reconcile it usually against anything unless the person has been in the hospital in the last 30 days or something.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Well, at intake they are.

Neil Calman – The Institute for Family Health – President and Cofounder

No, they're not reconciling, they're just basically saying.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Oh, taking the list.

Neil Calman – The Institute for Family Health – President and Cofounder

What medications, that's different.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I've got you.

Neil Calman – The Institute for Family Health – President and Cofounder

The reconciliation process is really a different process where a provider has a list of medications, a patient's got another list of medications, electronically you may be getting another list of medications and the consult note has different medications and you're really trying to create...what?

Michael Barr – American College of Physicians

And the bag has also different ones.

Neil Calman – The Institute for Family Health – President and Cofounder

And the bag that you still haven't seen in two years...so...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So the hospital is reconciling it to what they hope to prescribe or order?

Neil Calman – The Institute for Family Health – President and Cofounder

No, they're just basically taking a history.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay.

Neil Calman – The Institute for Family Health – President and Cofounder

So, it's a very different process.

Yael Harris – Health Resources and Services Administration

But if you're talking about ambulatory, wherever they're coming from, then it's what we're concerned about they're carrying a bag of medications and you don't even know which ones they're taking daily.

W

Or the ED.

Yael Harris – Health Resources and Services Administration

Or the ED, yeah.

Paul Tang – Palo Alto Medical Foundation

So, one approach is to start moving toward the process we're really trying to engage folks in doing, which doesn't happen all that much in a proper way and worry less about pushing people to the higher threshold. So, are there ways that we can state this, both the objective and the specification, that moves us along this process we're talking about?

Neil Calman – The Institute for Family Health – President and Cofounder

I think that if we're asking the question at every visit and documenting that, that's going to trigger adherence rates way beyond 65%. So I don't think that the number is that critical. We should just, you know, call out that this is an important function and I don't think the number is going to really drive what happens here.

Yael Harris – Health Resources and Services Administration

I think we should call out that you've got to capture.

Christine Bechtel – National Partnership for Women & Families

The transition.

Yael Harris – Health Resources and Services Administration

Exactly.

Neil Calman – The Institute for Family Health – President and Cofounder

Capture the transition first.

Yael Harris – Health Resources and Services Administration

Because the onus is now on the physician to ask every time and somehow the EHR has to collect...asking, the clinician.

Michael Barr – American College of Physicians

The care team.

Yael Harris – Health Resources and Services Administration

The care team, exactly.

Michael Barr – American College of Physicians

That's anybody on the team who is doing the intake at an ambulatory visit, should be asking the question and that should trigger a cascade of questions and medication reconciliation. I agree with Neil the number is less of a concern, however, I think if you get them to do 50% they're going to do 65, you say 65 and you say I have to do 2/3 of the people, whereas you say, you know, it's a way of framing.

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

Profits will drive that.

Paul Tang – Palo Alto Medical Foundation

Okay, so a couple of things I've heard, one is the new EHR certification criteria which is capturing the fact that a transition has occurred, but we didn't say that before, so that would be actually new. And the second is we appear divided and I guess the only thing we can do is vote on the percentage. And I think it's all about the appearance and the acceptability, and the attitude of the physician and hospitals in terms of meaning what we're intending. I think it's going between 50 and 65. All in favor of 65%? All in favor of 50? Okay, so it's actually, you didn't vote?

Neil Calman – The Institute for Family Health – President and Cofounder

You didn't say 65 did you?

Paul Tang – Palo Alto Medical Foundation

I did say that already.

Neil Calman – The Institute for Family Health – President and Cofounder

Oh.

Paul Tang – Palo Alto Medical Foundation

Okay, so we have one for 65 and so I need the vote for 50 now?

George Hripcsak – Columbia University NYC

Fifty.

Paul Tang – Palo Alto Medical Foundation

One, two, three, four, five, six, seven. What a difference.

Christine Bechtel – National Partnership for Women & Families

I'll be 65.

Paul Tang – Palo Alto Medical Foundation

Okay, it's 7-2.

Christine Bechtel – National Partnership for Women & Families

Not anytime soon.

Paul Tang – Palo Alto Medical Foundation

Just to clarify. I might have to apply the medication and elderly rule too.

Arthur Davidson – Denver Public Health Department

I think your question about the comments and the FAQs that they have. I didn't see anything there that really defined how you would measure a transition. It just says...it assumes that you know the denominator.

Christine Bechtel – National Partnership for Women & Families

Okay, that's helpful.

Arthur Davidson – Denver Public Health Department

I'm looking through and I just can't find anything there.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation

Okay.

Christine Bechtel – National Partnership for Women & Families

I mean that's going to stay with us as an issue, particularly in the next objective as well.

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

...that's a big part the vendors can't discern.

Paul Tang – Palo Alto Medical Foundation

Right. Well when payment policies make it in the best interest to coordinate care then I think we won't have to worry about measuring it.

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

Okay.

Paul Tang – Palo Alto Medical Foundation

That's the end goal, is we shouldn't have to measure all these things, these process measures. Okay, next one was the menu as well and it also wasn't heavily subscribed, a lot because we probably didn't describe a summary of care document that well.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation

Okay, so it is that you provide a summary of care record for more than 50% of all transitions and referrals, and that could be on paper, that was Stage 1 final. What we proposed was that we record and provide, by paper or electronically, a summary of care record for more than 50%, that was essentially mimicking Stage 1. What we added was to include a care plan goal and patient instructions for more than 10%. So, we we're trying to act on care coordination by trying to move toward shared care plans. The problem we ran into is the lack of professional standards about what a care plan is, at least among the physician's community, and lack of standards to specify it. So that's why we had to sort of back off to goals and instructions.

Okay, the way the proposed rule read was to have two measures. One is that you...it says provide, yeah the verb is provide a summary of care record for more than 65%, so they upped it from 50 to 65% and the second is that for 10% they're actually electronically transmitted. Okay, so let's try one at a time. I think the other thing is the list of things in the summary of care plan. Does someone have a page?

Christine Bechtel – National Partnership for Women & Families

Yeah, well it's in the spreadsheet that does have some certification criteria in it. So, it's sort of interesting how this reads, incorporate summary of care records. So, upon receipt of a summary of care record formatted and according to the standard adopted previously, electronically incorporate, at a minimum the following data elements, name, gender, race, ethnicity, language, date of birth, smoking status, vital signs, medications, medication allergies, problems, procedures, labs and value results, the referring or transitioning providers name and contact information, hospital admission and discharge dates and locations, discharge instructions, reasons for hospitalization, care plan, should I keep going? Including goals and instructions, name of providers of care during hospitalization and names and contact information of any additional known care team members beyond the referring or transitioning provider and the receiving provider.

Paul Tang – Palo Alto Medical Foundation

So, George this is on page 108.

Christine Bechtel – National Partnership for Women & Families

That was the summary of care document.

Neil Calman – The Institute for Family Health – President and Cofounder

From the NPRM?

Christine Bechtel – National Partnership for Women & Families

From the certification NPRM.

Neil Calman – The Institute for Family Health – President and Cofounder

Okay.

Paul Tang – Palo Alto Medical Foundation

So, we can't read it.

Michael Barr – American College of Physicians

Page 108...

Paul Tang – Palo Alto Medical Foundation

Yeah, 108...

Michael Barr – American College of Physicians

I know...

Paul Tang – Palo Alto Medical Foundation

So you can't toggle over to your...oh your only sharing that window.

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

...must include, right? You said it sounded like it expects them to incorporate them, right? You didn't say that did you?

Christine Bechtel – National Partnership for Women & Families

Am I missing medications though on that list?

Paul Tang – Palo Alto Medical Foundation

The verb is "must" so we have to deal with this.

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

Okay, I see it.

Paul Tang – Palo Alto Medical Foundation

I guess, I'll read it again and try for...patient name, referring or transitioning provider's name, that makes sense, procedures, now the question will be over what period of time, relevant past diagnoses, lab test results, vital signs, smoking status, demographic information including preferred language, gender, race, ethnicity, date of birth, care plan field including goals and instructions, and known care team members.

Christine Bechtel – National Partnership for Women & Families

And then Paul you have to go down the page for the medication stuff.

Paul Tang – Palo Alto Medical Foundation

Oh, in addition, they should have up-to-date problem list, medication lists, medication allergies. So, I think what happened in Stage 1 was we had an e.g., and I believe what we had was problems, medications, medication allergies. It seemed like there was one more, so it was more like the second paragraph, the problems, medications and allergies. Oh, and we had lab test results. So, those were the four things. And that's not a full spec, that was just a minimum, and that's how we proposed it.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is in response to the need for parsimony across multiple documents. So, you see these same terms being used across these specifications from ONC in anything that is being moved with a patient or reported to a patient. So, I think that for purposes of simplicity, we sort of have to buy off on this bucket to be used in multiple places or if we change the bucket, that bucket has to be used in multiple places. And looking at these data elements, you know, this is largely gathered today, it's part of the specifications people have been talking about for consolidated CDA.

So, there is a lot here that is available within the EMR, it's now saying we have a need to gather this up into one document and ship it someplace and we need to do that in the same way regardless of whether you are the receiver of a patient, you are the patient, you are the specialist or the hospital. So, I would encourage us to be supportive of this effort because of the detail that the standards and interoperability group and ONC went to, to create parsimony across these specifications. So, done once, used often. I think we've heard that over and over again.

Paul Tang – Palo Alto Medical Foundation

Does everybody have in some form the list in front of them? So, we can sort of put...

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

Paul, this is Charlene, so of note this is where they are validating that you've got up to date problem list and...

Paul Tang – Palo Alto Medical Foundation

Correct, correct.

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

The outcome oriented approach toward capturing currently.

Paul Tang – Palo Alto Medical Foundation

Correct, although we dealt with that...

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

Separately.

Paul Tang – Palo Alto Medical Foundation

Yeah, separately. Okay.

Yael Harris – Health Resources and Services Administration

...within this?

M

I'm sorry what was that?

Yael Harris – Health Resources and Services Administration

Is there a time period, did you guys discuss like it says for 65%, but is there a time period by which this needs to be transmitted?

Paul Tang – Palo Alto Medical Foundation

So, that's interesting. One way to look at it is it has to be there before the patient is, that could be the hard line. Yes, it would be nice to have it, you know, if you are going to review before that day...

Neil Calman – The Institute for Family Health – President and Cofounder

Is this the complete document? I mean, I guess the question is if this is being looked at in a care transition kind of way, where's the introduction?

George Hripcsak – Columbia University NYC

Like the reason for referral is one of the...

Neil Calman – The Institute for Family Health – President and Cofounder

Like why you're sending the person.

George Hripcsak – Columbia University NYC

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

So it's great to have all this historical information and everything, but where's the meat of it, which is what, you know, why are you sending the person and what's the question that's being asked or what's the help that's being sought? And do we have...is there a standard for how that gets conveyed?

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

One of the areas that we had thought might be the transition of care comment was the intent, and I think we talked about this in the early analysis was what this care plan field was, was kind of just more a field so that they could put the purpose of the transition in it and it got evolved to be actually the care plan. So, our initial intent in communicating it was keep it really simple so that they could communicate the intent of the transition with that field, as a...

Neil Calman – The Institute for Family Health – President and Cofounder

So...basically?

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

Yeah, and now it's a bit more complex because for each problem you got to have goals and interventions and, you know it gets a lot more complicated than just a simple way of community intention of the transition.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But the order is left out. I think if the order for transition were here that would give you the reason for movement.

Neil Calman – The Institute for Family Health – President and Cofounder

No, there is a contextual piece here that's missing which is, you know, what you want to say to the person on the other end. I'm referring this person because they have been in and out of the hospital for the last year with intermittent episodes of congestive heart failure and, you know, I'm looking to get your advice on whether or not we can change the medication regimen in some way that would keep that from happening or, you know, there's a message in a question that's part of that process that's critical because otherwise you're just communicating a lot of data.

Paul Tang – Palo Alto Medical Foundation

So we may want to go ahead and add it's basically a reason for a referral or transition.

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

Right.

Paul Tang – Palo Alto Medical Foundation

And we know that specialists would kill for this information.

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

Yes, exactly.

Paul Tang – Palo Alto Medical Foundation

All right. So, this would be doing an enormous favor to them if we could add that field, which doesn't exist right now.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, I think we have to...

George Hripcsak – Columbia University NYC

Without this it's really...

Paul Tang – Palo Alto Medical Foundation

Like here's a document.

Neil Calman – The Institute for Family Health – President and Cofounder

...without the meat in here.

Paul Tang – Palo Alto Medical Foundation

So, I think what we're including, and this is specific to this transition document, is reason for referral or transition. So it is an addition to the standard document is the way it's being billed.

Neil Calman – The Institute for Family Health – President and Cofounder

Can I just...while I'm on a roll here. In the return part from specialist to PCP, the specificity, I don't know what the care plan, the specificity is in the care plan, but that's also really critical to call out, so, you know, it's what type of follow-up, what further diagnostic testing, what treatment recommendations, what follow-up interval is being recommended, you know, the things that really, I mean if we could do anything right now to structure this information that passes back and forth it ought to be done in a best practice kind of way not to just sort of create these open fields that create the same insanity that we have not where people don't either give or get back the information they really want.

Paul Tang – Palo Alto Medical Foundation

So, we talk about a referral result or consult results field in one of our discussions. I don't remember whether we ended up putting it anywhere.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Well that would be in the observation message, right? So I can have a clinical observation as a result of a transition that's...I'm just thinking about an HL 7 construct, right? So that observation could be sent back and is also part of the construct of...

Paul Tang – Palo Alto Medical Foundation

So it could be in that HL7 field but we want the construct to be the results of the referral.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Paul Tang – Palo Alto Medical Foundation

And then we could time it against two. So, we not only we get the fact that there was a result communicated back to the referring doctor, but you can time it. So this concept of having a results field in this referral, I'm speaking generally, would be useful.

Neil Calman – The Institute for Family Health – President and Cofounder

What we don't want to get back is sort of the coded diagnosis, because that's not really the meat of what the referring provider really wants. What they really want is again it's the context of so, so here's what I think at this point and then there's usually further recommendations either for further diagnostic work or trials of different kinds of interventions and some recommendation about follow-up. And in free text field what you end up with is people write whatever they want and I think if we can call out this stuff in a very specific way according to a best practice right now, again we'd be doing...primary care people would see this as a huge benefit to them to be able to do this and so would specialists.

Paul Tang – Palo Alto Medical Foundation

So to try to respect the NPRM and trying to work within the rules, what we can do is in the care plan, I think I'd call it more than a field, but in the care plan section, that's it, one there should be goals, there should be a reason for a referral or transition, another is goals, a third is instruction, and a fourth is results of the referral.

Neil Calman – The Institute for Family Health – President and Cofounder

Recommendations.

Paul Tang – Palo Alto Medical Foundation

Results and recommendations. So results could be their diagnosis. Recommendations could be for the diagnostic or treatment plan. So in some sense we could say that we're just being more precise about our specification of the care plan and not add anything.

Neil Calman – The Institute for Family Health – President and Cofounder

Exactly.

Michael Barr – American College of Physicians

Paul, I just also want to point out by doing what you just described I think we're also supporting one of the proposed clinical quality measures, which is closing the referral and measuring a report.

Paul Tang – Palo Alto Medical Foundation

Yeah.

Michael Barr – American College of Physicians

So, I think that is aligns nicely.

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

...outcome oriented.

Paul Tang – Palo Alto Medical Foundation

You mean to parsimony? All right. Acceptable?

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, let's try to get some best practice information before we just come up with this list off the top of our heads right now. I think there's some good stuff out there about, you know, state-of-the-art.

Paul Tang – Palo Alto Medical Foundation

Okay, so who can take a point on that? Did the HIT standards already, did they already do this?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

The actual care plan definition?

Paul Tang – Palo Alto Medical Foundation

Well and capturing this reason for referral and referral results. Is there anything out there?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

No, not that I recall. I mean the closest thing that we would have to something like that is some of the work we talked about in the care coordination team that there needed to be a closed loop and I think we were still thinking of it in terms of just that an order and order response, so right now I order that referral I get something back because the order has been acknowledged.

Paul Tang – Palo Alto Medical Foundation

Right.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And so, you know, that's the geeks in the room. I'm one of them, but I didn't...sorry, thinking about it, with Neil's point it's really about making sure that all care providers involved are more informed as a result of that transition, right?

