

Meaningful Use Workgroup
Draft Transcript
March 23, 2012

Presentation

Operator

Ms. Deering, all lines are bridged.

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

Thank you very much. Good morning. 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 Meaningful Use Workgroup. This is a public meeting and there will be an opportunity for comments at the end. I would ask everybody to identify themselves, as there will be a transcript that's made. And I am this time going to ask the staff to also identify themselves so that the people doing the transcript will know who's speaking. I'll begin by taking the roll. Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

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

George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Here.

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

Michael Barr?

Michael Barr – American College of Physicians – Vice President, PA&I

Here.

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

David Bates? Christine Bechtel?

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva Powell in for Christine.

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

Thank you. Neil Calman? Tim Cromwell? Art Davidson? Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO

Here.

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

Joe Francis? Leslie Kelly-Hall?

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Here.

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

Yael Harris? David Lansky?

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

Here.

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

Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

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

Greg Pace? I believe Greg is going to join us, Paul and George, but he said he would have to leave by 11:00. Latanya Sweeney? Rob Tagalicod? Charlene Underwood?

David Tao – Siemens Health Services – Interoperability Champion

David Tao subbing for Charlene.

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

And would staff identify themselves?

Josh Seidman – Office of the National Coordinator

Josh Seidman, ONC.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

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

Okay, over to you, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great. Thank you very much, Mary Jo, and thank everyone for participating in this next call. We’ll see how far we get. The two things we’re going to go over, the two tabs in a sense; one is we’ve answered a lot of the questions along the way of course, we finished the objectives, and there are a few that we overlooked, so we’ll pick those up, I caught some and if Michelle has ones that we still are missing, please let us know. And then we’ll move over to her HIT PC comments solicited tab, which has some more questions enumerated, and we’ll try to go through those. We might have a chance of getting through all of these today, but we do have one more call. The next one is when, Mary Jo? I think it’s even before the April 4th meeting, correct?

M

Mary Jo, are you on mute?

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

Oh, I’m sorry. Yes, April 2nd.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so just before We’re expected to present our initial thoughts to the HIT Policy Committee on the 4th. We’ll be one of five workgroups, it turns out, reporting related to the NPRM and we’ll carry the bulk of the time because we’ve gone to a lot of them. Another big bulk would be Quality Measures, and then there’s Information Exchange and Privacy and Security and Adoption considering some of the certification processes. So it’s going to be an active meeting. There will be, I’m sure, a lot of feedback

from the rest of the full committee on the things that the five workgroups present. Then after that we'll be coming back into all the workgroups and revising and updating the recommendations based on the full committee input.

Any other questions about the agenda? Anything else to add? Okay, if we go to – and Michelle, I think you have control over the public Web site, if we go over to your section to the Stage 2 comparison tab and we'll go through, the first one I caught was on page 5 and it's advanced directive. Here, as you know, we had recommended to start advancing the ball in two ways. One is to include EPs as well as hospital. As you recall, it was only hospitals for Stage 1 and it was to record the presence or absence of advanced directives in 50% of patients over 65 years old. What we had suggested to also include is that for EPs, and we took the approach was to count the number, at least 25 you need patients seen during the time, and the second thing we added is if it does exist point to where it might be available, trying to move the ball towards when people could really have real-time access to up to date information about an advanced directive for patients.

So that's where we're headed and where we had recommended was to add EPs and to add the location of an advanced directive if it were present somewhere and if it were acceptable. In the NPRM they did not add the EPs and they did not feel it was appropriate to include a point or two where it is. Part of the rationale was the issue of state laws being potentially different, and my understanding is whether state laws would permit someone to act on electronic copies of the advanced directives. And they also kept it as a menu item, so it's one of the two, I believe, ones that they kept menu instead of moving menu Stage 1 to core. Let me just open that up to folks' comments. Let's try the first one, which is EPs.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie, Paul. Can you hear me all right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, we can.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

I would encourage us to get that back into the EPs because that's oftentimes where the first discussions of ... care occur ... are the first diagnosis of a more life threatening or long term chronic condition.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. Others?

