

Information Exchange Workgroup
Draft Transcript
March 22, 2012

Presentation

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Thank you very much. Good afternoon; this is Mary Jo Deering in the office of the National Coordinator for Health IT, and this is a meeting of the HIT Policy Committee's Information Exchange workgroup. It is a public call and there will be an opportunity for public comments at the end. We're going to ask everybody to identify themselves as we are making a transcript of this meeting. I'll start with Micky Tripathi.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Hunt Blair? Tim Cromwell?

Tim Cromwell – VHA – Director of Standards & Interoperability

I'm here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Jeff Donnell?

Jeff Donnell - NoMoreClipboard's - President

I'm here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Judy Faulkner?

Peter DeVault – Epic Systems – Project Manager

This is Peter DeVault for Judy.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Good. Hi, Peter. Seth Foldy

Seth Foldy – Centers for Disease Control and Prevention

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Larry Garber? Dave Goetz?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Jim Golden? Jessica Kahn? Charles Kennedy? Ted Kremer?

Ted Kremer - Cal eConnect - CEO

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Arien Malec? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Stephanie Reel?

Stephanie Reel - John Hopkins University - VP Information Services

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Cris Ross?

Cris Ross – SureScripts – Executive VP General Manager Clinical Interoperability Services

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Steve Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Chris Tashjian?

Christopher Tashjian – Ellsworth Medical Clinic – Family Practice

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Jon Teichrow?

Jon Teichrow - Mirth Corporation - President

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Amy Zimmerman?

Amy Zimmerman – RI DoH – Chief, Children’s Preventative Services

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Okay.

Lawrence Garber - Reliant Medical Group - Informatics

And Larry Garber just joined, sorry.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Good. Thank you, Larry.

W

Wait. Hey, Mary Jo, I think Arien is now on too, so group two, right?

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Yes. I called his name but he didn't answer.

W

Okay. Sorry, I missed it.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Yes. I called his name but he didn't answer. Okay. Thank you. Back to you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Great. Well, thank you, Mary Jo, and thank you, everyone, for joining the workgroup call today. We have a deceptively short agenda that just has the review of the agenda, and then, diving into the review of the Information Exchange objectives, but as you'll see, that is a sort of very meaty set of things that we have in front of us. We'll be sure to stop five minutes before the end to get public comments as well.

Why don't we move to the next slide here to start talking about the actual sort of course of events here at this meeting and a couple of future meetings? This is the workgroup list. I think all of you have seen this, and I think we did finally straighten out some of the organizational affiliations so hopefully there are no surprises there. And as someone just mentioned, Arien Malec is the new member of the workgroup, who I think isn't on yet, but just so everyone knows he will also be joining.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

And we have corrected Ted Kremer's affiliation.

Ted Kremer - Cal eConnect - CEO

Great. Thanks.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Today, I think as you may recall from the last workgroup we have—I forget how many it was—maybe 13, something like that, objectives that we had gone through the Stage II MPRM, just looking at the meaningful use side, and pulled out those that were directly related to information exchange, and those will be the one that we'll be considering for our recommendation. And tried to break those out in to—just lay them out over the next set of meetings so that we could deal with these in manageable chunks. I don't think we have the full schedule here but I think we have what we'll try and cover in this meeting and then the next two meetings. And have just given some tag lines here to describe what the topics are so I'll just go down this very quickly just so you know what we're going to cover. We might not get to all of this today, but just so you know what's there, and then, we'll look at the next slide, which shows the next two meetings. And then, we can take a pause, have any workgroup thoughts and comments around that, and then, dive in to it, if that makes sense.

We started our discussion last week on ePrescribing, and I think that was really at the tail end of the meeting, and probably none of us had enough time to really fully engage on the format and the structure and the concept and all that. It was at the end of the meeting so we probably want to take a look at that again, confirm where it seemed like where we did end up, which was, I think, feeling comfortable with the MPRM recommendation of ePrescribing with 65% on the eligible ... side. I don't think that we talked to the eligible hospital side so that's work that we want to do today.

We did put in something that was a Stage I requirement that got dropped in the Stage II MPRM, which was having a requirement to have a test of HIE capability. Again, just thinking about the MPRM we want to think about both what's in there as well as what might not be in there, and this was a particular case

where something was in Stage I and got dropped. And so you won't see it in the Stage II MPRM, but we probably want just a little conversation about whether we agree with that.

Also, just thinking about the general comment that we got last time from Claudia, I think, which was we want to be able to talk about things that we're happy with as well as things that we have some comments about changing.

But the next one is incorporating lab data, which is a requirement on the eligible ... side. Sending lab results, this was another one that got dropped from the recommendations from the HIT Policy committee. So those of you who were on the last go round of the Information Exchange workgroup you may remember that this was a recommendation that actually originated in this workgroup, which was a recommendation that hospitals who receive meaningful use incentives should send lab results according to the same specifications that EHR vendors were to be able to accept. And the providers were being measured with respect to their having certain percentages of structured lab results in their EHR.

That recommendation that came from us was endorsed by the HIT Policy committee and was a part of a formal recommendation, was not accepted by CMS in the Stage II MPRM, so we want to take a look at that again and have a discussion about how we feel about that.

There's the transitions of care, which is about the summary of care records, and then, the electronic medical administration set of objectives as well.

I don't anticipate that we'll be able to get through all of these today, but I think we should give it a shot. As you'll see, we have, I think, a little bit of space perhaps in the next two meetings. The next meeting I think we'll try to cover public health. We're trying to group together the three objectives really of the public health so we can have a single conversation about public health because there are a lot of cross cutting issues, I think, as you think about public health generally. And as we discovered, I think, in our last set of sessions with the IE workgroup, the public health conversation is a complex one that we want to be able to save a lot of time for.

And then, April 2nd we'll consider the final set of objectives that were in the Stage II MPRM; the ones about the reports to registries and the view and download capability in the patient engagement area. And will, along the way, keep a running tally and a running record of the recommendations and the comments that we're having so that we'll be in a position, hopefully, at that meeting, and depending on the timing, to be able to review the initial set of comments that we had coming out of this workgroup. In anticipation of the April 4th HIT Policy committee, I'll be presenting the first set of comments to the policy committee, as will all the other workgroups.

M

So is all the patient connectivity then wrapped in to the four to view and download section?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Well, I think that was the only one. Adam, in the grid, are there other ones in the grid? Did you just summarize here or were those not considered in the IE workgroup?

Adam Aten - Office of the National Coordinator

Yes. I think the view and download is going to encompass most of the patient connectivity.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Alright. Good. I didn't get that on that part of the grid.

Michelle

This is Michelle. I would think that there's a group reporting question out there that this group should probably at least talk about at some level. I'm not quite sure where that will fall but just something to think about.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Where is that Michelle?

Michelle

Well, they're asking for comments on it so it doesn't necessarily fall within an objective, but I think it's important that this group provide feedback.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. CMS is asking for meaningful use workgroups?

Michelle

Um-hmm.

M

And this is different than the non-cancer registry; the so-called specialty registry?

Michelle

Yeah. It's just within the context they are asking for comment on a group reporting. The ability to do it and there's a lot of questions associated with it.

Claudia Williams - Office of the National Coordinator

Michelle, this is Claudia. Can you talk a little bit about where—I think in general we haven't seen the quality reporting as fitting squarely in the IE group. Can you talk a little bit about the exchange; the jurisdictional issues there around what we should be looking at?