Paul Tang – Palo Alto Medical Foundation

So at this point I think we did try this before and we didn't get very far, which is how we got stopped. We can at least...

W

...there are some initiatives in the S&I Framework...

Claudia Williams -- Office of the National Coordinator

Claudia Williams, ONC. Probably someone on the ONC side should check in with the S&I initiatives because I know they've been dealing with this question of instructions and also acknowledgments and I just don't know the status of those.

Paul Tang – Palo Alto Medical Foundation

So maybe for our recommendations we would like to recommend that we include reason for referral or transition and a referral results, and recommendations. And then we'll pass this off to Standards Committee and see if we can get more specificity. But, the really attractive thing is it would be perceived as a win to both specialists and PCPs.

W

As well as long-term care.

Paul Tang – Palo Alto Medical Foundation

And long-term care, yeah, it would be such a win.

Michael Barr – American College of Physicians

Paul, I'll offer the ACP has been working on the medical home neighbor concept and the Council of Specialty Society has been working on it so that that referral agreement type of document, so I think that would also be useful for the conversation and I'll forward that to Mary Jo.

Paul Tang – Palo Alto Medical Foundation

You want to send that up, yeah.

Josh Seidman – Office of the National Coordinator

Absolutely that you should recommend whatever you want. The definition did emanate from the recommendations from the S&I Framework. So just in terms of it is something that there was in a process.

Paul Tang – Palo Alto Medical Foundation

No, we have got back into this same bind of not having the standards, but we're just trying to up the success factor, and I think it would be a win. So, if we can try to work it into the care plan section and get you some stuff we'll try to do that.

Neil Calman – The Institute for Family Health – President and Cofounder

I think the critical piece of this is that, you know, we're putting a lot of requirement on people. So if we can actually give them back something that they feel has been useful in their practices that would be tremendous.

Paul Tang – Palo Alto Medical Foundation

Not that we haven't been trying to do that all along.

Neil Calman – The Institute for Family Health – President and Cofounder

I'm not saying we haven't, but this is, you know, one of the crazy parts that you hear from all specialists and all primary care people is around this communication issue.

Paul Tang – Palo Alto Medical Foundation

That's true. Okay.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And then the timeliness as to Yael's point earlier, does timeliness have to be part of this?

Neil Calman – The Institute for Family Health – President and Cofounder

Now we're getting into sort of the measures piece, because we really would love to add something around that in relationship to measures.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

To get to the benefits you guys are talking about, right? It's the long-term care provider getting it before the patient shows up on the door. It's the inpatient getting it before the patient leaves the ED even, it's the, you know, specialists getting it from the primary care doctor and back again, so back to Neil's point of best practice, that's what we're shooting for, what is appropriate?

Arthur Davidson – Denver Public Health Department

That's an important thing, I agree with Yael, but I don't know that at this point, you know, the receipt of something is not something that the person attesting to this activity can assure.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah.

Arthur Davidson – Denver Public Health Department

So.

Yael Harris – Health Resources and Services Administration

...sending it.

Arthur Davidson – Denver Public Health Department

So how do we know when date of the appointment is to go see the specialist and when it was sent with regards to its 10 minutes from now versus its 10 days from now?

Yael Harris – Health Resources and Services Administration

Well, I was thinking within a certain amount of hours, just because if they're...if you're thinking about transitions of care, I'm not talking if it's a specialist or a referral, I'm talking about transitions of care, I mean 24 hours is probably too long, but that's at least a reasonable time, but you're saying if the person is being transferred from the ED to the, you know, to a unit on the hospital they should have it within, you know, that business day. If they're getting transferred to a nursing home down the street they should have it, maybe not right when the patient gets there, because it's only a 5 minute, you know, ambulance

drive, but at some point that day, they shouldn't have the whole day without knowing about the patient's status and what the conditions are.

Arthur Davidson – Denver Public Health Department

I agree, I agree. I'm just not sure how we measure that, that's all. But I agree, the time is...it needs to be soon, yes.

Paul Tang – Palo Alto Medical Foundation

Okay. The second piece, which is that for 10% of the transitions this document is sent electronically.

Neil Calman – The Institute for Family Health – President and Cofounder

Electronically to somebody you're not related to.

M

And somebody...

Paul Tang – Palo Alto Medical Foundation

Oh, excuse me, well maybe we...

Neil Calman – The Institute for Family Health – President and Cofounder

We dealt with that already.

Paul Tang – Palo Alto Medical Foundation

Maybe we can take it one step at a time, actually. So now we pretty much thoroughly discussed the part that the computer doesn't know when a transition occurs anyway. So, I mean one line of thought is the more stringent we make it the less people are going to dedicate genuine efforts to satisfy it. That's the tension we have here.

Christine Bechtel – National Partnership for Women & Families

So, I have two issues and I'm not certain that it would be dealt with using the same kind of two-part construct. One is it seems to me that whether the threshold is 50 or 65% of transitions of care have a summary, according to that measure all of them could be on paper and I don't think that's what Meaningful Use is supposed to be about, and this is Stage 2, so I do think that we need to consider some, you know, either a high percentage of the summary of care documents that do need to be transmitted electronically, preferably outside organizational boundaries dealing with the vendor, the vendor thing separately, but, you know, get this stuff moving electronically number one and that we should move away from a fairly high threshold where 100% of it can be on paper. That is, I think not consistent with where we're trying to go, particularly for Stage 3.

And then the second piece that occurs to me or maybe one other way to look at this would be can we rather than dealing with this through threshold setting, can we do something, is it practical to say that if you're transmitting a summary of care record to another provider who is engaged in Meaningful Use, because we know exactly who they are, then those transmissions need to be electronic because you don't want to unfairly penalize, but on the other hand if they are either Stage 1 or Stage 2 they should have that capacity to receive.

Paul Tang – Palo Alto Medical Foundation

Okay, that's an interesting approach. Okay, so what we're dealing with is trying to get this stuff to flow electronically and there's a to what kind of a receiving party and a percent and you're suggestion is that we only include in the denominator those who are Meaningful Use qualified?

Christine Bechtel – National Partnership for Women & Families

I think so. I mean that's...I'm thinking out loud a little bit, so because it does require you to...now websites are being built that would allow me to look up directories of Meaningful Users. So the data is there.

Paul Tang – Palo Alto Medical Foundation

Okay.

Christine Bechtel – National Partnership for Women & Families

You know, to the provider level, but they would have to stop and think, oh, and it is an extra step, okay the person I'm sending to, are they a Meaningful User. Now I think that is less intensive than trying to figure out what kind of vendor that person has.

Paul Tang – Palo Alto Medical Foundation

Okay, so let's...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...view, download or transmit. So we don't get to the point like the long-term care provider can't go and download something quickly. I mean, is there a way to accommodate someone who is moving to be a Meaningful User too? So we're not...we don't want to penalize the interchange or the...

Yael Harris – Health Resources and Services Administration

Well what if they have an EHR even though they're not eligible for Meaningful Use, they may have a fully functional EHR in which case then are we just saying, well the 10% doesn't apply to you because you're not...you can't get the Meaningful Use incentives even if you are using fully functional EHR.

Paul Tang – Palo Alto Medical Foundation

So, let's go back to the problem we're trying to solve, I mean this seems like one of those things need go back and revisit. So we are trying to, first we're not trying to force people to refer to people they don't normally refer to. So, I think there's a notion of a clinical trading partner that is not embedded in this rule. Second, we're not trying to penalize good work and/or disadvantage people who don't have anybody to trade with...so that's where your suggestion of if you have a clinical trading partner who is Meaningful Use qualified then that should be something we try to incent you, motivate you to communicate with electronically. Those seem like the objectives. And then we've got to figure out how to get there and measure it.

Christine Bechtel – National Partnership for Women & Families

I mean, I think that coming up a level, the objective is to get providers talking to each other electronically, right?

Paul Tang – Palo Alto Medical Foundation

When the possibility exists for that to happen.

Christine Bechtel – National Partnership for Women & Families

Correct, but I think Yael's comment about that fact that, well I could have an EHR but not be a Meaningful User necessarily and capable of receiving should that count.

Yael Harris – Health Resources and Services Administration

I'm thinking long-term care. There's plenty of long-term care providers that have an electronic health record and are we saying just because they're not eligible for Meaningful Use we can't send them the summary of care electronically?

Paul Tang – Palo Alto Medical Foundation

It doesn't say we can't send them.

Yael Harris – Health Resources and Services Administration

But it says you don't get credit and that's part, I mean...I get e-mail to my long-care community then it's reviewed and ruled out, I'm telling you they're going to be up in arms saying you won't give us an incentive payment, yet we're still striving ahead to become adopters and now you're saying this 10% doesn't even include us.

Paul Tang – Palo Alto Medical Foundation

Well we're not at the measurement phase yet. We're just trying to figure out what are we trying to...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But those are the most frail patients and so we want to make sure that we're not, you know, unintentionally doing the wrong thing.

Christine Bechtel – National Partnership for Women & Families

Yeah, so is there a way, again, I was thinking out loud, so to reframe it rather than Meaningful User, but, you know, that you would know that people were counting your denominator, Meaningful Use is sort of an obvious yes they can deal with this, but is there a way to also incentivize perhaps using direct protocols, the receipt of information electronically by a broader range of providers? I'm not sure I know the answer, but it's the right intent.

Paul Tang – Palo Alto Medical Foundation

So, maybe this is a good use of the counting method, because I don't know that we really want to get into denominators. So, if you electronically transmit a summary of care record to a clinical trading partner than that's just really good.

Yael Harris – Health Resources and Services Administration

You would want count how many times that happens.

Paul Tang – Palo Alto Medical Foundation

Pardon me?

Yael Harris – Health Resources and Services Administration

In other words it's going to count?

Paul Tang – Palo Alto Medical Foundation

The fact that you do this...once you set this up you are not going to stop doing this, this is in your best interest. You pick a clinical trading partner by definition that's something you refer to, you get this going and there's all the disincentive in the world for you to stop doing that.

Christine Bechtel – National Partnership for Women & Families

But, I'm not sure there's incentive for you to keep doing it. I think that's fundamentally why I worry.

Paul Tang – Palo Alto Medical Foundation

Why would you not want to do it that way?

Christine Bechtel – National Partnership for Women & Families

Because you can't get paid to do care coordination today, you don't get paid to do transitions of care, I mean, right? So, I'm not...when it does require...

Paul Tang – Palo Alto Medical Foundation

But, you've got the electronics there...

Christine Bechtel – National Partnership for Women & Families

Well, right because it requires a couple of extra steps that you didn't do before which is to figure out, you know, who else can I do this with, it requires some extra work. So, if you're just counting it doesn't help you incentivize the establishment of a broad range of connections which might A, get you outside other vendor proprietary systems. B, get you to other settings. C, get you to specialist or primary care, right? So, I mean, I think we do actually need to incentivize more widespread connections.

Yael Harris – Health Resources and Services Administration

...one partner, so I've established one partner who is electronic and I'll keep sending to them, but it doesn't encourage me, if I, you know, have 30 for that one and that's a denominate, to initiate contacts with other ones that have it.

Paul Tang – Palo Alto Medical Foundation

But, I think the assumption is you think people enjoy the way things are now. Nobody likes this faxing stuff. So, once you go through the trouble. So, what you are trying to do is get over the activation barrier of setting it up, get the meetings going and doing the electronic transfer in an understood way. Once you do that, there are plenty of disadvantages, disincentives to maintaining this paper, fax and human method.

Christine Bechtel – National Partnership for Women & Families

Right, and I think where I'm maybe differing with you is that I'm assuming that's it's easier for me to set those connections up with one, two, three people if all I have to do is count and then to just keep relying on fax, because you know what, I know their fax numbers and I know how to get them, right? No, for the rest of the people. The work it takes to establish the connections on a broader level is what I'm getting at.

Paul Tang – Palo Alto Medical Foundation

Art?

Arthur Davidson – Denver Public Health Department

So, I think this discussion has been around is it between eligible providers and eligible hospitals versus non. I think that's an important one for us to keep in mind. And it may be that some sites are not ready yet to receive it in this electronic format. How about if the EHR is capable of producing, as Leslie said, the CDA that has this information and that the EHR is capable of sending it to an eligible provider, to eligible hospital, to a site that's advanced that's not one of those or even send it as a fax to a phone number because the CDA is so structured that it can be sent in that format.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So we do that today for 20 years converting electronic information to fax, right?

Arthur Davidson – Denver Public Health Department

Right.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

That's done. I don't think that necessarily advances Meaningful Use. So my concern on at that would be instead of resorting back to a fax what if we had the ability to make all of the things you just described plus view and download, which counts. I've logged in as a long-term care provider, I viewed it. I've logged in or I've downloaded it, so that we still have a way to get it out there.

Arthur Davidson – Denver Public Health Department

That would be another...but there may be some sites that don't even want to get to that they just want to go back to their fax machine and we should say, we now have the ability to produce a summary of care document that, as Yael has been pointing to, within the proper amount of time so that it can possibly affect the transition.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay.

Christine Bechtel – National Partnership for Women & Families

I guess, but all I heard you say, Art, was the capability and I'm trying to build on the piece we just talked about in Stage 1 where you have established already that your EHR has the capability because you've done one successful test, I mean not test, once successful transmission in Stage 1. So, in Stage 2 how do we go beyond more than let's say two, how do we get...we already have the capability in Stage 1. So, what's the use metric that gives us some...

Arthur Davidson – Denver Public Health Department

So we need to create a denominator. We need to figure out...so what is an intended transition of care at this, you know, during this visit in the care plan and that we say that X percent of those have to receive a summary of care document.

Christine Bechtel – National Partnership for Women & Families

Electronically.

Arthur Davidson – Denver Public Health Department

Electronically, yeah.

Neil Calman – The Institute for Family Health – President and Cofounder

Or I think we could go, you know, here's a place where we might want to go to just using a number to say that we want, you know, 25 such transmissions to at least two different electronic health record systems, you know, instead of that...because we're going to hit that next bump in a minute where it says you have to go outside of your system and outside of your network for 10%.

What we really want to do is basically, if you think about it from the provider's point of view, you want to be able to send and transmit this. It should be invisible to me whether it's to the same EMR, to a different EMR, to the same, you know, to a provider in my network, to a provider outside of my network. I just want to transmit this document and so I think that what we could really do here is just specify a number, because once the capability is there people are going to use this capability. They're not going back because they're not developing one on one links with each of these people, they're developing a way to do this through Direct or something where you can direct a message. And once the people are there and they know they can receive them they're going to use this functionality.

Christine Bechtel – National Partnership for Women & Families

So, what about rather than focusing on, you know, some percent of transmissions, what if we focus on the connections, how many connections and maybe one is, you know, even if you don't send anything to it, but how do you establish connections through your electronic health record outside your organizational boundaries.

Neil Calman – The Institute for Family Health – President and Cofounder

Right.

Christine Bechtel – National Partnership for Women & Families

Including to people, this will get to ONC's point, including to people who are not on your same system, but that you need to establish a number of connections and maybe it's a report the usage on those connections or something like that.

Neil Calman – The Institute for Family Health – President and Cofounder

I think it's enough to basically say, you know, that we want X number of transmissions, successful transmissions of data because that keeps you off the denominator piece which is going to be a bear here, you know, to try to figure out the denominator here of the numbers of people that are being, because people are being sent around for all different things. They could be sent for an x-ray, they could be sent for a dental exam. I mean, you know, if you just...I think the denominator here is going to be a huge issue. And so I would be satisfied to say we want X number of these documents transmitted electronically and half of them have to be to, you know, and I would keep the number low because we're really just interested in getting this stuff moving in a...

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Neil, this is Farzad on the phone. Can I ask you, part of the...on the EH side we have discharges from the hospital and the denominator seems relatively straightforward there. Does this change your thinking on the EH side?

Neil Calman – The Institute for Family Health – President and Cofounder

No, on the eligible provider side.

Paul Tang – Palo Alto Medical Foundation

So, even with the hospital discharge you don't really know where the patient is going to go often times unfortunately.

Neil Calman – The Institute for Family Health – President and Cofounder

Right. But, I think it really is important to call out that we need people to be able to do this across systems.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Neil Calman – The Institute for Family Health – President and Cofounder

And inside and outside of their network. I think the 10% number drives people into relationships that just may not be the way we're moving folks at this point, but I think we do need to keep that as a requirement.