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. I would support that. I would support our original recommendation actually and think it's worth reiterating. I really don't understand the hesitancy to at least make this core, after all it was in Stage 1, and it is something, as Leslie said, that's a critical piece of information from both the provider perspective as well as the patient perspective if we're going to ensure that patients get the care that they want and not the care that they don't want. And if we don't start capturing this critical information in an electronic fashion then it's going to be left behind. It makes no sense to me not to advance this unless there's some political reason going on for that, and frankly, I think this group should be beyond that.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven. When I was reading some of the reasons why they didn't include this and the mention of some possible concerns about conflicting state law, that can be the basis for an exclusion. It shouldn't be the reason to leave it out all together. I don't know what state laws they're talking about, because I don't do a lot of legal work on advanced directives. I actually don't even do that much legal work on state law issues, because it's too much, but nevertheless the fact that some states might have laws that arguably preclude the inclusion of just a piece of information about whether an advanced directive exists, again, shouldn't be the basis for not including the criteria, it should be the basis for an exclusion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that's a good approach.

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

This is Amy and I have a clarifying question. The objective is just to say whether it’s known whether it exists. It’s not necessarily saying that the advanced directive or the contents of it are existing in the system, it’s just checking off if the person has one or not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, let’s separate those two. First of all, the discussion is really two things. One to move from menu to core, the structured data that indicates whether one exists, as you said, Amy; and the second component of that is to make that also a requirement for EPs, then later on we can talk about whether we have a point as to where it is. But right now we’re still just looking at what advancing for hospitals, the menu requirement that a field exists, to indicate whether one exists as you ask the patient, for hospitals, and then we had recommended to extend that to EPs. Deven’s further suggestion is to accommodate any conflict with state law that if such exists then that be an exclusion.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Paul, this is George. I suspect part of the reasoning is just overall burden and value, and so I think it’s a desirable objective but I’m guessing that there was a desire to keep it at a certain number of objectives total for EPs and for hospitals then to say which are the 20 highest priority, say, after you do the menuing selection, and that this one ended up number 21 or something. I think it was just a burden versus what other objectives might be more important to push things forward is probably some of the reasoning.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Although I believe end of life care appears as an IOM priority area, meaning that we as a country don’t do as well as we could by patient ... wishes.

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, this is Michael Barr. I think we’re talking about the EP side, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We’re just talking about EP and moving it to core, but –

Michael Barr – American College of Physicians – Vice President, PA&I

So I think first since it wasn’t in Stage 1 moving it to core for Stage 2 doesn’t seem like a reasonable thing.

Deven McGraw – Center for Democracy & Technology – Director

It was menu in Stage 1, ... hospitals –

Michael Barr – American College of Physicians – Vice President, PA&I

... hospitals.

Deven McGraw – Center for Democracy & Technology – Director

Oh, I see.

Michael Barr – American College of Physicians – Vice President, PA&I

We’re talking about EPs. So I think for the EP side in particular I don’t think we can jump all the way to core for this. I think the value here is actually in the conversations a measure like this would hopefully promote. So I think in terms of the first part of what we propose for Stage 2 for EPs recording whether it exists for 25, I think that’s reasonable. I’m not sure about the second part of what we have proposed in terms of provide access to a copy of the directive itself, if it exists, I don’t remember the conversation about who we’re supposed to provide that to, and that might be the issue that was in the narrative about whether anybody can act upon it. So I think the value is really on having the conversations for 25 unique

patients and making sure it's recorded. And if we were to do that I would recommend it be a menu and not jump to core. On the hospital side, I think that's a more acute situation, a more acute setting, and I support more care. I'm not sure whether it should be core or not. I'll reserve judgment on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. Other comments?