Michelle

Yeah. So I think we still need to kind of flush that out a little bit, and so hopefully we'll be able to flush that out a bit more. We have another meaningful use workgroup meeting tomorrow, so hopefully coming out of that we can then provide feedback to this group. But there are just a few things regarding reporting that I think the feedback from this group will be important. I think the meaningful use workgroup will come at it from the policy side and this group will be able to come at it from, you know, feasibility, if that makes sense.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. Maybe we can, Michelle, after that meeting tomorrow we can just sort of have an offline set of emails among the smaller groups just to see whether there is a policy issue here for this workgroup versus the other.

Michelle

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Now, on the implementation workgroup that Cris Ross co-chairs, we had a somewhat analogous conversation the other day about whether there was anything related to transport standards connecting to a clinical quality warehouse or a PHR or anything like that, and have backed away from anything related to specifying connectivity. I'm just wondering if we're going to be in the same thing here, which is, I think, is what Claudia's getting at as well.

Cris Ross – SureScripts – Executive VP General Manager Clinical Interoperability Services

That was fun, wasn't it?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That was really fun. It was really fun, and Cris, to continue the fun you'll see that Adam has shamelessly stolen from the grid format that you use in that workgroup so you're going to be reliving your nightmare.

Deven McGraw – Center for Democracy & Technology – Director

Micky, this is Deven; just to be clear in terms of the scope of issues are we essentially, in Information Exchange, taking on anything in the rule that has to do with information exchange versus just limiting ourselves to the things that may have initiated out of our group? Because view and download, I'm pretty sure it came through Meaningful Use but maybe we talked about it in IE too and I just don't remember.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. No. No. This is anything related to information exchange, yes. And I think just in terms of the longer term agenda, just so everyone knows, we just had a call with ... with the other workgroup chairs—some of them are on this call—and in general I think our high-level roadmap here is going to be we're going to have the AMPRM on governance that's going to come out sometime soon here. That will be on sort of our near-term plan. We're going to have these draft comments for the HIT Policy Committee meeting, and then, there's May 2nd HIT Policy Committee meeting where, I think, the final recommendations on the Stage II MPRM are going to be presented. We're going to have a month in there to take whatever feedback we get from the HIT Policy Committee, any further considerations that we have, and then, start to sort of finalize that.

The governance AM TRM could come in over that time period as well, and we'll have to see that. And then, one other request that we got from ... on the—Dr. Mark ... from the previous coordination call was that we have at least a session to do a little bit of the—sort of standing back kind of blue sky discussion about where is interoperability headed in the 2014 timeframe, let's say, based on where we are today? What we know about Phase I as we're thinking about the Stage II MPRM, having a little bit of ... conversation about that to help inform our final recommendations on the Stage II MPRM.

Claudia, is that a fair—well, I know Cris and Deven were on that call too—is that a fair rendition?

Claudia Williams - Office of the National Coordinator

That sounds good, yeah. Actually, Micky, I think that sounds a lot cleaner than what will probably actually happen, but it's a good plan.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

A lot cleaner, but then, afterwards we described it in a very clean way too so the middle of it may not be. Then, over the summer, again, just thinking about the longer term agenda, just so all of you know, we have a grid that tries to give a little more detail on this so we can share that at the next call. Over the summer we want to have a hearing basically on what the current status of these key information exchange transaction items related to basically the question of, where are we after Stage I? And getting a little bit of information back from the market and from people's experiences to help inform us, and then, that will hopefully lead to a hearing sometime in the summer, and I think, as all of you know, hearings take a lot of work so that will be a pretty concerted activity. And then, towards the end of the summer, Meaningful Use Stage III recommendations and beginning that process.

Ted Kremer - Cal eConnect - CEO

Ted, in Rochester. So are the optional menu sets included in this discussion as well?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes.

Ted Kremer - Cal eConnect - CEO

Okay. So one that I don't know shows up here and maybe it's part of the thinking on lab results, but it's the whole piece on image exchange; was one of the menu sets, I think, too.

M

Which is a little thorny.

W

Michelle, maybe you can help us here. I think the main requirement there was ability to view within your EHR.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That's right, I think so.

W

Just as a general jurisdictional thing where it's a capability to view something but not necessarily you're exchanging it. We haven't always included it in our scope so we can discuss whether we want to include it, but we're trying to stay out of capabilities EHR just to handle information.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. So unless there are any other questions on sort of the agenda and our overall roadmap I would suggest we just dive into the grid. Okay, could the folks please load up the grid? There it is. Okay. So Cris, you'll no doubt find this very familiar. This grid is—Adam has taken the different objectives that we looked at and laid into a grid that—I want to thank the Implementation workgroup for allowing us to steal it shamelessly—basically gives us a bunch of information on the proposed Stage II objective, which is what's in the MPR now; the measure, to the extent that there is a measure, for each one; what the HIT Policy Committee recommended; and then, what was in Stage I. That's sort of a set of information on the objectives and the measures themselves and a little bit of background.

Then, it shows the numerator and denominator for the measure calculation; any questions, comments, directions we have from a Meaningful Use workgroup; and then, it shows whatever is there with respect to the corollary specifications for the certification MPRM. And I think this is more of a holdover from the Implementation workgroup because it also has the workgroup lead column, which is what the Implementation workgroup is using to assign out work. I don't anticipate in these timelines and with a relatively short number of things that we're looking at, that we would do that.

I think to Claudia's earlier point, I think in the last call, we're not really focused on the standards. We're really focused more on the meaningful use side of this, but that's there for information. I would propose for each of these we want to talk about the objective, first off; if we're comfortable with the objective. We want to talk about the measure. Given we're comfortable with the objective, how do we feel about the measure. Is it appropriate? And then, the last thing is the numerator and denominator maybe coupled with the objective, coupled with the measure, but not quite comfortable with how it's being measured. And those seem like they cover the three dimensions that are important here. Is that fair?

M

Yeah.

W

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. And then, of course, I'll try to keep us looking at the right columns here. I want to make sure that we're coving any questions or comments that are coming from the Meaningful Use workgroup. I think on this first one we did have some discussion about it last time. I didn't hear any objection to the eligible professional objective where basically all it's doing is raising the threshold from 50% to 65%.

Lawrence Garber - Reliant Medical Group - Informatics

Mickey, I actually did some research since that last meeting, and I thought I should get some information about that. I'm a practicing intern. Most of my staff patients are established. I'm seeing them largely for chronic follow up, and I encourage my patients to use mail order pharmacies. So I took a look at my prescribing patterns and it looks like almost one-third of my prescriptions that are non-controlled substances are to mail order pharmacies.

Then, I took a look and saw how many mail order pharmacies actually ePrescribe right now, and it's only 20% of the mail order pharmacies ePrescribe. So if a third of them are mail order and 80% of the mail orders aren't ePrescribing, 65% is cutting it kind of close considering that they're also recognizing that some patients have to have it printed because they don't know what pharmacy they're taking it to, or whatever reason they may be printing them. So I'm a little concerned about that 65% mark, and I wonder if 50 actually makes more sense.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That's interesting. Do other have any even top of the head information that would suggest that's true across the country?

Christopher Tashjian – Ellsworth Medical Clinic – Family Practice

I'm also a practicing physician but I'm curious where the 20% of the mail order is because we use all the big houses like MedCo and Express Scripts and such, and we just haven't run in to that problem. It seems unusual to me that you'd be running in to that big of a problem, but if you are we definitely need to take it into account.