Yael Harris – Health Resources and Services Administration

I think the number is great because it gets away from the denominator issue. My concern is, back to what Neil said, it would cross multiple systems, so if we just said a number, is there a way...to separate that it's going to more than one system. So, I have established a relationship with...I'm an EP and have an established relationship with the hospital down the street, I've met my quota by sending, you know, transmitting 30 patients, you know, over the past three months, but it's only with one connection, with one hospital, so how...

Neil Calman – The Institute for Family Health – President and Cofounder

That doesn't meet your requirement.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But, no if I'm using Direct to 5 different EMRs I've only become compatible with Direct but those 5 EMRs have also become compatible with Direct and NHIN. So we don't want to say...

Paul Tang – Palo Alto Medical Foundation

That's good. What's wrong with that?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

That's good we want to reward that behavior.

Neil Calman – The Institute for Family Health – President and Cofounder

That should meet this criteria.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Yael Harris – Health Resources and Services Administration

But how do we figure out that its multiple entities? So, if we use Direct that's great, but is it going through multiple entities that are connected to Direct?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes, right, we can say it meets the standards of Direct and the Nationwide Health Information Network as both transport movement and then you're saying all of those providers who can demonstrate compatibility with these things automatically have the ability to receive one or many.

Neil Calman – The Institute for Family Health – President and Cofounder

Exactly.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And that's what we're trying to build is an infrastructure of interoperability rather than saying I've got to buy this from vendor X and this from vendor Y, when we're trying to move to interoperability with the common standards around the document that gets transitioned and a common standards about how. So, perhaps, because we've been very specific in the ONC side of this to say demonstrates compatibility with Direct and the Nationwide Health Information Network, and uses this to exchange information with one, two, with 10% of their population. You can put a percentage when you have a mechanism that carries one or many.

Paul Tang – Palo Alto Medical Foundation

So, let me see if I can make some sense of it.

George Hripcsak – Columbia University NYC

I'm not actually hearing a proposal that is that much better than what we've got, but anyway.

Paul Tang – Palo Alto Medical Foundation

So, I'm going step by step. So, I think the latest, and it seemed to generate some enthusiasm is moving toward a countable number and we can deal with the kinds of organizations and the kind of systems. So, kinds of numbers, because a lot of it is because of the denominator problem and this would be all relying on human entry...

Christine Bechtel – National Partnership for Women & Families

But, what's the denominator problem again?

Yael Harris – Health Resources and Services Administration

Figuring out how many.

Paul Tang – Palo Alto Medical Foundation

Figuring out how many are...

Yael Harris – Health Resources and Services Administration

How do we get to 10%?

Christine Bechtel – National Partnership for Women & Families

How many transitions?

Paul Tang – Palo Alto Medical Foundation

How many people, how many all kinds of things. Okay, so a countable number, okay so that's one step. Okay, now...

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

This is Farzad, is this effecting...are there two parts to this measure, one was simply whether any sort of care summary people or electronic accompanies a transition or are we having the same denominators? Are we saying that part of it also is not countable?

Paul Tang – Palo Alto Medical Foundation

Actually, we were only on measure two, you raised the question of whether we have the same problem in one. It's not quite as hard, because of all the other stipulations on two. So we left one the same actually.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

So we're saying that it is feasible to count the denominator of the total number of transitions of care for one?

Paul Tang – Palo Alto Medical Foundation

Correct.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

So what's the denominator problem?

Paul Tang – Palo Alto Medical Foundation

Sorry?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

So, what's the denominator problem?

Paul Tang – Palo Alto Medical Foundation

So the denominator problem in number two is 10% of what? Is it to be able to catch all of the transitions to all the places because you've got to see who's eligible to have an electronic conversation?

Neil Calman – The Institute for Family Health – President and Cofounder

And you'd have to be very specific about what kinds of referrals you're talking about, is it a referral for dental care, is it a referral for substance abuse treatment, is it...

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

I think, Neil, that part is the same for the first part, for the first measure.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, I think we probably have to do that for both.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think what we're trying to avoid is that the just eligible provider to eligible hospital and back and forth is not going to satisfy the gap in transitions of care, which are the people who are not covered under Meaningful Use like long-term care facilities, right? That's why two is different than one.

Paul Tang – Palo Alto Medical Foundation

Actually, I think I have a little better explanation for one. One is almost totally under the control of the referring provider. You know how many people leaving your institution, you don't know exactly where they're going, but you can make this information available to them. Two requires two to tango and to know all those twos it seems much harder. So, how does that sound, Farzad? That's why this has become more challenging for two.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

So, you're suggesting that for one you could have a transition of care, but not to know where that transition is to. It's just...

Paul Tang – Palo Alto Medical Foundation

We're just making this document available.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

How are you making it available if you don't know who you are making it available too?

Christine Bechtel – National Partnership for Women & Families

Because, it does say, Paul should provide a summary care record for each transition, so I think that implies you're providing it to someone, it's not should produce.

Paul Tang – Palo Alto Medical Foundation

I think if the word is the same, as we had with patients, so if I say I can share this CCD document with anybody who wants it electronically or I can provide a paper, I can meet that requirement and I have control over creating that document and making it available. I don't have the same amount of control or know all of the pairs...

Christine Bechtel – National Partnership for Women & Families

Yeah, but in order to provide patient's with the ability, I think it's fundamentally different to me, you do know who they are and in order to provide you can't just create it and not tell anybody, right? You have to say hey we have this available; these are instructions for how you might do it, right? That's the 50% provide. So, I think if it's under summary of care it does sort of require.

Paul Tang – Palo Alto Medical Foundation

But you always had the paper to fall back on too. So, you know that you can deliver at 100% if that's what it takes.

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation

The open ended electronic connection is where we're having more difficulty in specifying the denominator.

David Lansky – Pacific Business Group on Health – President & CEO

...question on number one, whether those are electronic or paper?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

And is that...certify the EHRs will, when this comes into effect will all be certified to be able to receive, what is the...I'm still trying to understand the problem in terms of finding the denominator here? The trading partners are likely...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Farzad we don't want to discourage the use of connection to noncertified players like long-term care. So, that's the issue is that we want to make sure that we're...

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

So, there's a presumption that long-term care providers would not implement the same national standards by 2014.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

They're not Meaningful Users right now.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Right.

Christine Bechtel – National Partnership for Women & Families

So, actually that gets to Yael's, I mean...finesse that, but I think we're actually trying to solve two different issues. The way to finesse it is say that you would send a care summary electronically to any provider who has a system that uses these standards.

Yael Harris – Health Resources and Services Administration

Right.

Christine Bechtel – National Partnership for Women & Families

And you know that's all Meaningful Users and it may be some long-term care, and it maybe some behavioral health, but if you are working with partners that have a system that uses these, that can receive, then you need to transmit electronically.

Paul Tang – Palo Alto Medical Foundation

Well, actually the numerator actually specifies certified EHR. So, actually it's truly...

Yael Harris – Health Resources and Services Administration

...long-term care.

Christine Bechtel – National Partnership for Women & Families

Right, but wait, wait, wait this is...we're not talking about what is says, I mean, we're trying to talk about what's a good recommendation and I think that is on the table. But, I think part of the issue that we're really grappling with is how do you figure out who those people are, whether they have a certified EHR or not, that's the denominator component. Because I, Farzad, I had stated a concern early, which is that we could have 65% of transitions of care, the majority of them, or all of them could actually happen on paper, and so how do we get to a place where we're really incentivizing more and more, and more electronic movement and that's I think how we got to the who is in the denominator kind of, or what is in the denominator question.

Michael Barr – American College of Physicians

Not to complicate it further. I know we've been using the long-term care facility, but let's recognize a Meaningful User is going to be in communities with lots of other Non-Meaningful Users without certified EHR and we certainly, from a patient perspective don't want to disincent the certified user, the Meaningful User from sending things where he or she can to get the care.

The other issue and it speaks to the other part of the part two is, you know, I might be in a rural community and there's only one hospital and so to say I have to transfer, I have to send information to other places just to satisfy number two, that's not a Meaningful Use...you'd be better off making sure I'm referring all of those electronically, all those care documents to whoever is in that system within the same system over and over, and over again. That wouldn't be a bad thing. That would be good.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, could the denominator be all the parties that have certified compatibility with the Nationwide Health Information Network and Direct? Or those that meet the other criteria we have here? Because then you are getting to interoperability.

George Hripcsak – Columbia University NYC

So, this is George, one way to look at this is should we push on the system and infrastructure what we should put on individuals and we're getting trouble where we're trying to do both. So, for example, why would you say not the same vendor? So, you can't just have a large vendor, say I'm going to solve your Meaningful Use problems with this objective, because I'm just going to have you transfer it to someone else, anywhere else, anywhere with the same vendor and you haven't really done anything big and you haven't solved the system-wide problem where EHRs can't talk to each other. So this objective is trying to solve that problem as opposed to figuring out well what should we encourage an EP to accomplish, which is slightly different.

My personal opinion leans toward the system on this one, and I think, you know, going for a lower threshold, I mean I don't know if 10% is too high, then go for a lower threshold, but leave it like this. So that's kind of my direction. I also have a question, which is what is a transition of care, it does include long-term care facilities or not, because that is the difference, because if the denominator includes all your transitions but the numerator includes only to EHRs, then you can't...that's the difference between option measure one and measure two. Measure two, what if you know 91% of your transitions are not to an EHR. Then you can't meet the objective under any circumstances.

Paul Tang – Palo Alto Medical Foundation

That's correct.

George Hripcsak – Columbia University NYC

So you'd have to know...it really should be the proportion that are going to another EHR or you can just make it like 1% or 2%. So, keep it low, but force the vendors to communicate with each other.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Or 10% proven compatibility with some sort of national standard that gives you that interoperability, because we really don't want to force \$30,000 interfaces on an EP, right? We don't want to force that.

Yael Harris – Health Resources and Services Administration

...exchange not the EHR and if it's an EP, yes it has to be certified, but we've already established that. But if you're...exchange you want the information to be exchanged electronically, they may not have a certified product then because there might not be certification standards in existence. But if you're using national standards, it's a CDA...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right CDA and Direct.

George Hripcsak – Columbia University NYC

So you're replacing transferring to a certified EHR with...

Yael Harris – Health Resources and Services Administration

Transferring using national standards.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Either or, certified EHR or...

George Hripcsak – Columbia University NYC

You might get in trouble there, you may not accomplish...

Yael Harris – Health Resources and Services Administration

No, because if you're using national standards but it goes to a noncertified EHR that means that noncertified EHR can accept those standards, but it hasn't been certified because there is no certification criteria for that. There is no certification for right now there's not even one for a dental EHR, we're trying to get one there...

George Hripcsak – Columbia University NYC

But, wait; wait so that's two different goals.

Paul Tang – Palo Alto Medical Foundation

So, let's try to get in order...

George Hripcsak – Columbia University NYC

Going through the system one goal would be to try to pull a Non-Meaningful Use, use this objective to pull a Non-Meaningful Use providers

Yael Harris – Health Resources and Services Administration

Well it's trying to...

George Hripcsak – Columbia University NYC

A different goal is to try to get EHRs to talk to each other.

Yael Harris – Health Resources and Services Administration

One way or bidirectional?

George Hripcsak – Columbia University NYC

So it's hard to do both of those things in one objective.

Yael Harris – Health Resources and Services Administration

One way or bidirectional? I think for care coordination we're trying to get at least one way.

Paul Tang – Palo Alto Medical Foundation

So, let's try to go in order here, Neil?

George Hripcsak – Columbia University NYC

I think we're giving up the other call by doing this.

M/W

Multiple voices.

M

It's not part of the national standards, George.

Neil Calman – The Institute for Family Health – President and Cofounder

So, from a distance point of view, from a distance point of view, don't we accomplish what we want by requiring people to be able to use a standard format either using direct exchange protocols or using, you know, health information exchange, isn't that really what we're trying to do? We're trying to say we don't want proprietary systems to be able to meet this requirement, right? So, the heck with all of that stuff, why don't we just say...why don't we make the requirement that people must be able to transmit using these standard protocols either the Direct exchange protocols or whatever they must be able to do that and they must demonstrate that they're using that to satisfy this requirement and keep the number low because once you can do that whoever is going to be able to receive it on the other end will be receiving it. I mean, that's really what we want. We don't really want people developing six separate solutions to go to six different hospitals to meet the requirement. We want people to be forced into using standard protocols to exchange information, right?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Exactly.

George Hripcsak – Columbia University NYC

I worry though; they're all going to say they're using standards.

Neil Calman – The Institute for Family Health – President and Cofounder

No, I'm talking about using whatever, and, you know, this is not my area of expertise, but using whatever the standards are that make them truly interoperable using Direct exchange. There is no such thing? Okay.

Paul Tang – Palo Alto Medical Foundation

Okay. Christine?

Christine Bechtel – National Partnership for Women & Families

Okay, so what if we, I heard Paul say and I agree we're trying to solve two different problems and to me I'm thinking of a slightly different approach, so what if we said that for, I'm picking a number, 80% of the transitions of care where it is going from a certified EHR to a certified EHR, that transmission happens electronically. But what if we also...and we have, you know, the overarching kind of kind of paper option is there for noncertified EHRs, but if we also a menu item that allowed people to choose, you know, that they could transmit summary of care records to noneligible providers using the same national standards? And that way you separate them and you give people credit and try to incentivize connections, which also would lay some important groundwork for Stage 3?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think...more difficult to do...

Paul Tang – Palo Alto Medical Foundation

Let's...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Oh, I'm sorry.

Paul Tang – Palo Alto Medical Foundation

Art?

Arthur Davidson – Denver Public Health Department

Yeah, I'm not sure, I think in principle I totally agree with the idea that we should talk about transport mechanisms, but I don't know that that is what this was about. It's about sharing content and I don't know that for us to say that it will be Direct or NwHIN exchange that we know that all that innovators may provide for us in a way of sharing content. So we've kind of blended, I totally believe in the idea of interoperability, that's not my purpose in making this comment, but I am just worried that we're tying an object about sharing content for coordination of care to a particular method of transmit. That conversation is kind of come together here and I don't know whether we, in following the rules about what's in the CMS, whether they actually make reference to that in this CMS report.

Christine Bechtel – National Partnership for Women & Families

They do, that's where this is all coming from.

Arthur Davidson – Denver Public Health Department

Well, I just did a search for the word Direct and I couldn't really find it.

Christine Bechtel – National Partnership for Women & Families

That's not what the standard is technically called, that's the lingo for it, but if you look in the column on the right side of the document, I don't know if that's what George has, but it talks about the standards specified in X, Y and Z, and it is the exchange related standards.

Arthur Davidson – Denver Public Health Department

Okay, and is it only those two?

Christine Bechtel – National Partnership for Women & Families

No, there's more.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

There's more.

Christine Bechtel – National Partnership for Women & Families

So the point that Farzad, just by way of explanation, was trying to make earlier and I think what they say in the rule is people are doing what you're saying, they're innovating, but the problem is that they're creating walled gardens. So you can't get outside that. And if your trading partner is in there you're in good shape, but if not then...so I do think we're trying to actually drive, at least the ability for systems to talk to each other regardless of vendor and organization.

Paul Tang – Palo Alto Medical Foundation

Okay, Leslie?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Go ahead, David had a comment.

Paul Tang – Palo Alto Medical Foundation

David?

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, it seems like another dimension to this, I like Christine's direction a lot is to create network effects that we haven't had yet. And I think...the good news is that in Stage 2 we're running into the problem of having Meaningful Users be ahead of the pack with a defined set of standards and expectations of performance and bringing in the dentist and long term care, and behavioral health, and others is a good opportunity. This element gives us an opportunity to drag in other service providers into our network effect model. So to me, the idea of...in a sense...and the other thing I'm thinking about is provider directories and creating a stimulus for HIEs around the country for building out the capability to help find them. So the more we can strengthen this the more that will stimulate that.

So, I like the pathway, I think Christine was on, on adding to it, which is we have Meaningful Users who are going to be capable of doing this exchange. We have a set of users using other technologies that have not necessarily been certified but conform to the standard set and we should give them a name, we should create a classification for such entities, precertified users, there is something else we can call them like...

Michael Barr – American College of Physicians

Pre-Meaningful.