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

This is Amy again. The reason I was asking for the clarification was because I support recording whether someone has it or not. I think there is more complexity to actually having a copy of it and I think that's where the state and legality gets into it. But to the extent that asking a patient generates a conversation, I think that that is certainly doable and worthwhile and shouldn't be a huge additional burden.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, this is in essence the check box measure, if you leave the actual copy out of it, and while we certainly want to move away from those, I think the reason why we want to move away from them is because they're not that difficult to achieve. So I think this is an instance when at least having the information that one exists available is worth the time and effort, as little as it may be, to get the check box.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie. The natural conclusion of a "yes" answer from a patient, if one exists, is "Oh, may I have a copy," because there's an expectation that the provider will act on those instructions. I don't believe it increases the burden to get a copy and to scan it into the medical records, just as insurance cards are scanned and many other items are scanned. So just having a check box item I don't think either helps the workflow as much as a check box scan ... copy, and then also looking forward if we think about how a patient might be involved long term in HIT the opportunity for patients' directives ... is very well facilitated by HIT. So, for instance, a patient who has a religious preference that does not allow for certain blood byproducts or certain blood products, that information could not only be available in the medical records, but also trigger future alerts. I believe that this is a beginning stage of integrating patients' desires and wishes and specific medical directives into the electronic medical records, and I think it would not be responsible for us, so it would be irresponsible for us to leave that out.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. To springboard off of what Leslie just said, it strikes me that this is an opportunity to address something that I'm not sure is really addressed in the ... is the priority of patient contributed data. We've got, later on, the view, download, and transmit, and so to make sure that that activity is bidirectional so that we can achieve what we've all stated is a priority for the patient contributed information, then perhaps this could in some way be tied such that if the answer to the question is yes and the patient has a copy, then they can push it themselves to the provider and thus promote electronic communication and patient contributed data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Can I just interrupt here? There's someone who I think is moving furniture, and if you can, when you're not talking mute your phone, that would help us out.

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

Paul, this is David. I just want to chime in on this side of the debate. I think this is actually a win-win across many of our categories: care coordination, patient engagement, and patient safety. I think it's a really important area for us to speak up on. There may be some technical and legal reasons to ... moderate it, but I think our voice has to be, this is one of the places where HIT can provide a huge value to the ... and I would also push that the document itself should be available, just bundle it up, it's literally life and death and people need that access to the information and their preferences to ... and ... HIT enables that and ... down the road

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't know, operator, if you have any control, or whoever's got a lot of background noise probably isn't listening, but if you can help us with that one, that would be helpful. Thank you, David. Just to speak up, I think it's well known that not a high proportion of folks who are in their advanced years have thought about this or been given the benefit of discussion and we're doing some proactive profiling of seniors, out of context it's like understanding a number of their needs and this is one of those, and finding the people who haven't even had the discussion. I think that it's consistent with what I think everybody on this call is saying, is that this is an important topic, certainly of importance to the senior, and one that we do want to, as David said, speak up about.

Let me separate the EP side from the hospital for the moment, I think I've heard unanimous opinion that this is an important one that we would like to weigh in on and one way of doing that is at least to preserve what was menu and make that core for hospitals. Have I heard that correctly?

Deven McGraw – Center for Democracy & Technology – Director

Yes, yes.

M

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Any dissent? No. So that's part one. Let me turn to introducing that as menu or core on the EP side. Do people want to weigh in? We heard Michael, and his suggestion was introduce it as a menu on the EP side.

Marty Fattig – Nemaha County Hospital – CEO

This is Marty. I would concur with Michael. I think where we did not have it as a requirement in Stage 1, that menu for Stage 2 is appropriate.

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, it's Michael, a quick clarification. A second part of what we proposed earlier, I apologize for not recalling the conversation, but provide access to a copy of the directive itself, is that the patient providing access to the copy, or the EP being able to provide it to somebody else?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We're not quite at that point yet, and I'll try to clarify at least what I thought we had, so let's work on the just yes/no –

Michael Barr – American College of Physicians – Vice President, PA&I

Well, my opinion might change depending on what the definition of explanation is in the second half of what we wrote for the Stage 2 proposal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, this would be to introduce the same requirement as the hospitals had to the EP side and right now we're looking at your suggestion as a menu.