Lawrence Garber - Reliant Medical Group - Informatics

Yeah. I don't know relative volumes. I just know that there were about 72 mail order pharmacies and they're only about 16 that do ePrescribing.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin

But you don't know what volumes or whether they were the big houses?

Lawrence Garber - Reliant Medical Group - Informatics

Correct. I don't know the differences of sizes.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin

The ones you deal with are they the big houses?

Lawrence Garber - Reliant Medical Group - Informatics

We deal with a mix. I don't know from my analysis—I couldn't look at my volume of ones that actually went to ePrescribe mail order so I don't know. I know my total mail order was about a third of my prescriptions. I don't know which of those actually were ePrescribable. But looking at a separate analysis I know that only about 20% of the mail order pharmacies can accept it but I don't, again, know what their volume is.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

I think we tried to make this a more data driven recommendation when we came up with the 50 to use any data points we had, and I think we found it was hard to get. I'm wondering if now there may be an opportunity to try to make this a little bit more data driven so that we can actually put a benchmark or a rate that is pegged to something that is really achievable by in large. I mean, having a couple of data points just described as we did here is really helpful. Having something that a little more comprehensive may just make for a better recommendation, so is there any way you can get some of this data from some source; SureScripts or somewhere else?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. I don't see why not. Adam and Claudia is that something we can do for the next meeting?

Claudia Williams - Office of the National Coordinator

Let's just maybe go first. It sounds like the data we would ideally want are a) the share of mail order and b) what percentage is going to mail order houses that ePrescribe. Is that correct?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yep.

Claudia Williams - Office of the National Coordinator

We can certainly ask. Let me look in to it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Well, why don't we see if there's any information available? I guess one other thought on that, and maybe we can just move on and then come back to this. Unless there are any other comments on this, we can sort of just put a ... over this one. Larry, given that you're in Massachusetts, which I think is more electronic in almost every dimension than most other places in the country—but not all but most—and if you can get up to 65% perhaps barely then knowing that the rest of the country is—or knowing that we're heading though toward—that we're going to have, what, two years almost before this kicks in. So it will be almost two years before it kicks in for all the professionals. How confident are we that mail order percentage will be substantially higher over the next two years than it is now?

M

SureScripts may have some idea about that as well as to who they've got on the table.

Claudia Williams - Office of the National Coordinator

Micky, I love that framing because that's the best of mind work here so we're dealing with, of course, everything. It's trying to kind of see in to the future a little bit so we'll take that in to account. If there's any trend data we'll come up with that too.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

I have one question; why in the world aren't mail order—does anyone have an idea why mail order pharmacies are unable to handle this when it's not as if they don't have stable groups of people and large volumes? It's not like their small Mom and Pop operations usually. The second thing is, so these eligible providers—and maybe for the other physicians on the call. I'm an emergency doctor so I have a different bias. Does it represent a challenge if you have large out-patient clinics, say like an academic medical center, who have folks—some in Lexington, Kentucky, they have come to the University of Kentucky in Lexington but may be from an enormous feeder community of numerous, numerous counties throughout central Kentucky, and if you have problems with the patient saying, "I'm not sure which pharmacy I'm going to or it's a local one."? Could that be a problem in that setting? It may not be a problem in an urban environment, of course, a single physician in an office with an established patient, but I wonder about for the episodic if it represents a challenge identifying the destination for the script.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. On the second question, Steve, I think ... did address that a little bit on the last call where she was explaining—obviously she's from CMS so she's not going to advocate one way or the other but she was just explaining the thought process, which was just that you would never expect this to be 100% because of the issues that you're talking about. And so, part of the question is how high do we think we can reasonably take this knowing that there's always going to be some percent that won't be able to accomplish what's in the meaningful use timeframe anyway.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

And why do mail order people have a hard time with this? I don't understand that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That I don't know. Does anyone else on the call know any more of those dynamics?

M

I just think we need the updated information from SureScripts and maybe that will shed light that their all just a bunch of small specialty—they do oncology drugs or something. I don't know.

Cris Ross – SureScripts – Executive VP General Manager Clinical Interoperability Services

I'm sorry. I had to step away for just a moment so I didn't follow that conversation but I'm picking it up now. I don't personally know the answers to that but we can get the answers. I'll make the available. Apologies for the pause.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

My guess would be too that as we increase the threshold from 50% to 65% then you allow plenty of time for Stage II to kick in. That will give the lagging mail order pharmacies a real incentive to get hooked in to SureScripts as they should be.

Cris Ross – SureScripts – Executive VP General Manager Clinical Interoperability Services

I think what people are talking about is reasonable. I just don't want to speculate further and misspeak on behalf of our company or our clients. But I think you all are pointing it in the right direction.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Just so you know, the inspiration for this conversation was Larry Garber who put it out that he did a little bit of, you know, quick and dirty analysis of his own prescribing and found that a third of his prescriptions were mail order and only 20% of the mail order were ePrescribing capable.

M

My question for Larry is I was just asking ... we look at ... providers at our clinic and there's no one under 75%, and we do mail order and we do small town clinics and we do ... and we're still all I mean the listing scenarios is around 75% and the ... is about 90.

Lawrence Garber - Reliant Medical Group - Informatics

We're in the same range but I'm concerned that if the actual numbers are, as I said, if I'm prescribing one-third of them is mail order and I've looked out and seen that there's really only 16 mail order pharmacies that take ePrescribing. I'm concerned that in some part of the country this could be a big issue.

Cris Ross – SureScripts – Executive VP General Manager Clinical Interoperability Services

Well, let me also be clear that—this is Cris again—some of this has to do with vendor implementation as well and not just the PBM capability. There can be some lags in the vendor implementation of connectivity of mail order. Again, let me get with the public who've got sort of the true facts about this and we'll get an all-in assessment of it. By the way, I don't mean to cut off the conversation by any mean here either, but I'm here from SureScripts and I don't want to just leave sort of gaps.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

No. That's great, and I think where we ended up was we'll put a place holder on this and see if it can be informed by any more information.

Cris Ross – SureScripts – Executive VP General Manager Clinical Interoperability Services

That would be great Micky. I will get with Paul Uhrig and others and make sure we're getting complete information.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. And if anything I think I would like level trend and geographic distribution, I think also, so anything on those.

M

And prediction where it seems to added in to your—

M

SharePoint.

Lawrence Garber - Reliant Medical Group - Informatics

Micky, one of the things—as I'm stirring the pot a little bit—is the formulary issue because one of the things it requires here is a certain percentage, you know, that they check the available formulary. I couldn't find any clear definition of what an available formulary is because I think I mentioned in the last call I have 60% of my patients are with one health plan that refuses to put their formulary in to SureScripts, and they said, "Well, if I want to use ... I can get their formulary." So what does it truly mean

to be an available formulary and I'm expected to be ... formulary or is this formulary that's available through SureScripts. And perhaps maybe the way to control this is if in either the numerator/denominator they say, "Look, if the formulary's not available—". Actually, in the comments they do say that if the formulary is not available then that's fine, but they actually don't correct that. If you look at the numerator and denominator definitions they don't truly adjust for that. They don't really correct it in the numerator and denominator even though they discussed it.

W

I don't know as well as some other people do, but I think when we're dealing with exceptions those aren't generally in the actual definition of the measure. If they do we can check with Jess on that, but in general I don't think the MU measures include a definition in this sense.

Jessica Kahn – CMS – Project Officer

I'm here. The measure itself doesn't include the definition but that's in the preamble text in the reg text.