David Lansky – Pacific Business Group on Health – President & CEO

And that they meet the standards, they're capable of transacting these messages, but they are not necessarily Meaningful Users and they were in other disciplines and other industries. Then the transactions you have, you as an EP with either Meaningful Users or this new class of users becomes the denominator. And you must have 50% or 80% of all your transactions would then be electronic, because I think the goal we're trying to create here is to stimulate electronic exchange and we need a denominator to do that and Meaningful User denominator is too small and we don't yet have a way to define the bigger one, but we should come up with that.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And maybe it's compliant or adherent.

David Lansky – Pacific Business Group on Health – President & CEO

Yes.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

You know trading clinical partners or trading partners that are adherent to national standards...

David Lansky – Pacific Business Group on Health – President & CEO

And that helps, then you're motivated to know who they are.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Absolutely.

David Lansky – Pacific Business Group on Health – President & CEO

As a user to qualify and then the HIE and provider directory world is motivated to have a check box next to the ones who are long-term care who can receive messages.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

So, are you suggesting though that there would be a minimum for people that were noncompliant with standard?

Christine Bechtel – National Partnership for Women & Families

No, I think he's saying the universe is larger, so you pick but it includes people who are compliant and people who are Meaningful Users.

David Lansky – Pacific Business Group on Health – President & CEO

No, I'm not suggesting you need to communicate with someone who is outside of the network, but of those you do communicate with they have to be electronic to a large degree.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And they can either be other Meaningful Users in a certified system or those that are compliant with the following national standards for interoperability.

Michael Barr – American College of Physicians

I mean, I like the direction, David, you just described, we can talk about what the percentage is, but I think that would stimulate the exchanges that we want and from a patient perspective that's the right thing. I'm concerned about how a practice might know who in their community has a certified user or has a compliant system. I don't know how that's going to happen and that could create a lot of issues, because maybe there are and maybe there aren't, and I wouldn't know how to tell my doctors how to find out. But, be that as it may, I think that's the right direction trying to stimulate the exchange.

Yael Harris – Health Resources and Services Administration

What you have to set up in the systems for transfers anyway, so that's something that you do. When you transfer to a setting you have to establish what...

Michael Barr – American College of Physicians

We're talking about doctors who are barely using e-mail in some cases but are going to make the investment in Meaningful Use and now we're going to say you need to find out who is using whatever standard protocol, that's the challenge that you face in the practical world.

Paul Tang – Palo Alto Medical Foundation

So what would be against counting then so that we don't have to...what would be against getting away from the denominator issue by just doing the counting?

Christine Bechtel – National Partnership for Women & Families

Well, I think my challenge with it is let's take the easier of the two pools, right? Which is Meaningful Users. They're on systems that are guaranteed. So if the denominator is them, then really the vast majority of your transmissions should be electronic and so to me I don't...I think that it is more of a threshold rather than a number. But I think, and those people, to Michael's point, are knowable because CMS publishes public lists of them. The one that is less knowable, well I think, I mean you laugh but...

Michael Barr – American College of Physicians

No, no I am agreeing but I'm just saying the doctor is not going to be...

Christine Bechtel – National Partnership for Women & Families

Absolutely, but it would not be hard to create a database that is continuously updated, it would be very easy, but nonetheless, I think that more the challenging piece is who is the broader universe of people who use systems that are compliant with the exchange standards? We don't have a good way for that, so that is a challenge but not an instrumental one.

W

So it's an "or."

Christine Bechtel – National Partnership for Women & Families

Right.

Michael Barr – American College of Physicians

But I think expanding the denominator solves an issue in the rural communities or any other place where there are only a handful of Meaningful Users and they're not the ones I refer to.

Christine Bechtel – National Partnership for Women & Families

Right.

Michael Barr – American College of Physicians

You know, so you don't want to drive folks, you want to continue to establish patterns of referral and transitions when you can, they're meaningful relationships, you want to break those that are dysfunctional and maybe somebody...certified system becomes a better partner ultimately, but we want to make sure from the patient perspective we're not sort of changing patterns that actually work.

Christine Bechtel – National Partnership for Women & Families

Right.

Michael Barr – American College of Physicians

So expanding the denominator includes...I wouldn't use ineligible I would use not yet ready or some are ineligible, some are going to be the cardiologist who decides not to do Meaningful Use in 2014.

Neil Calman – The Institute for Family Health – President and Cofounder

The one thing we don't want to do, we don't want to drive people to establish one-to-one connections with folks that are not using standards, because that would be a complete waste. I mean, we definitely don't want somebody in your community to meet the requirement, having to go out and figure out how to make a one-to-one connection with somebody that's not using standard technology.

Michael Barr – American College of Physicians

Well, but the denominator would be that they are using standard technology or they have a certified EHR.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right.

Paul Tang – Palo Alto Medical Foundation

There is clearly a denominator here.

Neil Calman – The Institute for Family Health – President and Cofounder

But we've got to make sure that we...

Paul Tang – Palo Alto Medical Foundation

So, actually what if you go back to your first idea, which is just the Meaningful Users, you know who they are, as long as they're your trading partner then you should be conducting this information exchange electronically. That seems to align, it's simpler, it aligns, you can use the denominator, you know who the denominator is and the only challenge, and you even know who the trading partners are because somebody in CMS is getting the bills.

Yael Harris – Health Resources and Services Administration

But, it's disincentivizing the exchange with those who are not yet...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Because I could then say I'm only going to chose trading partners who are using my compliant EMR and so I have a walled garden.

Paul Tang – Palo Alto Medical Foundation

No, no, no. No, we haven't done that.

M/W

Multiple voices.

Paul Tang – Palo Alto Medical Foundation

Yeah, there's other stuff on top of this.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay.

Christine Bechtel – National Partnership for Women & Families

Well, I think what I heard Michael say, is if the denominator is larger than Meaningful Use, than just Meaningful Users and it would include other people in your area who use an electronic system that has those standards then you'd have a better shot at meeting a threshold and, you know...

Michael Barr – American College of Physicians

Forget about the threshold, I'm talking about caring for patients, that's what I'm talking about; I'm not really talking about thresholds.

Christine Bechtel – National Partnership for Women & Families

I know. I wasn't finished, but that's okay, I meant referring patterns and preserving them.

Neil Calman – The Institute for Family Health – President and Cofounder

The one thing that I would be worried about is in areas where there's a dominant player in the market, right? You could do this and you could still use proprietary technology for that interface, right? And not really develop the capability.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Neil, this is Farzad, I don't think we have to worry about that, the way it's defined, you have to use certified technology and you have to use those standards.

Neil Calman – The Institute for Family Health – President and Cofounder

You have to use those standards?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Yeah.

Neil Calman – The Institute for Family Health – President and Cofounder

So you couldn't use?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Proprietary, one-offs. My understanding of the way it's currently written.

Neil Calman – The Institute for Family Health – President and Cofounder

Well, then why were we pushing for 10% outside of somebody's trading partner network? If they're using standard protocols anyway, why do we really care who they're talking to, who they're talking to should be who they actually work with, right? I thought the purpose of that 10% outside of your, you know, using a different EHR and outside of your normal trading partners was because we didn't want people to be able to use proprietary technology to do this.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

What can happen is that, and some of what we talk about in the rule, is that even if you have a certified electronic health record, what we hear from a lot of hospitals is that the vendors, through business

practices may not make it easy as a business issue, not as a standard issue to exchange information with other vendors. So it's not something that can purely be addressed with certification.

George Hripcsak – Columbia University NYC

Not only that, but standards, this is George, three people use HL7 no one can talk to each other. So stipulating the end to endness of it is a good thing, just because you're both using exactly the same standards, protocols, vocabulary doesn't mean you can talk to each other. So, I'm still not hearing, remember this is Stage 2 not Stage 3 we're talking about. So, I don't want to get too far into 80% or transactions yet is Stage 2, which is 21 months from now, something, how we're going to ensure that 80% of the doctors in our community where if they tried to do Meaningful Use were communicating, so I think what's written is still okay although I think 10% sounds high to me.

Michael Barr – American College of Physicians

I don't know where the 80% came from, but we're looking...

M/W

Multiple voices.

Paul Tang – Palo Alto Medical Foundation

It's only a rumor. It's only a rumor.

Christine Bechtel – National Partnership for Women & Families

No, but I think the problem, George, that I have is, in the proposal that I'm suggesting around the denominator being people who are on Meaningful Use is actually, whatever the number is, the 50 or 65% of transitions can still be on paper. And I think that's not acceptable. So, I think if you know you're going to another Meaningful User or as Leslie and Yael have said, if you know you're going to somebody who uses the same transport, you know, exchange standards.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

This is Farzad, I'm struggling to understand how you would know, if you have a successful transmission then I think you could establish the handshaking, you can know what system the other person is using potentially and the standards to do that. But, I don't understand how you would know who everybody, of all the people that you do referrals to, how would you know if they are Meaningful Users or if they have that technology in place?

Christine Bechtel – National Partnership for Women & Families

Right. So and Michael raised that issue as well, and Farzad I pointed to the CMS website having an individual provider level listing of every Meaningful User in the country. So, while it would require an extra step for somebody to look at who you typically refer to and figure out which of them are in fact Meaningful Users, you know, during the time period, that that is really not an unreasonable thing to ask folks to do, just to go on-line and figure out who in their area they trade, you know, that they share with is a Meaningful User because if these standards are part of Stage 2 around exchange then they should be able to talk to each other and therefore we should have a higher percentage of the main measure, that 65% be required to be electronic.

Michael Barr – American College of Physicians

Again, we're not arguing about the purpose of the intent, but again for a general internist practice with a Medicare population you're talking about 200 different clinicians and 117 practices. So, for them to go through it's not just a few minutes to look and see who is a Meaningful User, it becomes an extra burden here. I don't know what the answer is, but I'm just saying it's not as simple as looking on-line.

David Lansky – Pacific Business Group on Health – President & CEO

I assume that functionality would be entirely in the product.

Michael Barr – American College of Physicians

It would be what?

David Lansky – Pacific Business Group on Health – President & CEO

Isn't that something to be addressing, that the product would say I have to go find Dr. Smith, I look at the CMS website, Dr. Smith is at this IP address.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, if that's the case, and it's that simple then we should just be calling out the fact that that protocol that you've just described is what is used for all the electronic transmissions and basically saying that...and pulling it out, sort of what Farzad was saying, you know, is that you might have that anyway but that doesn't mean that folks are going to use that, that you could have two systems on the same electronic health record system that are using a different way of communicating with each other, but if we call that out, that people are using this standard, if it's that simple all you have to do is look somebody up and you can exchange information because the protocols are that well defined. Then all we really need to say is that's the protocol we want used to meet this requirement for all connections. What am I missing?

Christine Bechtel – National Partnership for Women & Families

I guess I was assuming that it wasn't exactly that easy.

Neil Calman – The Institute for Family Health – President and Cofounder

Well, that's what I thought too.

Christine Bechtel – National Partnership for Women & Families

That you did have to do some sort of how do I send this to you electronically...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

If I want to send information to someone that's part of the Direct protocol, I need their e-mail address.

Neil Calman – The Institute for Family Health – President and Cofounder

Right.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Now, if I send that to Marty and he's received that e-mail as a secure e-mail it is now ingestible into my EMR, I can place it up into my EMR. I have not had to have anything be on the e-mail address to provide that. Now, as you build up the use, then you build up more system to system connectivity. But, I think it's important that we not try to create opportunities for just one-to-one communications or just Epic only or NextGen only or so and so, but that we really are trying to drive to a broader interoperability. So, I think it's "both." I think it's an "or." I do agree though if it's eligible provider or Meaningful User to Meaningful User only that should be way jacked up, because that provision is already there. However, the unintended consequences of that might be that, that's a proprietary interface, which then goes against the goals of interoperability and exchange.

George Hripcsak – Columbia University NYC

So, we're not getting towards consensus really, number one. We're at 3:00 o'clock, number two. Number three we already had this discussion and had the HITPC vote on it and they voted on pretty much this, ONC just made it 65 instead of 50 and they added there has to be a different vendor.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...vendor part.

George Hripcsak – Columbia University NYC

What's that?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

It's the different vendor part.

Neil Calman – The Institute for Family Health – President and Cofounder

The different vendor.

George Hripcsak – Columbia University NYC

I don't think you guys are objecting to the different vendor so much.

Paul Tang – Palo Alto Medical Foundation

Actually, George, we didn't propose number two. So, that's what we're discussing.

George Hripcsak – Columbia University NYC

Well, wait, wait, wait what did we propose?

Paul Tang – Palo Alto Medical Foundation

We proposed essentially one at 50%.

George Hripcsak – Columbia University NYC

Let me go back.

M/W

Multiple voices.

George Hripcsak – Columbia University NYC

What was part two of ours?

Paul Tang – Palo Alto Medical Foundation

We didn't have a part two.

Christine Bechtel – National Partnership for Women & Families

We didn't do it.

Paul Tang – Palo Alto Medical Foundation

So, let me try to move step-by-step and see...Josh were you going to say something?

Josh Seidman – Office of the National Coordinator

I just also want to let you know that the Information Exchange Workgroup will also be taking up these questions at some point.

Paul Tang – Palo Alto Medical Foundation

Oh, good. Okay, we have that as an out.

Josh Seidman – Office of the National Coordinator

They begin their calls tomorrow.

Paul Tang – Palo Alto Medical Foundation

That's right. So, I have a number of positions. Let's see which ones we can come to. Discharges have care summary.

George Hripcsak – Columbia University NYC

Electronically, in 25 electronically. So, we voted, so EH versus EP. So, we did do this electronically, they just changed it slightly.

Paul Tang – Palo Alto Medical Foundation

Okay. Okay. So let's see where we can have consensus. If we don't have strong consensus we can refer it over the...which group is it? IE, group? Okay, you said they have a call tomorrow?

Josh Seidman – Office of the National Coordinator

Thursday.

Paul Tang – Palo Alto Medical Foundation

Thursday, Okay. The first one is number or percent. The advantage of number is we don't have the denominator; well the percent would be fine if we were Meaningful Users only, because those are known, knowable. If you wanted to have a bigger denominator, then we do have a problem in the number. So, let's go, I'll just vote them all three different ways. So, denominator of Meaningful Users, Meaningful Use qualified only.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Sorry can I ask, this is Farzad, are we talking about EP or EH, because looking at the grid, and again following up on George's point, it looks here like the Stage 2 proposal by the HITPC on eligible hospitals was send a care summary electronically to the receiving provider or post acute care facility for more than 10% of all discharges. So, are we voting on changing the EH or the EP, or what's the problem?

Paul Tang – Palo Alto Medical Foundation

I think, since you combined them into one, we're looking at the one that applies to both unless people think we can get more consensus taking them separately?

Christine Bechtel – National Partnership for Women & Families

Well...

Paul Tang – Palo Alto Medical Foundation

We sort of acknowledged this problem; I think is how we went into...so you're right, we've faced this problem before. We got around it by resorting to a number for EPs.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

And the percent on the EH side.

Christine Bechtel – National Partnership for Women & Families

...remember we had that whole...

Paul Tang – Palo Alto Medical Foundation

Correct. Well, okay, so we might, who knows, maybe we can divide and conquer. Okay, so let's go back to EP and let's ask the question, number as we've proposed or percent of either Meaningful Users or Meaningful User or standards compliant? This is for EP.

Christine Bechtel – National Partnership for Women & Families

So, I'm not completely sure I'm understanding. So, are you saying, there is still one overarching transition of care criteria that says 65% or whatever the high threshold is, you've got to be able to produce a summary care record. That's still there, right? So what we're talking about is somewhere underneath that there is the criteria number two in the spreadsheet, which is the number of electronic transactions and you're asking for EPs should the denominator be...

Paul Tang – Palo Alto Medical Foundation

Should it be countable to get it away from the denominator or should we have a denominator consisting of option A-Meaningful Users. Option B-users or standards compliant. So, those are the three options for EPs.

Christine Bechtel – National Partnership for Women & Families

Meaningful Users, Meaningful Users or all transitions is the denominator for the first one, right? At least either some number or something...

Paul Tang – Palo Alto Medical Foundation

No, we're working on a measure two.

Christine Bechtel – National Partnership for Women & Families

Right, but the 10% in measure two is 10% of all transitions have to be electronic.

Paul Tang – Palo Alto Medical Foundation

Okay, so that's the fourth option then.

George Hripcsak – Columbia University NYC

So are you looking for suggestions or comments or what?

Christine Bechtel – National Partnership for Women & Families

What is the first option, because...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think it's 10% of all transitions of care and the denominator is either eligible providers or Meaningful Users or standards compliant.