Michael Barr – American College of Physicians – Vice President, PA&I

Right, I understand. But part of my suggestion before was the question, or embedded question as to what's the second half of what we proposed about, and I don't remember them, provide access to a copy of the directive itself if it exists, is that the patient providing a copy of it to the EP? Or, is it the EP providing a copy of that to somebody else?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right now the proposal on the floor doesn't even have that second half, but I'll go ahead and answer that the patient would indicate whether it was accessible in some way, and so one way they could do that is they could bring it in and have a doctor scan it. Another is to say, oh gosh, here's where you can find it,

here's the URL in the future world, but right now we're not even talking about that cause of the requirement, just to try to keep the discussion simple.

Michael Barr – American College of Physicians – Vice President, PA&I

I'm going to apologize for my confusion. What cause are we talking about specifically?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

If you look at the hospital side, it is to indicate whether an advanced directive exists for more than 50% of patients 65 or older.

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

What's on the table right now, let me see if I have this right, this is Amy, is are we going to take what eligible hospitals have in Stage 1, which is menu, which says record advanced directives for more than –

Michael Barr – American College of Physicians – Vice President, PA&I

Oh, okay.

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

... and make that same – the first question is do we agree that we want to move that menu to core for hospitals, just as it's written in Stage 1, but just make it core instead of menu. I think that's what Paul is trying to get confirmation on. Then the next question is, do we want to take that first half and make it menu or core for EPs.

Michael Barr – American College of Physicians – Vice President, PA&I

Thank you. I apologize. I was looking at what we had written in the proposed Stage 2 by HITSP, so my apologies.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we've heard two votes for make that same cause, two for EPs as a menu item. Do other people want to weigh in on that?

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie again. I believe that should be core. I do also agree that providing a copy may be more difficult in the provider setting than in the hospital setting, but ... get it in core, get a minimum in core.

Michael Barr – American College of Physicians – Vice President, PA&I

This is Michael. Now that I'm focused on exactly what you're talking about I would say 50% of 65-year-olds is going to be a big threshold for most folks in practice to achieve, even on the menu. So, whereas, I'm supportive of asking the questions, I was reading the 25 unique patients that we had suggested for Stage 2 as what I thought we were looking at, so I have concerns about making a threshold of 50% of patients 65 or older.

W

For hospitals, or for EPs, or for both?

Michael Barr – American College of Physicians – Vice President, PA&I

EPs.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven. I would support it as a menu item to begin with. I'd love it to be coupled with a strong statement that it be moved to core for EPs in the next stage. I think, as much as I want this to happen from a regulatory standpoint, it is highly unlikely that you would get something placed as a core item in the final rule when it wasn't even in the proposed rule to begin with. So I'm pragmatic, and from a practical standpoint I think we're more likely to get it as menu, if at all, and I'd love it to be coupled with a strong statement about moving it to three. And I'd be amenable to moving the threshold down, as Michael said, that's a big leap to go from nothing to 50% even for a menu item.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Let me try to move the discussion. Since there seems to be some building momentum, let me try to summarize the latest proposal and see if people feel that that's reasonable, because we did obviously have this discussion the first time around. We settled on 25 for the reason that was stated, the threshold, and we felt that once they're in the mode clearly they have started the workflow and the EHR's capable of accepting that information. I think that the motion on the floor really is to put in the same requirement of whether an advanced directive exists for at least 25 patients who are 65 or older, and make that a menu for EPs in this stage, signaling that we would recommend that it move to core in the following stage. Is that –

Deven McGraw – Center for Democracy & Technology – Director

All right, I'm not sure I would have – this is Deven – 25 single patients. I didn't realize we were moving not to a percentage threshold.

W

I agree, if it's a menu item moving to 50%.

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

I agree with it. This is Amy. I agree with the percentage because in a large practice 25 patients may be nothing and in a small practice it may be a lot. I'm okay dropping it from a 50% and making it menu for EPs as opposed to an actual number of patients.

Deven McGraw – Center for Democracy & Technology – Director

Yes, ... point.

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

Maybe it goes down to 15% for EPs or something, but I think a percentage on the EP side, if it's just documenting whether it's there or not, is more logical, because you really can't control for size. Otherwise it could be 1% or 20%, depending on the size of the practice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's see, previous low numbers have been 10% or 30%, I'm just trying to find where CMS has used low numbers before, so would people agree with 10% or 30%?