W

It sounds like maybe, Larry, you're question is answered by that.

Lawrence Garber - Reliant Medical Group - Informatics

Well, also it doesn't clearly say what it means to have an available formulary. I mean, everybody publishes a formulary. Am I expected to hand type it in or are we define it as available through SureScripts?

W

I don't think we define it. Please submit that comment.

M

But if it's in the electronic prescribing section I would assume that means it's electronically available. I think that's not an unreasonable assumption.

Lawrence Garber - Reliant Medical Group - Informatics

And, again, electronically mailed, if I can get my health plan to give me an Excel spreadsheet does that count as electronically available even though I can't import that into my EHR?

M

I would doubt it.

Lawrence Garber - Reliant Medical Group - Informatics

Right. So that's where the clarification needs to come.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Do most people agree with that? That seems like a fair point that we need to have some greater definition of what available means.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

Micky, I agree with that, and I would further add that it's important—I mean, it's not helpful if there's one formulary, say for Aetna, in there, and you're prescribing for a United Health Care patient. I mean other than demonstrating that you can look at a formulary. I mean we're doing this to increase value, right, so taking a United patient and comparing it to an Aetna formulary to comply with a measure here is the antithesis of value. It's work without purpose, and so I think there is value in clarifying this for more than one reason, and there's also value in encouraging formulary use so we can find cheaper alternatives but I think the details are all

M

But does this also deal with a formulary that's in an in-patient setting as well or are we just talking literally out-patient at this point?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

We're going to get to that objective next. One question, Larry, could I put you on the spot to just draft some quick language that maybe with an expert group we could look at related to this question of available?

Lawrence Garber - Reliant Medical Group - Informatics

Sure. I'll give it a shot.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Great. Thank you. And one other question before we go; Chris, I said no to answer to this because I'm on that workgroup, but did the Implementation workgroup—was there anything on the certification end related to this question of formulary and how availability of formulary would even be sort of tested or measured?

Christopher Tashjian – Ellsworth Medical Clinic – Family Practice

There was, and we were going to have a small workgroup look at this issue specifically. That was going to be David Kates area and Ken from NIST and myself to get with the appropriate folks at SureScripts and just make sure we've got a comprehensive view of it, and that workgroup would report back to implementations. There we were really focusing just on the testability and not on the policy components, at least at this point. All we discussed was the test cases.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. I'm just thinking there is a little bit of a dependency in our definition of available related to what the EHRs are going to be certified against.

Christopher Tashjian – Ellsworth Medical Clinic – Family Practice

Correct and part of what we were looking for was opportunities to make sure that we had alignment where possible between what was in the testing criteria used by the ATCBs and what was used by SureScripts. And just to clarify for people here, was to make sure that we're stepping out of that any other sort of ... requirements that SureScripts might impose as part of the industry above and beyond the certification requirements, but for those items where certification is required could we harmonize those requirements so that the certification for both ATCB and SureScripts could be similar or identical.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. So it sounds like a couple takeaways; we're going to get some more information on the data and Larry's going to draft up some language. And we may want to do a little bit of touch base as we get a couple weeks into this to see if the Implementation workgroup has done any further work that can help inform our recommendation on what available might mean. Is that right?

Christopher Tashjian – Ellsworth Medical Clinic – Family Practice

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. So why don't we move to the next objective, which is—let me just make sure. Are there any other comments, I'm sorry, on this one?

Peter DeVault – Epic Systems – Project Manager

Yes. We're looking for clarification on organizations that fill their own prescriptions with an internal pharmacy so either the prescription is sent through an HL7 interface or it might be part of an integrated system of the EHR. Are those prescriptions counted or excluded from the denominator and numerator?

M

According to the math, the numerator and denominator, they don't appear to be even though they do talk about it a little bit.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

And I forget the answer to this question because I remember it came up during the same one because it's also related to—if you're looking at the standard that's required, right, but this is just the certification standard.

Peter DeVault – Epic Systems – Project Manager

I mean clearly the intent—they talk about, in the discussion, how the intent is really for external pharmacies so they really should exclude it from the denominator—take the internal.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. So we can get an answer back on that because I distinctly remember having this conversation during the Stage I, but I don't distinctly remember what the answer was.

Peter DeVault – Epic Systems – Project Manager

Okay. Thanks.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Any other questions/comments on the EP side of the ePrescribing? No. Alright. Let me move ahead then. Hospitals: So this is a new objective. In Stage I the ePrescribing objective was only on eligible professionals, and in they, in the MPRM now essentially has the same ramp up or at least beginning with the same first step in terms of a threshold. No, actually it was smaller I think. So as you can read here there's a 10% threshold on all hospital discharge orders for permissible prescriptions, and, as I said, this is a new one, and then, you can read what the numerators and denominators are for that.

What are people's thoughts about this? I mean, a) of including hospitals, I guess, is the first question related to the objective; and then b) does 10% seem to be the right one; and then, c) does it seem to be measured correctly?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

I have a question about the 10%. Not that I care that it starts at ten if it eventually goes up anyway, but there's a highlighted comment from CMS being concerned with the effect the objective may have on patient preferences and thus limiting the measure of 10%. I don't understand that part. I mean, if we can say that they're required to do it 65% of the time in the out-patient setting where clearly an enlightened physician, or provider, or subscriber is going to say to patients, "No. You've got to have it electronically because if you don't I'm going to fall beneath my 65%. So tell me where but it's not going to you on paper." Then why would we say it's any different in a hospital? I can't follow the logic there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Good point. At face value 10% struck me as being low as well. I wouldn't really—I don't know. I'm not as familiar with the hospital side of that.

M

This are ... as patients usually.

Christopher Tashjian – Ellsworth Medical Clinic – Family Practice

I also work in the hospital as well as the out-patient side and 10% seems—we're already doing more than that now in our local hospital so it definitely is a low avertible.

Stephanie Reel - John Hopkins University - VP Information Services

I think some of the comments that were made earlier though about the eligible providers probably apply here as well. The mail order houses, the owned pharmacies, those that are filled within the hospital based pharmacies upon discharge, or those that are filled at other owned pharmacies. In fact, I think some of the data that we mentioned would be important to capture as related to EPs would also be important to understand for eligible hospitals. I agree that 10% sounds low but I'm not sure if we have the same numerator or denominator issues.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Because it does sound—I mean, I agree that all those things seem like they're the same but does seem like there's a big gap between 65% and 10%, especially among a group who are more technologically sophisticated in general.

Jessica Kahn – CMS – Project Officer

I can't speak to why we arrived at the 10% particularly, but I know that the Indian Health Service did bring up the point that the previous speaker did about their facilities having pharmacy in-house and what challenges that might pose for their IHS and tribal hospitals.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

... 10% on hospital discharge but yeah, so I guess the question is related to that one but the question be are those included in the denominator?

Stephanie Reel - John Hopkins University - VP Information Services

Yes. I mean that's part of the question; are the owned pharmacies that fill the prescriptions included, and then the exclusion about the distance from the hospital; those kind of things may be irrelevant if we learn more about the mail order pharmacy from the earlier discussion.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Okay.

M

You know it's also, with regard to mail order pharmacies at the hospital, I would think that when you're starting someone on a medication you're less likely to send it to a mail order pharmacy. It's really more common when you've got them and you've found the right does to say, "Okay, let's switch to a three month supply."