Paul Tang – Palo Alto Medical Foundation

I'm trying to see if we can converge at all.

George Hripcsak – Columbia University NYC

So, I think it's going to be a lot harder than you are thinking for every doctor to find out...I know that there will be provided directories in the future. But by Stage 2, 2014 January it's going to be hard for every doctor to know every other doctor that's standards compliant.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Every doctor, if they're using e-mail at all right now, they know who their trading partner's e-mails are period.

George Hripcsak – Columbia University NYC

Well do they know...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

No, but they can send can a Direct e-mail to them.

M/W

Multiple voices.

Paul Tang – Palo Alto Medical Foundation

I think we've actually discussed all of the points. It's a matter of we have to see if there is a way to converge and we'll have to ask the opinion of the Standards Committee if we cannot get a conversion. So, the four options, I think, one is to, and we proposed this for EPs to do a countable number, we proposed 25. A second is the way the NPRM is written now which is 10% of transitions. A third is to instead of using transitions as the denominator, to look at the denominator being Meaningful Users, clinical trading partners who are Meaningful Users. And the fourth is to expand the denominator to Meaningful Users or standards compliant.

Christine Bechtel – National Partnership for Women & Families

But I am confused. So on the Meaningful User piece what are you sending to them if you're not sending to them based on transitions related event?

Paul Tang – Palo Alto Medical Foundation

We are sending a transmission.

Christine Bechtel – National Partnership for Women & Families

No, you just said the denominator would not be all transitions it would be Meaningful Users so that's why I was confused.

Paul Tang – Palo Alto Medical Foundation

Well, it's...

George Hripcsak – Columbia University NYC

Not all transitions but all transitions to Meaningful Users.

Paul Tang – Palo Alto Medical Foundation

Yeah.

Christine Bechtel – National Partnership for Women & Families

Okay, right...

Paul Tang – Palo Alto Medical Foundation

It's what you suggested.

Christine Bechtel – National Partnership for Women & Families

No, what I suggested was really layered, right? So, that you would have the measure one up there, underneath that you would have, you know, a high threshold for Meaningful User as part of it but not the only part.

Paul Tang – Palo Alto Medical Foundation

Correct, that's correct.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation

Okay. So countable number, EPs, countable number 10% of transitions care what is written there or changing the denominators and probably changing the threshold as well to transitions involving Meaningful Users or transitions involving Meaningful Users or other standards compliant.

Yael Harris – Health Resources and Services Administration

Well, it's right there, but that one doesn't fit because you're saying 10% of transitions but here it says using a different certified EHR technology vendor, so therefore it's not all transitions, it's only Meaningful Users again, because the Non-Meaningful User doesn't have certified...

George Hripcsak – Columbia University NYC

No, I think the denominator is transitions but the numerator is...let me double check that. I have it right here. The denominator remains transitions. It's the numerator that has the different EHR.

Paul Tang – Palo Alto Medical Foundation

Only count, yeah its restrictive numerator.

Yael Harris –Health Resources and Services Administration

So, it has to be certified?

George Hripcsak – Columbia University NYC

Hopefully you want to keep that percent low.

Yael Harris – Health Resources and Services Administration

I don't like this restrictive numerator then.

Paul Tang – Palo Alto Medical Foundation

I know, but that's a separate discussion. That's one of the four things...

George Hripcsak – Columbia University NYC

Well then you factor that into the...

Yael Harris – Health Resources and Services Administration

But if effects the denominator, you know, if your just talking about certified technology, then I don't even care what's in your denominator because it could be to other Meaningful Users then. The whole issue is...your saying that...

Christine Bechtel – National Partnership for Women & Families

And actually other Meaningful Users is a larger pool.

Yael Harris – Health Resources and Services Administration

Exactly, so what you're saying is all transitions or your saying I'm just looking at 10% of Meaningful Users, well if you're saying that the numerator is a certified EHRs, then I don't care if it's 10% Meaningful Users as long as you have a second one that talks about non-certified EHRs. Do you see what I'm saying? But if you saying okay the...

M/W

Multiple voices.

George Hripcsak – Columbia University NYC

Yeah, that's why we have option three and four.

Christine Bechtel – National Partnership for Women & Families

That's option four.

Paul Tang – Palo Alto Medical Foundation

Yes.

Christine Bechtel – National Partnership for Women & Families

Option four is Meaningful User and...

George Hripcsak – Columbia University NYC

Option two is basically what is written...

Yael Harris – Health Resources and Services Administration

But that's by changing the denominator we're not changing the numerator. The numerator is still using different certified EHRs, that's what they're saying.

Paul Tang – Palo Alto Medical Foundation

So, it will be a little hard for me to get all the attributes orthogonal. So, I'm trying to get sentiment.

George Hripcsak – Columbia University NYC

Let's vote...more than one, which ones do you find acceptable?

Paul Tang – Palo Alto Medical Foundation

Okay, so let's use...the vote is can you find as acceptable. Okay, all those who can find 25 electronic submissions as part of the criteria, acceptable.

George Hripcsak – Columbia University NYC

How many find that acceptable?

Paul Tang – Palo Alto Medical Foundation

How many find that acceptable? One, two, three, four, five, six, seven, eight. So, is somebody writing this down? I think we're going to need that.

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

Can you vote twice?

Paul Tang – Palo Alto Medical Foundation

Yes you can, it's just acceptable and then we can find the max. Option two was as written.

George Hripcsak – Columbia University NYC

As written although we don't know the percent yet.

Paul Tang – Palo Alto Medical Foundation

Okay. So the denominator is all transitions and then you have to qualify in some way.

Christine Bechtel – National Partnership for Women & Families

And there's some electronic transmission.

Paul Tang – Palo Alto Medical Foundation

Yeah, the numerator has something to do with electronic. Okay, so the denominator is all transitions.

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

...

George Hripcsak – Columbia University NYC

We haven't picked everything yet.

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

...

Arthur Davidson – Denver Public Health Department

It could be 0.1%.

George Hripcsak – Columbia University NYC

Right.

Paul Tang – Palo Alto Medical Foundation

Yeah, okay.

Yael Harris – Health Resources and Services Administration

But if it's as written it's not all transitions.

Paul Tang – Palo Alto Medical Foundation

What is it?

Yael Harris – Health Resources and Services Administration

Go back to just using a different certified EHR technology.

Paul Tang – Palo Alto Medical Foundation

No.

George Hripcsak – Columbia University NYC

No, page 112, denominator, number of transitions of care and referrals during EHR reporting period which the EP and eligible hospitals blah, blah, blah was the transferring or referring provider period. That's the denominator.

Yael Harris – Health Resources and Services Administration

So, ignore the measure that is on our table then, right now?

M/W

Multiple voices.

Paul Tang – Palo Alto Medical Foundation

Okay, so do what George said. Okay, so one, two, three, four, five, six, seven, eight, nine. Okay. Option three was, considering in the denominator only those who are Meaningful Users. The trading partners who are Meaningful Users.

Christine Bechtel – National Partnership for Women & Families

... in the...

George Hripcsak – Columbia University NYC

Denominator.

Paul Tang – Palo Alto Medical Foundation

In the denominator.

George Hripcsak – Columbia University NYC

And then pick a percent after that.

Paul Tang – Palo Alto Medical Foundation

So the reason is that basically gives you knowable. One, two, three, four.

George Hripcsak – Columbia University NYC

Okay.

Paul Tang – Palo Alto Medical Foundation

Okay, the fourth one is to have, in the denominator, so consider only those who are Meaningful Users or those who somehow you find out are qualified or standards compliant and could meet Meaningful Use if they were eligible. One, two, three, four. Okay, so the majority we had of the four options were one and two.

George Hripcsak – Columbia University NYC

The most, yeah.

Paul Tang – Palo Alto Medical Foundation

And the most is two, but we had a majority voting is acceptable one or two.

George Hripcsak – Columbia University NYC

Right.

Paul Tang – Palo Alto Medical Foundation

Okay, another dimension is the affiliation. It restricts the numerator to those in which you are referring to a non-affiliated, non-business affiliated entity.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

...

Paul Tang – Palo Alto Medical Foundation

Go ahead.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

I'm just trying to understand. Are you paraphrasing what the rule says?

Paul Tang – Palo Alto Medical Foundation

I'm trying to tease out the attributes and see if I can construct somehow magically something that would be agreeable to most people.

Michael Barr – American College of Physicians

So, Paul, let me, I mean...

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

I just want to clarify that what the rule says does not say you have to go outside of your usual trading partners.

Paul Tang – Palo Alto Medical Foundation

Okay.

Christine Bechtel – National Partnership for Women & Families

...organization and a different vendor.

Paul Tang – Palo Alto Medical Foundation

Correct.

Yael Harris – Health Resources and Services Administration

And affiliated.

Christine Bechtel – National Partnership for Women & Families

...outside your...

M/W

Multiple voices.

Paul Tang – Palo Alto Medical Foundation

So, thanks for clarifying, Farzad. It had nothing to do with trading partners it's just that had to go across organizational boundaries.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Right, you're not referring to yourself?

Paul Tang – Palo Alto Medical Foundation

Correct. Okay, so people who would like that restriction to be in the numerator. Okay, the restriction is that the electronic...in order to count in the numerator it has to be an electronic transmission to another entity that is not part of your business entity, outside of your organization in other words.

Christine Bechtel – National Partnership for Women & Families

Paul, this is where I'm confused, because if it was in the numerator as I had to do that one or two times, that would be different than 10%. Because how I'm reading the proposed rule is that all of my electronic transmissions have to be outside my organization and not the same vendor, different EHR vendors.

Paul Tang – Palo Alto Medical Foundation

In order to count in the numerator, that's correct.

Christine Bechtel – National Partnership for Women & Families

All right, so if that's what you're asking about versus some formulation of that I think is two different things.

Paul Tang – Palo Alto Medical Foundation

I just said it's not orthogonal so it's not exactly...

Christine Bechtel – National Partnership for Women & Families

I know but I'm clarifying what, are you asking about that concept or are you asking about the exact number?

Paul Tang – Palo Alto Medical Foundation

Yeah the concept.

Christine Bechtel – National Partnership for Women & Families

Okay so the concept is good in a way.

George Hripcsak – Columbia University NYC

In the rule, measure two, does the denominator include referring to yourself?

Paul Tang – Palo Alto Medical Foundation

No.

George Hripcsak – Columbia University NYC

I know the numerator doesn't, but I'm just making sure that we don't come up with an impossible...

Paul Tang – Palo Alto Medical Foundation

Oh, I see what you're saying.

George Hripcsak – Columbia University NYC

So, the denominator is also...

Paul Tang – Palo Alto Medical Foundation

That's not considered a transition.

George Hripcsak – Columbia University NYC

I just wanted to make sure.

Michael Barr – American College of Physicians

Well, wait a second, but a transition within my system, if I'm an ambulatory care provider as part of the hospital, and I am transitioning the patient to the inpatient side that's still the same organization, same EHR that's still a transition, we still want them to do the same sort of reconciliation? We want to have the care plan, you know, so why would we...

George Hripcsak – Columbia University NYC

...

Michael Barr – American College of Physicians

But that's not being counted in the denominator is what you just suggested.

Paul Tang – Palo Alto Medical Foundation

Correct. So, we're saying it neither counts in the denominator or the numerator. So, you do not get penalized for having to have this...so let's say you're a big health system and you have...

Michael Barr – American College of Physicians

Right, a massive number of transitions in size.

Paul Tang – Palo Alto Medical Foundation

Right, then you would have to have a massive amount outside.

Michael Barr – American College of Physicians

Right.

Paul Tang – Palo Alto Medical Foundation

Okay, so people who like that concept to be in here that is the electronic transmission has to occur outside of the organizational boundaries?

Neil Calman – The Institute for Family Health – President and Cofounder

For some...

Paul Tang – Palo Alto Medical Foundation

For some whatever.

George Hripcsak – Columbia University NYC

...

Paul Tang – Palo Alto Medical Foundation

Yeah for a...

Michael Barr – American College of Physicians

Whether it's acceptable or not?

Paul Tang – Palo Alto Medical Foundation

Yes.

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

...long-term care I could or home health...

Michael Barr – American College of Physicians

...

Paul Tang – Palo Alto Medical Foundation

Yes. Okay, one, two, three, four, five, six, seven.

Christine Bechtel – National Partnership for Women & Families

What was the vote?

Paul Tang – Palo Alto Medical Foundation

Outside organizational boundaries.

Christine Bechtel – National Partnership for Women & Families

The concept?

Paul Tang – Palo Alto Medical Foundation

Yes.

Christine Bechtel – National Partnership for Women & Families

Yes, it's supporting.

Paul Tang – Palo Alto Medical Foundation

Eight, nine, ten. Wow, we've got...okay so that one's good. Now we're going to talk about...in order to count in the numerator, it has to go to an EHR who is not in the same vendors as yours is.

Christine Bechtel – National Partnership for Women & Families

Again, concept?

Paul Tang – Palo Alto Medical Foundation

Concept.

Michael Barr – American College of Physicians

Another certified or are we differentiating between a certified...

Paul Tang – Palo Alto Medical Foundation

That's a good point.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I have a question though, I mean, if I have NextGen in this organization and NextGen in that organization...

Paul Tang – Palo Alto Medical Foundation

It doesn't count.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And we're communicating through Direct, why wouldn't I encourage that? Because I might have completely different standards, for instance, Epic clients might upgrade once every six years. I mean we have, just because there is a vendor's name on it, does not mean that I'm interoperating effectively.

Paul Tang – Palo Alto Medical Foundation

I know, so you vote, no.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Well, I would vote that it's good to have.

Paul Tang – Palo Alto Medical Foundation

I know, so you would vote no against this concept.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...to each other through Direct.

Paul Tang – Palo Alto Medical Foundation

Okay, so...

Christine Bechtel – National Partnership for Women & Families

I think what the question is, is whether there is some aspect of this, not necessarily, that's why I keep asking about the concept, not necessarily 100% of the numerator.

Paul Tang – Palo Alto Medical Foundation

Correct.

Christine Bechtel – National Partnership for Women & Families

But, whether there is some part of it that we want to actually encourage to different vendor systems to talk to each other as well as...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But I wouldn't have to know. If I send to you a Direct compliant message and you had NextGen I wouldn't have to know. I don't know for you to receive it. So, I just don't want to end up being so prescriptive that we actually don't encourage interoperability, because I have to know that that person is not on NextGen even though I'm not using the NextGen to NextGen proprietary interface.

Michael Barr – American College of Physicians

So Leslie, you would be okay as long as it's outside? You're supporting outside the organization but not necessarily a different vendor?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Absolutely. Correct.

Paul Tang – Palo Alto Medical Foundation

So, let's vote. Right now, we're just talking about the cross vendor concept. So, those who would like to include that in the measure, please raise your hand.

M/W

Multiple voices.

Paul Tang – Palo Alto Medical Foundation

It's acceptable. One, two. So two. Okay, so it looks like, one we really agreed that it has to cross organizational barriers, makes sense. We are essentially equally predisposed to having either accountable or a percent of transitions.

Michael Barr – American College of Physicians

One other question.

Paul Tang – Palo Alto Medical Foundation

Yes.

Michael Barr – American College of Physicians

That you may have asked, but what about the folks who are using those standards but aren't using a certified system?

Paul Tang – Palo Alto Medical Foundation

We voted that one down.

Michael Barr – American College of Physicians

In the numerator?

Paul Tang – Palo Alto Medical Foundation

Well we took it out of the denominator so it doesn't make a whole lot of sense to the numerator.

Michael Barr – American College of Physicians

Not if you're doing 10% of transitions.

Paul Tang – Palo Alto Medical Foundation

Now we're getting towards that...

Michael Barr – American College of Physicians

Well, what I'm saying if it's 10% of all transitions, which is what the denominator originally was then why wouldn't you count those other, outside of the organization, to systems that are using either a certified EHR or in EHR that has standards?

W

...

Michael Barr – American College of Physicians

The way we wrote it down in the denominator.

Paul Tang – Palo Alto Medical Foundation

I see your point.

M/W

Multiple voices.

Michael Barr – American College of Physicians

It could be part of...if we do the count too, it's just when we made that the restrictive denominator.

Paul Tang – Palo Alto Medical Foundation

I'm going to try still triangulate here, it's tough.