M

Paul, I think that our initial intention of 25 was just to get us through the certification, so that would lean towards the 10% number. I agree with the percent, but the 25 maps to it, that feeling that's to 10% of patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So let me throw out the latest draft that I heard, which is to make a menu requirement for EPs to record whether an advanced directive exists for 10% of their patients seen 65 or older.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie. I would love to see it at 30.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. I would advocate for 30, too, and I think another thing that's important for us to not only remember but probably state outright, because it's an issue of alignment, is that the Joint Commission has pretty strict guidelines on advanced directives, and even 10 years ago, and this was in hospital, 10 years ago in my practice as a social worker we were required to talk to every patient about that, and it was a Joint Commission requirement. So I just feel like we're noodling over something that is extremely important and what we light on, at least if we light on the 10%, is going to be really inconsistent with the way the world works and is moving, and with the other requirements through Joint Commission.

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

This is Amy. Does anyone have any sense that in just provider offices how common providers ask for this or know about this? I’m trying to balance the jump from nothing to something. I’m clearly supportive and want to push it, but I’m also thinking about what’s practical too. Is this something that they never do, is it rare, or is it something that’s quite common at that age population in general provider offices? I’m not talking hospitals now.

W

For a family practice physician or an internal medicine physician or cardiac, this is very common, or any patient who’s being scheduled for surgery, this is all very common. Paul, maybe you can speak to that. Do you know anyone who doesn’t ask those questions?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think you really need to separate this from hospital or, like you mentioned, operations. I think this is a very different requirement in an office and I’d have to say that this probably is not very high.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is not for family practitioners. This is for all eligible professionals. I think that given that we made a request and then they backed off from that to make a much bigger request the second time, I don’t know, I would go back to a parallel request and insist on it, so that’s why I went for the 10%. I don’t know if it makes that much difference between 10% and 30%, but I’m just trying to keep it parallel and not – since they went back from that I’m going forward from that.

Deven McGraw – Center for Democracy & Technology – Director

I’m not sure it makes sense to quibble a lot over the numbers. We’re pulling them out of the air. I think our message is the threshold should be relatively low, but meaningful enough to get this started and to be doable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that’s very appropriate. And I think George’s argument is good as well, in the sense of I think it is going to be new to have this visible and have a threshold requirement, so we want to start the ball rolling, we don’t need to make it too high to jump over or scary.

Michael Barr – American College of Physicians – Vice President, PA&I

This is Michael. I support the lower threshold. I agree with you, Paul and George. Unfortunately, it’s not a terribly common thing even in primary care, let alone some of the other specialties to ask about this. What we want to do is stimulate the conversations. Once folks find it valuable patients will start asking, or telling, I have an advanced directive, please record it in both directions. Many patients don’t have advanced directives and some want to have them and this will start the conversation going.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven. If it’s an achievable menu item, more providers will choose it.

W

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly.

Michael Barr – American College of Physicians – Vice President, PA&I

Exactly, that would be the intended good of this.

Deven McGraw – Center for Democracy & Technology – Director

Yes, I totally support the lower threshold and making it a menu three piece.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, it sounds like we've got some waves going behind that ... EPs 10% menu item for patients being 65 or older, have I got a consensus on that one?

W
Yes.

W
Yes.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Now let's tackle the harder issue. Josh, is there a way, because this has come up more than once about the states, is there a way to get some kind of, short of a hearing is there a way to get a white paper on this or some information that would help us better understand those issues just so we don't get blindsided and we're saying something that really isn't practical?