Stephanie Reel - John Hopkins University - VP Information Services

Well, the only exception of that might be, and, again, it depends on what's in the denominator, but it might be that as we often do we give certain limited amounts upon discharge, and then, allow the patient to do mail order starting three days from now or whatever.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. So on this one it sounds like we need the information on whether the in-house pharmacy is included in the denominator and a little bit more information on the mail order titration with respect to ePrescribing penetrations and the mail order segment.

Stephanie Reel - John Hopkins University - VP Information Services

Right and not the nuance this too much but I think I heard Peter say one of the concerns; if it's a fully integrated solution and you have an in-house pharmacy or if it is not a fully integrated solution and you have an owned pharmacy, which in the case of Hopkins we have both. So in some cases it might appear to be an ePrescription sent to an unrelated—even though we own it—an unrelated business and in other cases it may feel like it's embedded within an integrated solution. I just think some understanding of what's expected in this objective would be good to know.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Okay. Are there any other questions on this one? I think we're going to need a little bit more information before we can come to a group recommendation on this. So unless there's any other information we think we need for this one we can move to the next one. We're just banging through them. As usually, more questions than answers.

M

Well, this one's removed. You can bang through this one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Great. Okay. Oh, and I should have pointed out on this grid—hopefully, all of you have the grid there in front of you—Adam was able to take, where appropriate, the preamble language, which is always very important for these measures, and put it underneath the grid.

Okay. So this is the one that was a phase I requirement, and is being recommended by CMS to be removed. I think a part of these are to move down to the discussion that they have, which we can certainly attest to the first sentence that people were just very confused about what this measure was supposed to accomplish. They're recommending the removal. Is there any concern, question, comments about that?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin

I guess I'm trying to understand. First off, I don't understand exactly why they're confused, but secondly, why not just make it successful? It has to be successful, and then—I mean, it seems to me that it would be kind of foot dragging question like I get from my teenager to say, "Well, what happens if it's unsuccessful?"

Claudia Williams - Office of the National Coordinator

I know part of the problem, and Jess probably has other thoughts too. Some of their problems occurred from folks in the field. It's just lack of clarity around what's being required, and even with a successful test like what is—

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin

What is the test?

Claudia Williams - Office of the National Coordinator

I think this has been one where there's been a lot of confusion.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin

And you can clarify it as an HL7 message.

Deven McGraw – Center for Democracy & Technology – Director

I can remember when the Policy committee discussed this even back when it was recommended and approved for Stage I. So that was quite some time ago, and the thought was at the time that even a minimum exchange requirement, beyond exchanges required for lab data and ePrescribing but actual exchange between two disparate health care organizations, was going to be difficult for a lot of people to meet. And so I recall that we discussed people have to have a successful test, and there was concern that folks wouldn't even be able to meet that. And so, ultimately what was decided is you have to at least try to get something going because the expectation is that in Stage II we want a robust exchange requirement, and essentially we were trying to find an on ramp that was reasonable at that particular period of time. And it really ended up causing more confusion than actually providing a valid on ramp, and so I think most people are sort of feeling like maybe if you don't have anything required to be demonstrated in Stage I but by 2014, which is—because we're really talking about whether we need to correct a Stage I requirement for the years that are left in Stage I and for people who are coming on later. But for Stage II you've really got to be exchanging fairly robustly assuming those proposed requirements actually hold, and so if you're not testing and figuring out what you're going to do by then already then you're kind of going to be screwed. And I just said that on a public phone call.

Hunt Blair – OVHA – Deputy Director

Deven, you go girl, for being bold.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Mary Jo, we need that seven seconds delay.

Hunt Blair – OVHA – Deputy Director

So were you just advocating for bringing this back or for moving on or moving to something different?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

It sounded like you were advocating for number three, the third option, yep.

Deven McGraw – Center for Democracy & Technology – Director

Yep. I mean, you know, it's sort of like we've spent way too much time talking about this. Let's move on to things that are—like lets shoot for what we really want to see happen and assume that people, since they're being given a signal fairly far in advance, will work to get there.

Hunt Blair – OVHA – Deputy Director

I support that. I think that makes a lot of sense. I also remember those painful discussions and our own confusion.

M

Well, and I think there's enough infrastructure getting deployed now through direct that we really shouldn't have to worry about that as much as we did before.

W

That's the theory.

Hunt Blair – OVHA – Deputy Director

And I think that—just speaking for the HIE community, I think that given the emphasis that's being placed direct I think there gosh darn well better be if an expectation in 2014 that there is exchange going on. So, yes, door number three. I'm with you with that.

W

And I fully support that as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Great. Is there anyone who does not support that? Okay. Good.

Claudia Williams - Office of the National Coordinator

Micky, just to make sure we're tracking, the proposal was option three?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes. So it would be, on this particular one it's eliminating the objective, but then I think we'll have to revisit the question once we get to—oh, no. Well, this says, "Require the providers select either the Stage I medications reconciliation objective or the Stage I summary of care." That's a good question. Do we want to specify that or are we saying more loosely that we think that's it's generally covered?

M

Is summary of care a menu option?

Claudia Williams - Office of the National Coordinator

Yes.

M

Oh, okay.

Claudia Williams - Office of the National Coordinator

In Stage I, um-hmm.

M

Oh, in Stage I right, yeah.

Claudia Williams - Office of the National Coordinator

Remember, this is Stage I.

M

Right. We're going backwards here, got it.

Claudia Williams - Office of the National Coordinator

This is what we do for the Stage I writes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah, but what does it mean then to say the third option require the providers select either the Stage I—?

Claudia Williams - Office of the National Coordinator

Well, those are menu sets so it would be like it now gets to the public health where you have to pick one.

W

But are we saying we're going to change this for the rest of Stage I or are we just saying this goes into effect for Stage II?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah, that's what I'm confused about.

Claudia Williams - Office of the National Coordinator

No. This is all Stage I. In other words, that was a Stage I requirement. We're taking it out to get replaced with something else.

M

It would be restored for Stage I as of the effective date of the rules and the regs, right? Is that how that would work? Or change for Stage I?

Claudia Williams - Office of the National Coordinator

This rule can also be given to what's in Stage I, and so it's just saying the proposal in number three would be Stage I no longer includes the test but folks would have to choose either the med req or the care summary exchange from the menu.

M

Okay. Got it. You're right.

Claudia Williams - Office of the National Coordinator

You guys please correct me if I'm wrong.

M

So making them choose the summary of care transition may move those working through Stage I yet to a higher hurdle than the first group though.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. But this would be finalized like in the December timeframe again, right?

Claudia Williams - Office of the National Coordinator

Well, it also—again, Dev, please correct me if I'm wrong but I think it's referring back to the Stage I care summary measure not the proposed Stage II, right?

Deven McGraw – Center for Democracy & Technology – Director

Right.

Claudia Williams - Office of the National Coordinator

So it's not—remember Stage I was it could be on paper, didn't get too incented, right?

Deven McGraw – Center for Democracy & Technology – Director

Right.

Claudia Williams - Office of the National Coordinator

The desire would be that there would be a guide path and if you have ... then, of course, you do that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. So this would apply to anyone who is testing for Stage I in 2013. That's the only group that it would apply to, right, because it's basically saying that we're assuming that whatever is in Stage II covers whatever was supposed to be accomplished by the test.

M

So in there we did have a good lead number that went for this vague but wonderful test. I wonder what that would do to those that now didn't have that option. I mean, they'd have to be looking at med req and Stage I summary of care so I just don't know what that additional effort might look like on their part.

W

The numbers were extraordinarily low so far for those who have selected this from the menu; extraordinarily low.