Christine Bechtel – National Partnership for Women & Families

Should this go to the IE Workgroup with our...

Paul Tang – Palo Alto Medical Foundation

Well, I'm even trying to get a sentiment, because I mean they're going to have the same issues. It's not as if the issues will go away. So, I'm just going to start constructing combinations of the things that we liked, that we found acceptable. So, one possibility.

Michael Barr – American College of Physicians

And you're doing a masterful job.

Paul Tang – Palo Alto Medical Foundation

One possibility, and I'm just taking the early options first, is you must have a countable number of electronic transmissions to non-business affiliates, we're not saying how many that is, but it's a countable number of electronic transmissions to affiliates.

Christine Bechtel – National Partnership for Women & Families

This is EP.

Paul Tang – Palo Alto Medical Foundation

Pardon me?

Christine Bechtel – National Partnership for Women & Families

EP.

Paul Tang – Palo Alto Medical Foundation

EP.

Michael Barr – American College of Physicians

Okay.

Paul Tang – Palo Alto Medical Foundation

One, two, three, four, five, six, seven, eight. Okay, so I'll just try to put another scenario across. You must have, let's see the 10%, so you must have X percent of your transitions have electronic transmissions to non-affiliated, non-business affiliated entities.

Michael Barr – American College of Physicians

But, Paul, that's part of that here, that's the comparable numerator to the denominator.

Paul Tang – Palo Alto Medical Foundation

Oh gosh. No, no, no the first one was countable, just a counting number.

W

Oh, I keep thinking of mutually countable...

Neil Calman – The Institute for Family Health – President and Cofounder

Countable versus percent.

Paul Tang – Palo Alto Medical Foundation

This is percent, yeah.

Michael Barr – American College of Physicians

...transitions...

Paul Tang – Palo Alto Medical Foundation

No, no, you can count vote either, it's just acceptable. I could be stuck in a draw. So, how many are this is acceptable? One, two, three, four, five, six, seven, eight. So they're split. Then, what is...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...the first one, because I thought you meant countable as part of...

Paul Tang – Palo Alto Medical Foundation

Okay, we're still split. So, now the leading argument against percent was the knowability and we either cannot decide amongst this group or we...so maybe I'll try one more time and see if people, recognizing that the major difference between that is the knowability issue and...

Christine Bechtel – National Partnership for Women & Families

What is the...

Michael Barr – American College of Physicians

Paul, this is where you're talking about...

Paul Tang – Palo Alto Medical Foundation

Michael has decided the number of...

Michael Barr – American College of Physicians

Are we talking about the...

Paul Tang – Palo Alto Medical Foundation

Go ahead.

Michael Barr – American College of Physicians

No, no, no are we talking about back to one of the earlier measures where we said there would be a checkbox here, this is actually a transition?

Paul Tang – Palo Alto Medical Foundation

No this a knowability of being able...

Neil Calman – The Institute for Family Health – President and Cofounder

Knowability includes meeting...

Paul Tang – Palo Alto Medical Foundation

Well, unfortunately you'd have to transition to the standards.

Michael Barr – American College of Physicians

Oh, okay, gotcha, gotcha, all right.

M/W

Multiple voices.

Neil Calman – The Institute for Family Health – President and Cofounder

Even if they're not certified.

Paul Tang – Palo Alto Medical Foundation

Well, I mean he does bring up another point, which is the checkbox for transitions. You would have to...

Christine Bechtel – National Partnership for Women & Families

That is a problem we have to solve here because so much hinges on it.

Paul Tang – Palo Alto Medical Foundation

Okay.

Michael Barr – American College of Physicians

That's probably your denominator.

Paul Tang – Palo Alto Medical Foundation

So, we in fact already put that, we recommended that.

Michael Barr – American College of Physicians

Right, exactly, we know what the...are.

Paul Tang – Palo Alto Medical Foundation

So, we're assuming that the knowability problem is knowing whether somebody can receive my electronic transmission.

Christine Bechtel – National Partnership for Women & Families

And how is that problem different if it's a percent versus a number?

Paul Tang – Palo Alto Medical Foundation

Well, you're right if the denominator is...

Neil Calman – The Institute for Family Health – President and Cofounder

...then you have to know the people who aren't using, the people in your community who aren't.

Paul Tang – Palo Alto Medical Foundation

Well, actually, but for number two it's only the denominator's transitions.

W

...

Neil Calman – The Institute for Family Health – President and Cofounder

But, you still have to know whether those transitions are to people who's non-certified EHRs are using standards or not.

Paul Tang – Palo Alto Medical Foundation

Oh, that's right, so in other words you can't be penalized, I guess.

Neil Calman – The Institute for Family Health – President and Cofounder

And how would I know that?

Christine Bechtel – National Partnership for Women & Families

No, because I think if it's 10% of all transitions, which is knowable, then that's when the care record has to be sent electronically, that doesn't mean you have to record, you know, the people who aren't capable, but you do have to know who they are and send electronically because the system counts the transmission, is that right?

Paul Tang – Palo Alto Medical Foundation

So, the thought is that 10% is low enough that no matter where you live you should be able to...the assumption is no matter where you live you should be able to transmit electronically. There should be enough partners out there that you can't transmit 10% of your things electronically, that's the assumption here.

Michael Barr – American College of Physicians

Right, we weren't going to talk about percentages yet.

Paul Tang – Palo Alto Medical Foundation

We're not talking about percentage yet. Well now we might have to, because we have a split between countable and percent.

Michael Barr – American College of Physicians

Well the problem is we don't know how many transitions are going to be in that little checkbox. We also didn't want to disincentivize folks from checking the transitions box by growing a much larger denominator. So, in other words they could game the system in theory by unchecking or not checking the transition box, shrink their denominator and making the 10% a lot smaller.

Paul Tang – Palo Alto Medical Foundation

So, let me try to...

Michael Barr – American College of Physicians

So, by counting you're forcing a certain number.

Paul Tang – Palo Alto Medical Foundation

Right. So, let me try to summarize the major differences between the two options that we were split on and see if that recall helps. So, the purpose of having a number rather than a denominator is one, you don't have to track transitions in both the documentation and the gaming.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Would you have to do it for measure one anyway?

Christine Bechtel – National Partnership for Women & Families

What was his question?

Paul Tang – Palo Alto Medical Foundation

Would we have to do it with measure one and the answer is yes.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Okay.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation

So, that might force us to revisit that one Farzad.

Michael Barr – American College of Physicians

Yeah, we're checking off to get the count.

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

We need the count.

George Hripcsak – Columbia University NYC

What do I need to write here about the checkbox, because I don't have it written down here?

Paul Tang – Palo Alto Medical Foundation

That we'd like EHRs to be certified to accommodate recording whether a transition had occurred. Well, gosh, actually this is a different...

M/W

Multiple voices.

Michael Barr – American College of Physicians

That was for medication reconciliation, but it's the same thing.

W

That was for medication reconciliation.

Arthur Davidson – Denver Public Health Department

The first one was had it occurred.

Paul Tang – Palo Alto Medical Foundation

The first one was had it occurred, right and now unfortunately we're asking for yet another one it's about to occur.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

I'm sorry, why is it not the same?

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

Like the process is going to be...you're going to prepare your summary document and as part of that you should say, am I transitioning this patient to one of these places? Yes. I've got my number and I'm gone, you know.

Arthur Davidson – Denver Public Health Department

Farzad the first one was the transition had occurred and you needed to do a medication reconciliation, that was an earlier discussion.

Paul Tang – Palo Alto Medical Foundation

So our issue was medication reconciliation also had a percent and we had to figure out what it was a percent of and the only way we could figure out since the computer can't tell is to have a human checkbox.

Neil Calman – The Institute for Family Health – President and Cofounder

This is different, because this is actually a transition out is usually an order.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Yeah, the referral.

Neil Calman – The Institute for Family Health – President and Cofounder

So, I don't think you really need to worry about that. I don't think you need a checkbox for the transition out, because that's an order.

Paul Tang – Palo Alto Medical Foundation

Okay. Why is it an order?

Neil Calman – The Institute for Family Health – President and Cofounder

I'm referring to a rheumatologist; I'm referring to the emergency room. I mean, it depends on I guess how you set up your system. I mean, ours is set up as an order so it can be tracked.

Christine Bechtel – National Partnership for Women & Families

So, Charlene is that how your customers are doing it?

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

You could do it either way.

Paul Tang – Palo Alto Medical Foundation

Either way, yeah.

Christine Bechtel – National Partnership for Women & Families

So, what would that not cover by way of a transition to another provider or to another...

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

The questions in transitions come up what really counts, you know, what counts as that transition across venues and, you know, again the scenario we talked about earlier, when they come back from the specialist. So there are some nuances in those transitions that we don't have consistency in how to count.

Neil Calman – The Institute for Family Health – President and Cofounder

So probably our number one transition is referring to mental health providers who may or may not have electronic health records or case management people or other folks. So, the definition of the denominator here is really important if you're going to create a percentage in the numerator, like who are you, you know, going to count?

Paul Tang – Palo Alto Medical Foundation

I'll try to recap the differences between the two and then let's see if there is any change in the vote. One, is the primary reason for doing numbers is to avoid the denominator problem and yes I guess that applies to one and two for the EP side which is what we'd recommended before. And if it is high enough, i.e., not one or two then it is unlikely that people would stop doing that. So that's the rationale behind numbers.

The rationale behind percent is to make sure that there is a sustained and more ubiquitous, 10% is hardly ubiquitous, but more uniform use of electronic transmission.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Systematized.

Paul Tang – Palo Alto Medical Foundation

More systematized, that's a good word. Okay, so those who would find, let me do prefer then to try to not get...so those who would prefer option one, countable, please raise your hand. One, two, three, four, five six. So there are six that would prefer option one. So, prefer option two? One, two, three, four. Okay, six and four. So, we're pretty evenly split. Then, I think what we'll do is we'll ask input from, is this a standards issue? It really isn't a standards issue. Really, it's a policy issue.

Christine Bechtel – National Partnership for Women & Families

I don't think so, it's a policy issue or IE Workgroup maybe, what would foster exchange kind of a thing...

Paul Tang – Palo Alto Medical Foundation

That's a good point. Okay. So, let's probably share with them the discussion, are there any of us in common with that group?

Christine Bechtel – National Partnership for Women & Families

David, are you still in the IE Workgroup?

Paul Tang – Palo Alto Medical Foundation

Okay, so we'll communicate the discussion and ask them to weigh in as well, they're not deciding, we're not deciding.

Christine Bechtel – National Partnership for Women & Families

Claudia.

Paul Tang – Palo Alto Medical Foundation

Claudia?

Claudia Williams – Office of the National Coordinator

...and Josh and I were talking about this, given that the IE Workgroup is going to be meeting weekly for the next four weeks, maybe it makes sense to let that group meet and have its initial discussion and either have a way to liaise with this group or have a representative talk about where we're heading, but just we might want to figure out a way to coordinate more tightly on these.

Paul Tang – Palo Alto Medical Foundation

That's great. That's great. So, we'll at least not have our time spent go to waste by ensuring...

George Hripcsak – Columbia University NYC

One, last question? Can I ask, if we do a percent do you want to leave it the lower?

Paul Tang – Palo Alto Medical Foundation

Correct. Okay.

George Hripcsak – Columbia University NYC

So we can ask that while we're all...

Paul Tang – Palo Alto Medical Foundation

So, the part, right as part of the discussion if they end up with percent then what percent? Okay, so they'll report back to...anyway we'll get the information. I mean, they should come back and inform this group too. I mean, obviously we're working the Meaningful Use part. Okay, I was hoping, based on plane time to be able to conclude by 4:15. I think it's still possible, but that was my goal. Okay, and we do have two more calls yet.

Moving onto population and public health. The menu was to perform at least one test. You had to pick from one of these menus. So, they were all menus but you had to pick one. So, one option for you to pick in Stage 1 was one test of submitting electronic data to immunization registries. What we proposed was basically the same thinking that it was, I'm sorry not the same, was to submit data instead of just test. The NPRM said that you would continuously submit except where prohibited basically. I got that right? I said it correctly? Okay, any discussion on this? It's basically moving from test to continuous submission. Charlene?

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

So the general feedback I'm getting in talking, you know, with the providers is because of the timeframe, the dependency on the states to be ready they can do about one of these per like, you know, 12-18 months timeframe, you know, in terms of...

Paul Tang – Palo Alto Medical Foundation

They, the states?

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

A provider in terms of building that transmission with the state. So, it just takes a while.

Paul Tang – Palo Alto Medical Foundation

Wait a minute, one provider?

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

It takes them about, like one of the customers did the lab interface, you know, the reporting and it took about 18 months to just get that one up and running. So the concern is if I've got to get all three up and running when I was just...

Paul Tang – Palo Alto Medical Foundation

Okay, okay you're talking about general categories not individual providers?

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

Yes.

Paul Tang – Palo Alto Medical Foundation

Okay, I think I see or had the same comments earlier. So, let's talk about that because I think that's the overriding concern.

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

Yes.

Paul Tang – Palo Alto Medical Foundation

So, there are three, at least for hospitals there are three different public health measures having to do with continuous transmission where it's not prohibited and they used to be a test of one of the three and now it's moved to two of the three for EPs and three of the three for hospitals, correct? Comments about that?

Arthur Davidson – Denver Public Health Department

I have just a questions, since I was a little surprised for the immunization data it said, except where prohibited, can you tell me a state or jurisdiction where it is prohibited? Because it was a bit of a surprise to me that it is prohibited.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Jim Daniels on the call if you want me to answer any of those questions?

Paul Tang – Palo Alto Medical Foundation

Go ahead you've got the court.

James Daniel – Public Health Coordinator – Office of the National Coordinator

Yeah, so I think the main point was where there were some Sovereign Indian Nations that could not report to the immunization registries for the states that they reside in.

Arthur Davidson – Denver Public Health Department

Oh, okay. Okay. Thank you.

George Hripcsak – Columbia University NYC

Actually, I think the reason though, for the phrase is to say only except where prohibited, not except, they're not a common practice.

James Daniel – Public Health Coordinator – Office of the National Coordinator

That's true.

George Hripcsak – Columbia University NYC

In other words, adding this phrase is not limiting it further, it's opening it up further.

Arthur Davidson – Denver Public Health Department

Yeah, I know, I just didn't understand where it came from.

George Hripcsak – Columbia University NYC

...any place and now we came up with this kind of example.

Arthur Davidson – Denver Public Health Department

Yeah, right, thank you, Jim, yeah.

George Hripcsak – Columbia University NYC

Okay.

Paul Tang – Palo Alto Medical Foundation

Okay, so let's address directly the concern that Charlene raised, which is for public health departments, local public health departments to work on all three, to receive all three of these kinds of electronic transmissions may be stretching it and that's true even for 2014?

Arthur Davidson – Denver Public Health Department

Well, it may continue to be true or it may be that the work that the S&I Framework is doing may make this easier. I think there's effort going on within ONC right now. The public health case reporting initiative is really working to see if it is possible to find a common method for all three that the state health department would use to be the receptor site for these three and 10 others. I think that's our goal in this effort, but I don't know that...certainly, we're not looking like it is going to be there for Stage 2, that's where we think it might be going for Stage 3. So, it does not address the problem. And there needs to be a way for either a federal agency to step in to show that these things can be received at least to say, I've gotten things organized and when my state comes along I can do that or that there is some site that has been put up by ONC for us to do that sort of testing. But, you know, we need to find a way so that the state health departments or local health departments, whatever they be, do not put up a barrier to getting these things done.

Paul Tang – Palo Alto Medical Foundation

Is there a proposal on how...

Arthur Davidson – Denver Public Health Department

So, Jim, do you know if there is any talk of either ONC or CDC creating some sort of test environment for this to be looked at?

James Daniel – Public Health Coordinator – Office of the National Coordinator

By that do you mean like a common infrastructure?

Arthur Davidson – Denver Public Health Department

Yeah or where some of the early stuff that the public health case reporting initiative might be tested out?

James Daniel – Public Health Coordinator – Office of the National Coordinator

Yeah, I mean they're definitely doing that with biosense for the syndromic surveillance reporting and that infrastructure is actually in place now for hospital reporting and they are certainly planning on expanding that to ambulatory syndromic surveillance as well as soon as there is an implementation guide out for that.

Arthur Davidson – Denver Public Health Department

But not for, you know, Charlene's comment is that the immunization registries or electronic lab reporting are not really...they don't have a receptor site.