Josh Seidman – Office of the National Coordinator

What we can do is we can do some research and see what's out there. I don't think we could do all of that research in any clinical –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Josh Seidman – Office of the National Coordinator

So what we can do is we can do some research and see what's out there.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie. We're really asking whether ... and put in the record, whether it's used as the legal document ongoing is a separate question. This is just back to, isn't it better to know, to have a copy of this in the record, and then you ask the patient is this the most current copy, because the question is documents change, ... someone might scan a ... for other purposes know that there might be a more current item later. But having access to the information helps to promote the dialogue and also it's ... the most recent copy you can take action on it. So I think we should look at it in terms of informational item in the record, rather than saying you somehow ... from the

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it might be hard to separate those two, Leslie.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Really?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let's pretend somebody initials documents, and clearly in this state you need a full signature, to have the initials could certainly mislead people on this veracity and validity, and I'd be careful with the –

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Well, it just seems that information scanned in, this is so powerful to have it there that we should push.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven. That is where the legal issues come into play. In my former life when I actually did counsel healthcare clients on legal compliance you would never want to put something in an electronic medical record that you weren't sure you were able to rely on, because that's the source of documentation for any care that is provided and could be a significant source of liability for a provider if it's inaccurate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right –

Deven McGraw – Center for Democracy & Technology – Director

It's totally where some of the state law issues come into play too. This is why I asked for a signal for something stronger in Stage 3, so that there would be time to drill down on what the barriers might be to requiring it to be scanned and included, because I frankly just don't know. But I do see some pitfalls with making it part of Meaningful Use and especially if we're really trying to get people to at least start having the conversations, if we load the measure up with too many obligations in a menu item it's not going to look that attractive.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Deven, is your idea about using it except where excluded by law?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I suspect, because we've been advised, I remember Tony's advice to us about really ... from the field, I suspect there's a lot more that we just are not cognizant of and that it would be well worth our getting more information. If it's available, for example, let's say Josh finds some white paper that's out there that can at least advise us of the ..., that would be helpful. Otherwise, I'm almost thinking that we're going to try to make a statement saying that we need to have this discussion more regularly and not just when you end up in the hospital. And that's a pretty big statement, and a good one, and maybe we need to do a little bit more homework to get the second piece, which is how do we get something that is legal and actionable immediately available, which was our intent for the second half of that statement, though we may not had all of the facts available to us.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven again. There are a lot of groups that do a lot of work on this particular issue and it would be in our best interest in this interim time to use them, reach out to them, and get more facts about what we can do, and where the incentives need to be.

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

This is Amy and I agree with Deven. The other thing is ONC had Challenge grants, and one of the areas was advanced directives around HIEs and stuff. I know some areas actually try to do advanced directive registries, and I don't understand all the issues. I know at one point in Rhode Island we put in a Challenge grant and didn't get it, but I'm wondering if there are things along that line of getting more information, even learn from the Challenge grants that ONC has already put out from those grantees and understand what some of the issues and challenges are around this as well. I think it's complicated. I would vote for deferring this part and getting more information and then trying to boost it in the next stage.

W

This is It might be useful to have some of these experts on some sort of panel down the road when we're discussing this as part of Stage 3. And Josh, I've got a couple of names I can send you, because of having done some homework on this, but not deep enough to answer our question today, and I'll send them to you so you've got a place to start.

Josh Seidman – Office of the National Coordinator

I think one question is you have the legal issue. But I think the more important question is the feasibility and how often will errors be made if we actually create silos of advanced directives. Maybe the solution is there needs to be, well theoretically I'm not saying that this is something we should push for, but there needs to be some way that they can be coordinated. And until we can really coordinate them I'd be afraid of sticking it in the electronic health record and then a mistake being made in either direction, which would be quite tragic. And one mistake like that would not play out well. So I think that the most important question is feasibility that we need if we're going to bring an expert, so I want to know how would it really work within EHR, and then we can also find out about the legal issues, but I'm really more worried about feasibility.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie. Now when you do ask for copies of something, the current practice, if you have an electronic medical record you just scan that in some way, shape or form. Otherwise, you're keeping a copy of a paper record and a copy of an electronic record. So, the ... insurance cards ... history, we can scan in ... results in a non-electronic way. So I would be interested to see what those who do have electronic records and are scanning information, what are they doing with their advanced directives.

Josh Seidman – Office of the National Coordinator

Okay. I'm sorry. I should quantify. I didn't mean the feasibility of getting it in there. I think scanning is feasible potentially. What I meant is how often do people change their advanced directives, what's the probability that that will be changed without it getting changed in your EHR and then you make the wrong decision. How often does that happen?