W

Probably just because people were so confused about what it meant. They were afraid if they were audited they wouldn't be able to do it successfully. So that's part of the reason we felt comfortable dropping it because it was clearly ... people were picking.

M

I absolutely think dropping it makes sense. It's just whether that parenthetic part of option three is what we're all agreeing to as well.

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

This is Amy and now I'm sort of rethinking what I supported because I agree with dropping it. I'm not sure I agree with changing it. I'm concerned about just the basic education. While we'll be trying to educate people on Stage II having to go back and re-educate on Stage I. I just think about the communication challenge that will have.

W

That's true throughout the MPRM. There are a fair amount of changes to Stage I; this is only one of them.

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

We'll have to deal with that one way or another. Okay.

W

But I just double checked with Travis and yes, health pharmacies are considered a denominator for that hospital measure that we were just talking about. We don't specifically say that in the rule, but we do have an exclusion that says, "Any eligible hospital or ... that does not have an internal pharmacy that can accept electronic prescription and there are no pharmacies that accept them within 25 miles." So the fact that we would assume that a hospital could have a pharmacy, but the exclusion means I think we'd accept it for the denominator clearly.

M

Okay. Thank you.

M

Okay, which speaks ... the lower threshold then.

M

For the HIE test—back to that topic—it seems to me that if we found that this isn't a useful criterion as sort of an on ramp to what we want to have happen in Stage II that simply eliminating it for Stage I and Stage II is the right thing to do as opposed to replacing it with a different requirement for Stage I.

Ted Kremer - Cal eConnect - CEO

I think I'm leaning that way too. This is Ted in Rochester.

Claudia Williams - Office of the National Coordinator

So just to bring that meaningful use discussion into this and, Michelle you and others can weigh in too, I think the consideration of others was because of the concern about not having any exchange requirements in Stage I. I think that was, I think, part of what led to the consideration of other options was concern that this was taking something out without having something else to replace it that would be a real exchange requirement.

Hunt Blair – OVHA – Deputy Director

Which makes sense. I just think the marketplace now has sort of leapfrogged us forward so that policy lever probably isn't needed as much now.

M

Exactly.

M

Well, also as a practical—I don't know the answer of this, but for someone who is testing in 2013 when do they have to move to Stage II?

Claudia Williams - Office of the National Coordinator

Are you talking about their first year?

M

Yeah, about their first year because—

Claudia Williams - Office of the National Coordinator

Everybody gets two years in each stage.

M

Because that's what we're talking about being effected, right? I mean, those are the only people so—

Claudia Williams - Office of the National Coordinator

Yes.

M

Right.

M

Yeah. So, alright. So they would have two years, and then they're going to be hit with the Stage II anyway.

Claudia Williams - Office of the National Coordinator

Yes.

M

It just seems like with the market direction and the fact that they're going to be hit with the Stage II soon anyway maybe you'd get away with not having these other requirements.

M

Agreed.

M

See what happens when you ask us to clarify things, Claudia? We change our minds.

Claudia Williams - Office of the National Coordinator

That's the last time I do that.

M

Unlike anybody else in the universe; clarification never needs to change.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

It sounds like the group is headed now towards option one and it may be that's where Deven was headed to but I just put the words in her mouth.

Deven McGraw – Center for Democracy & Technology – Director

Yeah. So thank you. There was some dynamic to this that I wasn't capturing, as usual. They're always more complicated than you think they are.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Is anyone opposed to option one? Okay. Alright. Well, there's a decision. Okay. We'll make sure we have that dialog too because that becomes an important part of the consideration given some of the points that, I think, Claudia and others raised about why people were concerned about just dropping the test without making other requirements related to the drop ability; take its place as it was.

Okay. So do we want to do a quick look back at the hospital question based on the information that just was provided or should we just pick it up at the next meeting? I'm happy to do either. Maybe we can take it up at the next meeting because we'll have the mail order information then as well. Okay. I just answered my own question. Let me move ahead then. This was an interesting one. This was—I'm having a hard time reading this one. Let me try to stand it. Oh, no. This isn't the one I'm thinking of. This is on the eligible professional and hospital side is the requirement to incorporate lab results, and Stage I was 40% and that's now moving up to 55%.

Let me just go over here and look at the meaningful use workgroup note. They were fine with the eligible professionals, the hospitals. The providers depend upon hospital labs, which are about 40% of the market, i.e. workgroup to further discuss.

Lawrence Garber - Reliant Medical Group - Informatics

Micky, I looked at what our numbers are and we're all in the 90th percentile, but we're directly connected to a reference lab for all of our testing.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

I don't know that I feel overly strongly one way or the other except I'd observe if CMS already observes that compliance is very high already, and as the example the previous speaker just mentioned, that they're 90%. I think it speaks to just in general we might see that raising some of these thresholds almost seems sometimes like a nonsensical exercise because once people do it they're going to strive to do it in general for everything that they can.

W

The only caveat to our current data that we always give is that it's only representative of on the EP side just Medicare and on the hospital side just acute care sub-segments and critical access hospitals but not the children's hospitals or other cancer hospitals that come in only under Medicaid. We just have to kind of think about as we're going through these are there particular aspects of any one of these measures that might be harder for certain provider types or for certain types of hospitals in certain settings? Maybe not and that's one of the things we're going to be analyzing for the final rule, but I do just put that out there as a caveat as when we look at performance to date.

Lawrence Garber - Reliant Medical Group - Informatics

And my only observation—see, I don't have the data like you will for that so I take that as a useful advantage. I mean, if it's 40% and it gets people to start doing that I just think once you redesign your processes and embrace the technology you generally tend to start doing it as much as you can.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So 55% does not seem unreasonable then?

Lawrence Garber - Reliant Medical Group - Informatics

Probably not.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I'm a little bit confused by the Meaningful Use workgroup comments. I don't really—that seems like it speaks more to the lab delivery question that we were talking about that was removed than it does for this particular objective.

Claudia Williams - Office of the National Coordinator

That comment was related to a—I'm just trying to look at the grid and look at something else to make sure, but there was the hospital objective that was not included. It was just specifically ask for comments and that is what the Meaningful Use workgroup comment is related to.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay.

W

... read that elsewhere though, I think, in the agenda, right?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. Okay. So is there anyone that has any discomfort with 55%? Is there any argument to make it higher?

M

Do we have data on what levels people are testing at right now?

W

I don't know it off the top of my head but I can look it up and send it on.

M

It'd be interesting to know what percentage of people are under 65%.

Claudia Williams - Office of the National Coordinator

I think that was presented to the Policy committee in that update from CMS.

W

Right and I think we presented it, as we always present, as an average but there is not a single measure. Even though we present an average doesn't mean that we had enough people that were squeaking by just making it, and had we raised it they wouldn't have made it. So what we present are the averages, just be aware of the highest denominator too.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Is there any data on rural providers? I mean, it's a little easier, at least in California—this is Jonah—for urban providers given that the bigger fulfilling labs tend to be the national chains that can support this. In the outlying areas a lot of hospitals and smaller regional labs don't have the capacity.

W

That's a great question. On the EP side we only have business address so that's not necessarily the site of practice. On the hospital side we are actually doing that rural/urban analysis right now.

M

So we can speak to just western New York. We don't have any national labs here. It's all hospital base and all of our small rural hospitals are capable of electronic exchange for this.