James Daniel – Public Health Coordinator – Office of the National Coordinator

I would say that states have done a great job of moving forward and having their own infrastructure to accept that and the numbers are much higher than they were a year ago. I think as far as CDC having a common infrastructure for those like they're doing for biosense it's a little more political in nature.

Arthur Davidson – Denver Public Health Department

Right.

Paul Tang – Palo Alto Medical Foundation

George?

George Hripcsak – Columbia University NYC

I would suggest that this Workgroup not focus so much on what...it's an NPRM period, so therefore CDC, states and local health departments can send in their comments about whether it's feasible on their side, although we have expertise, Art, and we focus more on what's feasible for the EPs and EHs, although we did have a comment earlier during lunch that if there was a choice among these three that they're in the right order. Immunizations perhaps most important. Reporting is second most important. And syndromic surveillance while still important is the third of the three. In case there needs to be a decision based on the things that CDC or states says. So, our first priority is to say whether this is reasonable for the EPs and EHs.

Paul Tang – Palo Alto Medical Foundation

Okay, so a fair way to look at it.

George Hripcsak – Columbia University NYC

If there is a recipient in other words.

Paul Tang – Palo Alto Medical Foundation

Correct. Comments on that?

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

The feedback with getting on that is to go from just doing a test all the way to ongoing submission is a big leap in the timeframe to do all three.

Paul Tang – Palo Alto Medical Foundation

To do all three?

George Hripcsak – Columbia University NYC

Really? So, is that true, because we're finding, I mean if you really did a good test, it's not such a huge leap.

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

But you only do a test to one.

George Hripcsak – Columbia University NYC

Yeah, but...okay, I didn't know.

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

That was just the experience.

Paul Tang – Palo Alto Medical Foundation

Okay, then so that's a helpful approach just to look at it from the EP and hospital side. So, let's go through individually, we started out with immunizations. Art made the comment that of the three that maybe one of the most interesting and important public health data to collect and possibly furthest along?

Arthur Davidson – Denver Public Health Department

I think so. I mean the investments for the last two decades have been significant in the immunization registries. So, I think probably more states, and we saw that as well, every month we see that in the presentation from CMS, that that is the most common category for providers and hospitals.

Paul Tang – Palo Alto Medical Foundation

So, I think we're saying we agree with the NPRM's statement and we have an additional comment that says of the three this is the highest priority and we can add that, because that could be useful input as CMS and ONC consider if they're going to back down on making all these core. Okay, so for hospitals we're talking about reportable labs and its basically continuous reporting except where prohibited.

Arthur Davidson – Denver Public Health Department

And Jim, is that true there also in the Native American populations and tribal areas that they don't have to report?

James Daniel – Public Health Coordinator – Office of the National Coordinator

I believe so. I think the main example was the immunization registries, but they applied that comment to all of the public health reporting measures.

Arthur Davidson – Denver Public Health Department

Wow, thank you.

Paul Tang – Palo Alto Medical Foundation

Okay, next one is syndromic surveillance, it applies to both EPs and hospitals, the same thing, continue submission except where prohibited. Okay, so if we agree with this, we would add the commentary that we think that it would be challenging for the providers and then the federal government obviously can look at it from the public health side, the federal and state governments can look at the public health side and see whether the recipients also find it challenging to move on all three at once by 2014 considering where we're starting is a menu test one. And then add our commentary that we find immunization registries and submission two of the highest priority.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Just a note, I think there's only 22 fields, maybe 17 that are required in the syndromic surveillance and they're very consistent with the fields that where already being gathering for the clinical summaries, there has been an attempt to make sure there's parsimony, it's the same vocabularies and the same code sets. So, although it might be challenging operationally, I think the Standards Committee has addressed it quite well in the actual data standards.

Paul Tang – Palo Alto Medical Foundation

That's helpful, thank you. Okay, two new public health submissions as menu items are cancer registry and non-cancer specialty registries. These are menu, they primarily address specialists.

Arthur Davidson – Denver Public Health Department

I just want to make a little comment about that, I actually don't know, even though this came out of our discussion around specialist, I look at this one that showed up, you know, this last item in the cancer registry was something that we did comment on but didn't really push forward with full force. But the second bullet about the specialized registries, I actually think that they may not only be for specialists but they could be for primary care people who know what, for instance in our community transformation grant we're looking at collecting hypertensive disease parameters, cardiovascular disease parameters like, who's got hypertension and who's controlled? Who's got hyperlipidemia and who's controlled? Who's got obesity problems? So, this may not be just about the specialists. This may be something where organizations and primary care doctors may contribute something of value to public health. So, this was like a windfall. I didn't think that this was something coming and it came. So, I'm very much in favor of this. This is similar to what's going on in New York City about the PharmaCare Information Project that Farzad worked on before he left and that they continue to do really neat things with.

Paul Tang – Palo Alto Medical Foundation

Good. So it might have been motivated or stimulated by a specialist but it certainly can have broader applicability. So some accompanying questions on this one, one is, are the standards ready for even the registries that exist? Another one that came up, actually part of our hearing from a long time ago on registries, we actually had a panel of registries are proprietary nature and cost. So, those are things that need to be considered if they are going to be consented by a government program. It's a little bit like

NQF you can't have a license, you know, cost associated with the measure if it's going to be endorsed. So, those are a couple things that we might need to comment re-comment on? Okay, yeah.

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

I would comment on, you know, from the vendor community again, I think as you look at an oncology or the cancer registries, typically, it's often a cancer hospital and there is special software that you build to be able to do that reporting, so it's not generally in a lot of products. So, I think we have a product gap there. The same thing with other registries that typically are more specialized and so to the extent to which, unless there is a standard, which I don't think there is, because that was kind of the call on the vendors call, it was like well do you know where one is and we don't do this today. So, from the vendor community I think there's a gap there in terms of supporting that reporting clearly specialized cardiology systems do. So in the specialized systems you're going to see it, but again it tends to be to one registry. So, if you go out in the market and say, well you've got to build interface to all of these registries, if that's what the requirement is then the slope for the vendor community it's a big reach in terms of the vendors accommodating reporting to all of these registries as well as the cancer registries.

Paul Tang – Palo Alto Medical Foundation

That is a good point. Art and then Neil?

Arthur Davidson – Denver Public Health Department

So the cancer registry, I think we had this discussion, and I think we had some testimony from CDC. They have an HL7 2.5.1.

James Daniel – Public Health Coordinator – Office of the National Coordinator

It's CDA, Art.

Arthur Davidson – Denver Public Health Department

CDA now?

James Daniel – Public Health Coordinator – Office of the National Coordinator

Yes and it's published on the Meaningful Use website.

Arthur Davidson – Denver Public Health Department

So, I mean, if we're talking about CDA as a common method to be sharing a variety of things we spoke about earlier today, is it that burdensome to the vendors?

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

We haven't done it so I don't think we know. I mean, clearly, I just think there's a knowledge gap, an implementation gap here. If the standards available we'd have to look at that.

Paul Tang – Palo Alto Medical Foundation

Okay. Neil and then David?

Neil Calman – The Institute for Family Health – President and Cofounder

So, I guess the question here is about capturing information. My understanding of cancer registries is that they're not just names of people and a diagnosis? They have all kinds of information about staging procedures, follow-up and they follow people longitudinally over time. We don't actually capture any of that information now. So are you going to want us to collect all of the information, you know, on the cancer patients in order to put this information into a registry? So, I guess I have a...we diagnose cancer, but we don't collect all of the information that I think is normally captured in a registry. So, I don't really know...I guess I am confused about the way the term registry is being used.

So, our diabetes registry that we've created in house has like 35 fields but that's not a standard registry. That's something we use for the ongoing management of diabetic patients, it includes their phone numbers and everything that we need to call them and who their case manager is and who their diabetic educator is, but from a public health point of view if you want to know about diabetes you probably want

to know some of those things, and I don't even know whether there are standards for these different types of registries.

So, I don't know, I mean, I agree I think this is a great thing. To me this feels more like syndromic surveillance than registry, because you want to know who in my practice has cervical cancer or breast cancer or whatever, you can get that right off of the diagnosis information when we're downloading our syndromic surveillance information, you have diagnosis and you could pull that information from there. But if you really want the full registry information with lab results and all the rest of that stuff that's a whole other ball of wax.

Arthur Davidson – Denver Public Health Department

I don't think the Cancer Registries of America would feel that this feed now from Meaningful Users is going to serve all of their information needs and maybe it's just, you know, creating the shell of a record that says, here's part of our workflow to fill this in afterwards. I think you're right, it's more like syndromic surveillance where you go out and collect more information to make sure rather than saying, hey you can dismiss all the who people work in the cancer registry because now you have an automated cancer registry. There is much more work to be done there.

Paul Tang – Palo Alto Medical Foundation

Okay. David?

David Lansky – Pacific Business Group on Health – President & CEO

I think this will good, this menu item is a good impedance to other activities that are already underway so there's a national qualities registries network that's trying to develop standards across specialties so that there would be some more uniformity in building on what cancer has already done and what cardiology is going to do. So, this is contributory to it and to Art's last point, in California we're doing a...from EHRs to a statewide total joint registry and what's happened has been there has been extraction from the EHR which populates part of the registry and there are other mechanism tablets and things to capture the rest of it, it's very specialized. So, we're kind of in a migrating mode here from what do we capture from the EHR that will populate registries cheap and free, easy and then how do we supplement that? Or do we need to go back and re-engineer the EHR to capture things we're not but need to. So, this will be a good impedance to drive that process forward and especially with...because finally the ophthalmologists and others have a place in the matrix here.

Neil Calman – The Institute for Family Health – President and Cofounder

So, you're using this to open the record basically to say, here is a patient who had a something or who had something and then using other methods to sort of fill in other information.

Paul Tang – Palo Alto Medical Foundation

Leslie?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie, I think this is a great opportunity to look at sort of the module approach that we took similarly to patient education materials where there is certain information that can be cached and shared even real-time with a registry application, but the registry application itself can sit outside the EMR and provide use. The same would apply to clinical decision support, for instance I'm going outside the EMR for something highly specialized, but I'm integrating with it by having common standards for sharing things like, you know, the patient name, the demographics, the chief complaint, the principal diagnosis, the lab results, the medication history, the family history and so forth that gets shared real-time. So, I think we can build upon the standards that we already have and also expand upon the need for...market solutions like registries or clinical decision support in the future.

Paul Tang – Palo Alto Medical Foundation

Okay, so, what where you going to ask?

George Hripcsak – Columbia University NYC

Well, I was going to ask, so what's our question about this?

Paul Tang – Palo Alto Medical Foundation

So, I think for the registries, I think part of the caveat is to just resurface what we heard from the hearing, which is consideration of...so are the standards there to populate the things that they want from the EHR and the proprietary nature of some of these registries and the cost associated with that.

George Hripcsak – Columbia University NYC

Should I write that in there or is that separate?

Paul Tang – Palo Alto Medical Foundation

Well make a note to ourselves so that we at least include it in the text. Okay, let's see here does that bring us to category five, which is...Deven are you still on the line? I think they basically essentially agreed with our recommendation about essentially data at REST. Okay, so I think we're in agreement there. Okay, so let's...we have a section, I don't know whether you can show it, George, of some of the seeking comment questions and we can go back to category one and see if we can knock some of this stuff off. So we basically covered all of the objectives except for summary of care where we're asking for additional help. Okay, I'm not sure; can you expand that even more?

George Hripcsak – Columbia University NYC

...that's as big as I can get it.

Paul Tang – Palo Alto Medical Foundation

Okay, so the first seeking comment is on CPOE, and I'm trying to get my thing to cooperate now...Okay, so they're asking the question of whether, as in Stage 1, CPOE must be conducted by a licensed healthcare professional versus other folks like scribes. So to recall our discussion with CPOE back in Stage 1, our notion was that CPOE is one of the important functions mainly to deliver information that would influence decision-making. And so we felt that ideally, it happens with the ordering provider, but as a surrogate measure, if there was a licensed professional receiving the information, that person has a professional responsibility to communicate this additional information back to the ordering providers since they're doing something on behalf of. So, is that still the same or the question is whether it be expanded to other non-licensed folks such as scribes? Neil?

Neil Calman – The Institute for Family Health – President and Cofounder

I don't think licensed professional describes what we really mean. What we really mean are people who can act on the information. So, you know, medical assistants for example can act on certain information and certain decision supports and, you know, do blood sugars based upon, you know, the results of a prior blood sugar that triggers an alert and other things like that. So I don't think, licensed, is really the concept here. I think the concept is that we want people to be entering orders and information if they have the ability or the authority whether through licensure or through delegation to act on that information.

Paul Tang – Palo Alto Medical Foundation

So, I don't think a medical assistant, was an example to use medical assistant? Because they can't enter orders.

Neil Calman – The Institute for Family Health – President and Cofounder

Well, they can enter orders based on standing protocols.

Michael Barr – American College of Physicians

Yeah, they can enter labs, they can enter vaccination orders, they can administer the vaccines, all standing protocols.

Arthur Davidson – Denver Public Health Department

It may depend on the organization.

Neil Calman – The Institute for Family Health – President and Cofounder

And on the state.

Paul Tang – Palo Alto Medical Foundation

Yeah, so in our state I don't think medical assistants can. Okay, so other non-licensed professionals can. Now the scribe actually, which is an example and I think was the motivation behind this proposal, they really truly are scribes.

Michael Barr – American College of Physicians

Well, in some cases they're nurses, so just calling them scribes, I mean that's not an accurate statement.

Paul Tang – Palo Alto Medical Foundation

Well, then the question wouldn't arise.

Michael Barr – American College of Physicians

Well, scribes is a bad example though is what I'm saying.

Paul Tang – Palo Alto Medical Foundation

But, I think it's a motivating example.

Michael Barr – American College of Physicians

In the best situation I've heard they are actually clinical people who are carrying on the visit before, during and then after the physician or a licensed professional.

Neil Calman – The Institute for Family Health – President and Cofounder

What we really want to say here...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...generally medical records professionals.

Michael Barr – American College of Physicians

May be in a hospital setting.

Paul Tang – Palo Alto Medical Foundation

Okay. Neil?

Neil Calman – The Institute for Family Health – President and Cofounder

I think what we really want to say here is that orders should be entered by those who can appropriately respond to decision support that might arise as a result of or in triggering such orders. That's really what we really want to say. I don't think licensure is the issue here.

Paul Tang – Palo Alto Medical Foundation

I might take it a step further, I'm not sure we're interested in the smack on the hand kind of alerts, there's a lot of things that during or in the process where you can provide information that bears on that order and you always like the order to be written right the first time instead of just alert. So, that's the theory behind how clinical decision support works with CPOE. So, that's sort of the rationale behind our original recommendations. Did you have anything, Josh? Okay. So, is that still the feeling of the group or does the group want to comment on other data entry people?

Arthur Davidson – Denver Public Health Department

I guess I'm...I mean, there's one thing that there is a person who is writing who may or may not be licensed, may not be in the workflow to act on something coming back from CPOE. So, that's one thing. So, the workflow may be such in some environments where it's not the doctor or whoever is the provider who is actually entering the order, but that person needs to be able to see and take action on that. So, I don't know how we want to describe that. That to me is the issue. That it should be actionable. And it doesn't mean that you have to do the keystrokes. You just need to know the results of the keystrokes. You have to be receiving the messages.

Paul Tang – Palo Alto Medical Foundation

Well, just one comment, I mean that's part of the reason we got to license, because there is a professional duty and a liability associated with acting on that information. So, we did very deliberately go there, but, Charlene?

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

A few comments. The customers actually like going to orders and they actually like at the same time the concept of licensed professional as defined by the state because they can get their handle on that. But it does say in the NPRM that, you know, the expectation is the originating provider, whose judgment creates the order must personally use the CPOE function. So, again, you almost need a handle on it to know whose judgment it is so that you can say it's a licensed professional as defined by the state because they've got the authority to create the order.

Michael Barr – American College of Physicians

Paul?

Paul Tang – Palo Alto Medical Foundation

Yeah, Michael?

Michael Barr – American College of Physicians

I'm sorry, since CPOE now includes laboratory and radiology, do we really want to have the requirement that a licensed professional is going to order a mammography based upon an algorithm for all the women who need it or likewise the blood tests for regular routine things that have to be done on a regular basis. I understand the concerns around pharmaceuticals, but I think if we get too micromanagement here and say it has to be a licensed person then all these population health things we want to get done in a regular way are going to rest on the shoulders of the eligible professionals, because they're going to be the ones who have to do click, click, click, click for all these kinds of things just to see the things that you're describing.