W

But also remember that you're held accountable for those results that you receive in structured form, so you're not held accountable for a lab not being able to send it to you that way. So you look at the measure it's the numerator is the number of tests who's results are expressed in a positive or negative affirmation, right, so if they're not sending it to you in a structured format it doesn't get counted.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

But I'm not sure—this is Jonah—I'm not sure I follow. I thought that was defining the kind of test result not the form of it; i.e. if it's a bilirubin test part of a panel and it's a quantifiable number or it's a yes/no that's different from a test blob for a result from a pathology screen. I thought that's what that was referencing.

W

Well, the denominator only includes tests whose results are expressed. That's interesting. Maybe we need to go back—

W

Yeah. The denominator is not whether it came in structured data form. The denominator is just it came as a positive or negative or a number.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

Right. A subset of tests to which this applies.

W

Yes.

Seth Foldy – Centers for Disease Control and Prevention

I don't know if it's an issue but I believe there's now added to this the stipulation that the exchange will be CLIA compliant. Is that likely to change meaningfully that number of providers able to meet the objective?

M

Don't they all have to be?

Seth Foldy – Centers for Disease Control and Prevention

Theoretically they already did, yes.

M

Right.

W

Right. So the CLIA only really affects a subset of labs comparatively.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So it sounds like we might want a little bit more information on the distribution of what people were attesting to in Stage I to see if 55% is the right number. But I wasn't clear whether we can get that or whether all of you are able to provide as the average.

W

We can do an average and a high/low, I mean, to the extent that's illustrative. As I said, so far in all of our analysis there has not been a single measure that every single provider that has tested exceeded the

percentage by a significant amount. There were always those that came in just at the threshold, but we'll give you a sense.

M

You can't do it on just a graph like how many were in the like 50 to 55? How many were 55 to 60?

W

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

You can do that?

W

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Alright. So it sounds like we're comfortable with at least 55 with no other changes recommended for this, and then, we'll revisit whether 55 is the right number when we get that information. Is that right?

M

Sounds right.

Seth Foldy – Centers for Disease Control and Prevention

That sounds right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Great. Oh, we're really knocking them out today.

M

Well, there was the discussion that the ... committee suggesting using LOINC. Did that make it in to the final?

M

I think it did.

M

Well, I'm sure it was the standards committee that recommended that.

Claudia Williams - Office of the National Coordinator

So the data Jess will provide will be much more detailed, but just the data so far for this pure mean shows that 38% deferred and of those who—4% were excluded and of those who choose this objective they had a 91% performance. But we'll get better data from Jess.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That's the average; 91%?

Claudia Williams - Office of the National Coordinator

That's the mean, yeah.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Wow. You'd have to have a really skewed distribution to argue that 55% is too low or even that we shouldn't be pushing it higher.

Seth Foldy – Centers for Disease Control and Prevention

... but with the question asked, the change in standards—this is Seth Foldy—specifying the use of LOINC code and also, if I'm not mistaking, a 251 message standard. Is that also part of—I mean that also would apply to this objective.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

This is just about the incorporating, right, that you're receiving it from someone else.

Seth Foldy – Centers for Disease Control and Prevention

Yes but the format—well, yes, so we certified—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So we certified that the technology is certified to receive those things, as you said, and this objective just says that you need to have a certain percent that are that.

Seth Foldy – Centers for Disease Control and Prevention

Very good. It wouldn't disqualify those that came by other standards.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right.

Seth Foldy – Centers for Disease Control and Prevention

Very good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

As long as it's structured according to the definition that CMS gives instruction.

Seth Foldy – Centers for Disease Control and Prevention

So it sounds like it's an effective thing, that's good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. So on the next one here this is the one that you may recall is the one that got dropped but did originate with this workgroup, I think, which was really about the other side getting a little ... question was about I think or related in that the idea and the original conception of this was that we have vendors being certified according to a set of standards. We have requirements on the eligible providers in particular that the growing requirement now as we've just discussed that they have a certain percent of their labs be structured. Presumably that one way of having the structuring would be according to the code that the EHR vendors are certified to be able to consume, but we didn't have anything that was telling those who were sending labs that they should be sending them according to the same standards.

And there was a lot of conversation that we had about the fact that large fractions of the market like national labs, for example, were not really under the jurisdiction of any of the high-tech provisions that they weren't around meaningful use or anything like that; however, the hospitals were, obviously. The recommendation that came out of this workgroup would be to basically say we need to fill in the last piece of the puzzle, which is to say that hospitals who are sending labs and as was noted in the meaningful use workgroup, note—I don't know where they got that data but 40% of labs delivered by hospitals. As Ted Kremer pointed out, in some markets it's easily 100%.

So this was the requirement was to say that hospital labs should send according to the standards that are being required of the EHR vendors with respect to their certification, which would be HL7 2.5.1 and LOINC. Well, I guess this says, "Use LOINC where available." I don't know what that would mean.

M

Well that little 'where available' is pretty key because I've heard where I think CVS or some of the others have said that they have—not CVS but LabCorp, that they do LOINC is people ask for it. And I know in our hospital setting that getting them to start LOINC and coding has been problematic and absent policy levers it's going to continue to be problematic for us.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. So you're talking about the hospitals now.

M

Yes. Where the nationals will do it if you ask for it—I've heard—where the hospitals aren't there yet much at all.

Claudia Williams - Office of the National Coordinator

If I can recall the sections of my memory where we discussed this before in the workgroup, one of the things that we suggested was that this would be an opportunity to call out the LOINC subset that is actually now specified in the lab results initiative through the SNI framework. I know we're not talking about standards, but one of the things we linked this to when we made the recommendation was actually the adoption and use of the subset of LOINC codes and the LRI specification—it wasn't finalized— then to create an easier on ramp and quicker transition to LOINC for hospitals. I don't think we need to go into the standard step but it does provide a fuller view of kind of what this could look like.

M

And was that workgroup trying to sort of peel the LOINC effort into sort of top codes and some—

Claudia Williams - Office of the National Coordinator

Yeah. That is the subset that's called out in the previous measure and could apply also to this one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

And so, Claudia, I read from that, that progress has been made on that front so one of the concerns that hospitals would have a hard time implementing this is hopefully somewhat allayed with the SNI framework on that subset.

Claudia Williams - Office of the National Coordinator

I mean, it might actually be that if we—depending on where you guys end up on this it may make sense in the implementation workgroup on the standards side to also look at that standard from the standpoint of hospital implementation.

Peter DeVault – Epic Systems – Project Manager

I'm just throwing my voice into the mix to suggest that I think it's a mistake to drop this measure. Of the two or three big hurdles towards real semantic interoperability of results this is probably the biggest. The fact that hospital lab systems don't today report LOINC codes where LOINC has adequately expressed the domain.

M

I also think it's a huge opportunity here to try and move things forward somehow referencing LOINC, absolutely.

Seth Foldy – Centers for Disease Control and Prevention

It is coincidental. It's the same standards as they will be using for public health reporting a laboratory condition.

Lawrence Garber - Reliant Medical Group - Informatics

I absolutely agree. This shouldn't be dropped, and we should require LOINC for the result codes where they are available knowing that actually there are still some results that cannot be mapped to LOINC.

W

And does the group have comments or feedback on making this requirement just for hospitals, and what this means in terms of applying meaningful use to one subset of the laboratory market, and given the fact that this also applies to small critical access hospitals not just large hospitals? And the ... that we've

heard about creating a natural disparity and meaningful use between hospitals that do have labs and those that don't in terms of their pathway and their cost ... and to meet meaningful use?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Well, I think, one thing I think that we just heard at least from one person's experience, which I think was Ted, was that in his market the "national labs don't seem to have a hard time doing this and will give you the option of it if you want it and it's the hospitals who are the problem."

Lawrence Garber - Reliant Medical Group - Informatics

We also did Quest and when we asked them for LOINC they did it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I don't know if Stephanie's still on the phone; would love to hear her perspective, but I myself have talked to a number of hospitals who have said that in some ways they would consider this a blessing because it just allows them to quantify something that's ... setting some firm rules around.

M

We've seen in some of our smaller hospitals too where the clinical leadership would love to have something closer to a mandate because they struggle internally on getting it on the radar, and yet it's absolutely imperative for all their health reform efforts.

Stephanie Reel - John Hopkins University - VP Information Services

I am still on the phone and I completely agree.

M

I also think it's critical for EDC measures, right? I mean to be able to ... transferable, right? So I mean for people who are being held accountable for that it's important to have this also.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Absolutely. Right. Just for the clinical quality measures in general.

Stephanie Reel - John Hopkins University - VP Information Services

Right. So all of those are really good points and I encourage you to put that with the data behind it, the locations, and everything in the common

M

Is there any reason that you can't differentiate between some of the critical acc—I mean do you have to hold critical access hospitals to the same standard that you hold—

W

Yes.

M

There's no—that's period. There no—

Stephanie Reel - John Hopkins University - VP Information Services

There's no meaningful use for hospitals. Now, there could be exclusion criteria.

M

Right. And so is there a way to finagle that?

Stephanie Reel - John Hopkins University - VP Information Services

That's something for people to consider when they're making comments is could that be applicable in certain scenarios allowing for some exclusion ... and what would be reasonable and quantifiable, easily verifiable as well as what that would look like.

M

So I mean what would be reasonable exclusion criteria if you're not delivering anything electronically, right? I mean, if you are why wouldn't we require that they do it according to a certain set of standards?

Claudia Williams - Office of the National Coordinator

So the other thing—and Steph alluded to this but remember that for lab public health reporting of reportable lab results they also already ... in HL-7 2.5.1, right, and there are already requirements built in to this. It does mention that this is parallel but that also means that they already have to be ramping up on that side, so just something else to consider.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. So it sounds like—is there anyone who disagrees with what seems to be a sort of growing consensus, at least of those who are speaking, that this really ought to be put back in?

Hunt Blair – OVHA – Deputy Director

I just wanted to say that in the case of the critical access hospitals, at least in Vermont, who are, along with all the other hospitals, at Principle Labs, we actually have been having a lot of discussions with them about assorted LOINC coding issues. And I think that the comments that were made earlier about actually appreciating sort of having the bar moved by this would be welcomed by both lab directors and the administrators.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Okay. Great. Well the Meaningful Use workgroup wanted feedback on this one and they're going to get some. Okay. Great. So let's just move ahead here. I'm just looking at the clock; it's 5:20. This one is actually a fairly complex one, I believe, and I would suggest —what's after this one? Do you remember, Adam?

Adam Aten - Office of the National Coordinator

eMAR.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

eMAR, so let's just take a look at that one. I would suggest that this is something that we can deal with quickly in four to five minutes, and then we do it. If we think that we can't then we should save this and the care transitions for our next meeting. This is just moving menu to core.

W

Micky, I'm sorry. Where are you?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I'm sorry. I'm on eMAR. It's up on the screen. This is just moving menu to core, correct?

M

The med rec yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

And it looks like it's upping the threshold from 50% to 65%.

W

Yes.

M

So this is not eMAR; this is med reconciliation, right?

Claudia Williams - Office of the National Coordinator

Yeah, eMAR is a new measure, but the one that's here isn't eMar.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Oh, alright. So we've got—okay. So that's right. This is not eMAR even though the title says eMAR. Alright. We'll have to straighten that one out.

Claudia Williams - Office of the National Coordinator

This one probably will go better with the one above it because they're both kind of related in the transport; in the transition of care piece of it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. And so, yeah.

Claudia Williams - Office of the National Coordinator

Well, not the eMAR one, the one you skipped.; the two part objective.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. No, I get it. Yeah. So this one—I mean the transition of care is a little bit more complicated because it's got that 10% requirement that they be electronic and it's just a significant jump whereas this is just a relatively small jump in that it's saying take something that's menu, move it to core, and then, raise something that's 50% to 65%.

M

I think when we do have the discussion about this med reconciliation it will be useful to get statistics on what people have been attesting to.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Why don't we say that we should defer this because it's 5:23. Jess, would it be possible to get information on this one too?

Jessica Kahn – CMS – Project Officer

Sure.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Great. So at the next meeting we will start with this one and with the summary of care. Oh, okay, let me just move back. So next time we will start with the transitions of care and this med reconciliation one; not the eMar one. And then, we'll—maybe, I wonder if we should—

Seth Foldy – Centers for Disease Control and Prevention

If I'm not mistaking the next meeting was reserved to begin with public health.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. Yeah. That's what I was just thinking. That maybe we should pick those up at the following one because I think the public health should—we should at least start with that and allow the full meeting if it's going to take that.

Claudia Williams - Office of the National Coordinator

Just a ... I'm wondering if it would be helpful for either us or someone one the workgroup to summarize the, at least initial conclusions from each call and get them out to people along with homework assignments that people volunteered for so that we can keep track of kind of where we are on each thing.

Cris Ross – SureScripts – Executive VP General Manager Clinical Interoperability Services

Micky, I'm sorry to jump in but I think some of the hard learning we had from the Implementation workgroup might be helpful here in terms of the status report that we got from ONC on that. Micky, I don't know if you were engaged in those conversations as we were struggling with it, but it was really important to get someone on point from ONC to help with that and to turn those documents around promptly. When Liz and I were trying to do them ourselves it got to be a mess.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. And it's just me on this one.

Claudia Williams - Office of the National Coordinator

So I think what—and I'm unfortunately going to be out for the next two weeks, but Adam is on point for this and has been doing a great job helping so he can summarize those things. We just have to be pretty careful because we can't editorialize in any way. We'll try to be very—more keep track of the decisions and less editorialize on the content, if that makes sense.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. Because I think all we're asking for is documentation of what we've discussed and what we agreed to.

Claudia Williams - Office of the National Coordinator

Yeah. So Adam, does that sound—so we'll try and send that out in maybe the next day to people along with notes on who agreed to do what and when that should be sent back.

Adam Aten - Office of the National Coordinator

That won't be a problem.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Adam, we can touch base tomorrow and why don't we compare notes tomorrow and that will allow you to get the draft code.

Adam Aten - Office of the National Coordinator

Great. Thanks.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Alright. Thank you, Cris, for that. Okay so actually for the next call I'm thinking I agree with you, Seth. I think we should start with the public health and then if there is time at the end we can take off the two items that we weren't able to on this one. Otherwise then we can sort of—then we can have a reset and see how we want to cover the remaining territory. But I think it's important to get to the public health next time.

Okay. Mary Jo, I'm going to turn it over to you.

W

I think she may be out. Mary Jo, are you on the line? No.

W

All you need is someone to open the lines for public comment.

W

We'll take care of that here.

M

If you would like to make a public comment and you're listening via your computer speakers please dial 1-877-705-2976 and press star one, or if you're listening via your telephone you may press star one at this time to be entered into the queue. We have no comments at this time.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Let me just thank everyone in the workgroup for a great discussion and look forward to our next call. Thank you.