Paul Tang – Palo Alto Medical Foundation

Well, but actually it wouldn't be the eligible professional.

Michael Barr – American College of Physicians

Well it would a licensed...or nurse who could be doing other things, or a physician assistant, or a nurse practitioner, a medical assistant in the states where they're not "licensed" or a clerical person. If I provide the patient list, here are all the women who need their mammography's, schedule them an appointment and order their mammograms for me, that would not be permissible then if we say it has to be a licensed professional.

Arthur Davidson – Denver Public Health Department

Right, that's my concern.

Michael Barr – American College of Physicians

Right. So, population health and those kinds of proactive things where you're looking for gaps might suffer.

Neil Calman – The Institute for Family Health – President and Cofounder

Most of those end up being countersigned by a licensed professional.

Michael Barr – American College of Physicians

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

There is a process, but if the process stops at the point where that person is not immediately available, you end up interfering with lots of workflows that are set up, you know, to facilitate these things.

Paul Tang – Palo Alto Medical Foundation

So, just to comment on your, it's not just drugs, I think there is a lot of decision support that can apply to labs and radiology and in fact we're even considering, right the expense of imaging, so there's a lot of things that are not necessarily appropriate, and it's not just a cause, even though the downside is a false-positive.

Michael Barr – American College of Physicians

Right, but also, that's where the licensed professional, in this case the EP has to make a discretion, so what in fact he or she is going to delegate to those people that may or may not be a licensed. I think that's the professional responsibility of the EP. To say, I'm not going to have somebody order, you know, imaging tests with renal insufficiency, because I want to make sure the creatinine and all of those kinds of things, but some sort of routine things by standing order might very well be excluded by this restriction.

Paul Tang – Palo Alto Medical Foundation

Marty?

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

We do a lot of charting as we're rounding in the morning with the team and the person actually doing the charting may not be the physician, it may be an RN or something, but they are entering things into the chart with the physician present. So, I think it's more of a presence, while this is happening, or at least aware that this is happening at the time rather than who is actually poking button.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, is it really who takes action from an alert versus who enters in the order? So, what we're saying is we want someone whose judgment is going to recognize that alert or condition and take action and that might not be the same person who actually physically keys it. So we're trying to measure the action and clinical judgment...when the alert was given.

Paul Tang – Palo Alto Medical Foundation

In the extreme we don't want to just electronically paper. So, and the real key area, I mean this is validated by decades of research, that it's really the ordering process that influences a lot of both quality and costs. So, we're trying to make sure we don't have an out where basically they're just all scribed in, because we could do all of this work just to influence the orders and make those most appropriate. So, that's our...there's a balance, yeah.

Michael Barr – American College of Physicians

You want to have some things that can be done this way and others I completely with that sort of clinical decision support...here should be directed at the deciding person. Somehow we have to nuance that here, because otherwise the unintended consequences would be limiting some good practices.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...to turn to standard orders.

Paul Tang – Palo Alto Medical Foundation

Right, I mean, that's where we came from.

Michael Barr – American College of Physicians

Another good example of that is adult immunization. I mean, do we really want to limit that?

Paul Tang – Palo Alto Medical Foundation

Another out is to defer to state licensing groups. So, just like we said, there's scopes of practices that are determined by state licensing boards and to the extent that an individual can order in that state, then that's what the state has decided.

W

...

Paul Tang – Palo Alto Medical Foundation

It's still a state law. Right now, it's still a state law.

Yael Harris – Health Resources and Services Administration

Under practices, not under...

Paul Tang – Palo Alto Medical Foundation

Under?

Yael Harris – Health Resources and Services Administration

Under non-public...the military has been expanded to allow services at any site, at least for telemental health, so.

Paul Tang – Palo Alto Medical Foundation

But, I think they come under like the VA, they're basically the federal government and they bypass state laws.

Yael Harris – Health Resources and Services Administration

Right. But I am wondering if we're going...I hate to set things up by state lines when there's already such a barrier to a lot of what we want to do with health IT is because of state boundaries and now we're going to set yet another thing based state boundaries.

Paul Tang – Palo Alto Medical Foundation

Well, it's the state acting on...it's not...the states are the ones that issue even our medical licenses. So, they're taking...the theory is they're taking responsibility for the public's health and determining who should be able to do what kinds of actions.

George Hripcsak – Columbia University NYC

But states are going to do this independent of us. So, if the state says someone can't do CPOE then that'll just go through, we don't need that in our rule.

Paul Tang – Palo Alto Medical Foundation

That's right, so the thing was just to say...

Yael Harris – Health Resources and Services Administration

Whoever the state says okay...

Paul Tang – Palo Alto Medical Foundation

Whoever the state says can issue orders then they can issue orders in the electronic health record as well.

Yael Harris – Health Resources and Services Administration

And what if you...

Neil Calman – The Institute for Family Health – President and Cofounder

...

Paul Tang – Palo Alto Medical Foundation

Pardon me?

Neil Calman – The Institute for Family Health – President and Cofounder

If that's the case, then we can just eliminate this completely.

George Hripcsak – Columbia University NYC

Well, no then we would agree we would not limit it to licensed professionals.

Neil Calman – The Institute for Family Health – President and Cofounder

What?

George Hripcsak – Columbia University NYC

Paul's saying, we're being asked should we limit it to licensed professionals anymore. Paul's stipulation is no we should get rid of licensed professionals let the state decide, so the answer would be.

Paul Tang – Palo Alto Medical Foundation

I didn't say it like that, but...

George Hripcsak – Columbia University NYC

No.

Neil Calman – The Institute for Family Health – President and Cofounder

The states already decided. The states have rules about what each person can do with their license or not, but...

Paul Tang – Palo Alto Medical Foundation

Okay, so I guess, and I didn't think of it the way George said it. So, if what George is saying is in order to get Meaningful Use dollars in addition to their scope of practice rules of your state you would have to have a licensed professional enter orders in the computer to qualify for Meaningful Use dollars. That's sort of the net effect, which is...

George Hripcsak – Columbia University NYC

Right, that's the way it is now.

Paul Tang – Palo Alto Medical Foundation

That's the way it is now and you're saying just to let the states...

George Hripcsak – Columbia University NYC

I'm saying you said.

Paul Tang – Palo Alto Medical Foundation

It didn't sound the same way.

George Hripcsak – Columbia University NYC

I think we're getting tired.

Paul Tang – Palo Alto Medical Foundation

I agree.

George Hripcsak – Columbia University NYC

So, I just wrote down the essential features that the user be able to act on the automated decision support, so that's the question. Do we force it so that they...and I don't say whether they're licensed or not, that's why we're doing this now. You're saying well maybe there needs to be some exceptions to that, there are some areas where...

Paul Tang – Palo Alto Medical Foundation

Okay, so can you say to act and be accountable for?

Michael Barr – American College of Physicians

Paul, that's what I was going to get to where if I have the staff who are doing this and I say anytime you see an alert you need to bring me in, then you get the...there's still an accountability for what the concerns are. You see a warning, you see a drug alert, you see whatever. You should let the EP know.

Paul Tang – Palo Alto Medical Foundation

How are we feeling about this?

George Hripcsak – Columbia University NYC

But it does a dose a weight calculation.

Paul Tang – Palo Alto Medical Foundation

Well...

George Hripcsak – Columbia University NYC

Some of them get complicated again, like if it's not an alert it's some other kind of...

M/W

Multiple voices.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

...add radiology to that...now you have contrast...

Paul Tang – Palo Alto Medical Foundation

Correct.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

How big is the area scanned, there's a lot more complexity, do we add in each area.

Paul Tang – Palo Alto Medical Foundation

Exactly. And actually you picked a good example, George, of dose calculations because that's actually where we've had patient safety issues. So, we've overdose because vendors haven't limited the max dose and so they just dose up, right for a very heavy kid. And is the scribe, whoever you're saying is going to enter this going to be accountable and responsible for this?

Arthur Davidson – Denver Public Health Department

I think we take away the licensed professional. Then we need to have this accountability. So, you know, and I think that's sort of the question here is if workflow is going to say that, that can't be a licensed professional then we need a phrase that deals with accountability.

Paul Tang – Palo Alto Medical Foundation

Correct. So the scribe has to be open to...

Arthur Davidson – Denver Public Health Department

Has to call Michael.

George Hripcsak – Columbia University NYC

So, the big question is, the essential feature is that the X, being able to act on and be accountable for the automated decision support, so do you want to say the user or the EP? So, if its EP means you can delegate and then you get in trouble if they screw up the user means the scribe would have to be accountable, which is not quite...never quite true.

W

EP.

Arthur Davidson – Denver Public Health Department

It should be the EP, right.

Michael Barr – American College of Physicians

I'm comfortable with that...delegation...

Paul Tang – Palo Alto Medical Foundation

Okay, to be able to be accountable for...

George Hripcsak – Columbia University NYC

It's professionals within the EH...

Paul Tang – Palo Alto Medical Foundation

So, it's also not just the automated decision support, it's accountable for the orders and any decision support that is provided.

Michael Barr – American College of Physicians

But, as Neil was saying that's pretty much the way it is now when you delegate, whether it's the physician assistant or a nurse, or anybody under your license.

Paul Tang – Palo Alto Medical Foundation

All right...

Neil Calman – The Institute for Family Health – President and Cofounder

We should eliminate it.

Paul Tang – Palo Alto Medical Foundation

Well, I mean is the status quo where we want to stay and the only difference is that we're using the computer?

Neil Calman – The Institute for Family Health – President and Cofounder

But the status quo was that people under my medical license. I don't delegate authority for people to do anything unless there are protocols and standards in place for how I'm overseeing that, because ultimately they practice under my license, that's the standard now and that should be the standard in electronic health records. In other words, I don't think the EHR has to introduce some new level to jump over because that's exactly what happens now. Now we're adding some support into that and so in the workflow for those supports the same standards hold true. You know, you would have to make sure that whoever it is you're delegating to, just like they, you know, pick the right blood test and whatever else you've done in your protocols also knows that if there are decision supports that they have to respond to them appropriately.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Neil, I think if you can fast forward to now, you've got a lot of advanced clinical decision support that's coming as a result of all of this automation, there's lab, radiology, or I now have a remote function that monitors an ICU patient and gives me an alert. Fast forward to the natural conclusion of success and do you still feel that it can be anyone that you delegate?

Neil Calman – The Institute for Family Health – President and Cofounder

You mean one that can delegate?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Anyone that you would delegate that to or would it have to be the...

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, because they're either practicing under an institutional protocol or they're practicing under, if I'm in private practice, they're practicing under my license and so that's a pretty strong incentive to make sure that things are done the right way.

Paul Tang – Palo Alto Medical Foundation

The difference is they were literally being a scribe. In this case they're having to make a decision what to do when the yellow or the non-yellow pops up, or when the calculated dose is too high. How would they

know what's too high? But, they're having to react to new information...right in the past world the paper didn't talk back to them. In the new world they're actually getting new information, literally new information as a result of conducting this action and they have to have either the accountability or the judgment to do be able to do the right thing.

Yael Harris – Health Resources and Services Administration

But, that's what this language basically says; it's still on the EP.

Paul Tang – Palo Alto Medical Foundation

That's correct.

Yael Harris – Health Resources and Services Administration

Or the EH professional, but we're not saying who can put the paper to the pen or the fingers to the keyboard, it's that they...if they feel comfortable that this person is going to come back to me and say the dose looks wrong, if they have that confidence then that's okay.

Michael Barr – American College of Physicians

Or they won't ask them to do those kinds of entries to begin with.

Yael Harris – Health Resources and Services Administration

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

Which they're not asking them to do now.

Michael Barr – American College of Physicians

Which they are not doing now.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, I see.

Paul Tang – Palo Alto Medical Foundation

Right.

Neil Calman – The Institute for Family Health – President and Cofounder

The things we're talking about are things that people are being asked to do now, to write a mammography order for something or a flu shot, you know, order so that they can give the flu shot before they end up seeing the provider or without seeing the provider, according to protocol...what?

Michael Barr – American College of Physicians

Laboratory tests.

Neil Calman – The Institute for Family Health – President and Cofounder

Yeah, ordering a laboratory test, yeah. So, anyway, you know, I think that this is probably superfluous in a lot of ways unless we think that there's a huge number of people out there who are basically delegating all of this stuff out and having to establish the appropriate protocols.

Michael Barr – American College of Physicians

...themselves a call from the malpractice attorney.

Paul Tang – Palo Alto Medical Foundation

Okay, so let's see do we have consensus around the wording that's on the screen? Essential feature is that the EP or EH be able to act on and be accountable for, it should be the order and any decision support?

George Hripcsak – Columbia University NYC

Let me separate those two things.

Kevin Larsen – Office of the National Coordinator

I'm Kevin Larsen with the ONC Meaningful Use Team. There is some CMS rule already around who can do orders that are non-providers and the CMS language requires that it be in the physician's plan of care in order for someone else to do that order and that is actually a billing component of CMS as opposed to language around the Meaningful Use. So, they could potentially do an audit to any provider to see that that provider is actually articulated that they want that care done; it's to get rid of the sort of routine kind of care that's automatically order.

Michael Barr – American College of Physicians

Kevin, would a standing order be acceptable in that...?

Kevin Larsen – Office of the National Coordinator

Under the CMS rules the standing orders have to be applied to individual patient not to a population. So, that would mean that could do a standing order for a patient for the whole year like in a cancer therapy plan, but it can't be done for every patient with cancer. Again, that's current CMS regulations around how they look at billing compliance for their orders.

Michael Barr – American College of Physicians

Wow.

W

There you go.

Neil Calman – The Institute for Family Health – President and Cofounder

We should revisit this.

Michael Barr – American College of Physicians

Yeah, we need to talk more about this, because that would eliminate sort of the vaccine campaigns in other words.

M

...

Michael Barr – American College of Physicians

Okay, so it's important, so the kinds of things.

Kevin Larsen – Office of the National Coordinator

So vaccines and mammograms I think are the only two exceptions.

M

...

Michael Barr – American College of Physicians

Right, that's probably 80% of what is going to be done on this, it's not going to be the chemotherapy orders, it's not going to be the CT scans, it's going to be the routine things to take care of populations.

Paul Tang – Palo Alto Medical Foundation

Okay, so is that a vote of approval of the wording? It's interesting. Okay, well, one thank you so much for spending the time. We spent a solid six hours of work here, got a lot accomplished, a lot of discussion, we've made it through all of the categories. The work we have remaining to do are the questions that were in the NPRM and make sure we have all the questions that Farzad is interested in, revisiting the summary of care document and the exchange transitions of care, and what else is there?

Christine Bechtel – National Partnership for Women & Families

The first bucket that after a phone call that we said needed to come back to around disparities and data, demographic data.

Paul Tang – Palo Alto Medical Foundation

Correct. We have two more calls and I think they're each at least a couple of hours. So, we should be able to make it in those two calls, clean up the remaining work and tidy it up before presenting to HITPC for their comments at the beginning of April. So thank you very much and see you on.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Paul.

Paul Tang – Palo Alto Medical Foundation

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Public comment.

Paul Tang – Palo Alto Medical Foundation

Oh, public comment. All right. I'm getting ahead of myself.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And, I did want to say that you have a call on the 23rd 10 to 12, you have one on the 2nd of April 10 to 12, and then assuming that you've got until the May 2nd Policy Committee meeting to actually lock all this down you have one on the 1st of May 10 to 12 for any final tweaks.

Paul Tang – Palo Alto Medical Foundation

You know what if possible it would be nice to have it earlier than the 1st of May, because we do have to get it in by the 6th of May. So, we need to reconcile all of the HIT Policy Committee's comments into the draft to get final approval by that meeting.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

We'll work on another one in April then.

Paul Tang – Palo Alto Medical Foundation

Correct.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Operator, would you open up the lines please for public comment?

Caitlin Collins – Altarum Institute

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

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Is there anyone in the room to make a public comment? No.

Paul Tang – Palo Alto Medical Foundation

So, I'll talk to you in March.

W

Thank you, Paul.

Paul Tang – Palo Alto Medical Foundation

Thank you.

Public Comment Received During the Meeting

1. How would the WG propose to treat reflex testing or orders generated in the laboratory?