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

I think that's an important question, but I don't see how that's any different in the electronic world than in the paper world. If it is, then I think that there are two important ways to address that that we would need more information on and need to explore. But one would be what I said earlier, to have this be a place where people are encouraged to include patient generated data, or patient submitted data, because if anyone has the most updated copy it would be the patient. So that's one way to go about it. But then I think this also has really significant implications for the concept of the care plan, which obviously we've not fully fleshed out, but these are the same issues that there are with the care plan that is shared among all members of the care team and who has the right answer at the moment where we are, the current moment. So I think it's an important question, but I think it's one that we have to grapple with and one that isn't necessarily different than our paper world, so I would hate to hang this up on ... too hard.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, let me try to ..., remember that we have more questions to consider, and certainly this is one of the most important, I think, for patients and for the nation, so I think it's a worthwhile and very productive discussion. Let me try to summarize where I think the sentiment is. I think we all could benefit from a better understanding of the issues involved and that have been brought to the attention of CMS, which is why they elected not to go that far. It would benefit us to have more of that information before going on to the next stage. I think we've made tremendous progress by saying we still believe this is a high priority, ... says it's a high priority, and that one of the ways to act on that is to bring it to the attention and have those discussions more often, and what we've done is introduced the menu low threshold objective on the EP side, which is I think a major accomplishment. We've also recommended that it be core in hospital. So two substantive changes and that I think we're asking that we'll go back and get more information before we advance on how do you constructively and reliably and legally get access to documents that are actionable. Is that a fair summary? Are people on mute, or do I need to restate that?

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, I think you did a good job. It's Michael.

Deven McGraw – Center for Democracy & Technology – Director

Likewise, Deven.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Marty Fattig – Nemaha County Hospital – CEO

This is Marty. Yes, I agree.

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

Yes, this is Amy.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great. Okay, the next one I have on our list has to do with, this is on page seven –

Paul, can I interrupt? I’m sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

W

The next one, the hospital objective, I’m not sure if we want to talk about it now. Just scrolling down, I don’t know if you can see my screen, but we did say to be discussed further. I don’t know if you want to discuss that now or wait on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Which objective is that?

W

Generate and transmit permissible discharge prescriptions electronically for more than 10%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me see, do you happen to know what page that’s on?

W

I believe it’s on page eight.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, okay. Didn’t that get, the question is, okay, wait, is this ERX or is this hospital discharge instructions?

W

Hospital discharge medication orders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Because that did come through, right, 10%?

W

Right. We had decided we wanted to discuss it further, so I just didn’t know if you wanted to discuss it further now or later.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I’m thinking it was discharge instructions, not discharge prescriptions. The issue I’m remembering is, remember we went from discharge instructions at discharge versus within originally proposed to be four days and we moved it up to two days. So I think what got missed and overlooked and the question on the table would be is that okay, is whether you have access to your discharge instructions electronically at discharge. And that may be okay, because thinking about how we thought about it, most people when you’re being discharged from the hospital are going to want to see the instructions and get that reviewed, and that’s probably going to be on paper, so having electronically at that moment versus within the whole summary of that admission that occurs in our proposed two business days, is probably still within the spirit

of what we were interested in as well, and we didn't talk about that so I was just going to raise that. Is that okay with folks?

Deven McGraw – Center for Democracy & Technology – Director

Sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't think it's that much different actually. It's consistent with our Another area, this is on page 12, Michelle, has to do with recording the healthcare team members. The NPRM included healthcare team as part of that summary of care document, and remember we talked about and they also included problems with med-med allergies, our thought with problems with med-med allergies is that's such core information that we want to make sure that it stands out, and we were planning to increase the completeness and accuracy as we go from stage to stage, that's why we had recommended still keeping it as a separate objective so that we can ensure that it's more up to date and complete. Similarly, part of our reason for healthcare team members outside of a transition summary of care document is because it's really useful for the patients to have at any time. That was part of our thinking, are we okay with having it incorporated in the summary of care document as it stands in the NPRM, or have it as a separate objective? This could be that it's okay to keep in the summary of care document as well; thoughts about that?

Deven McGraw – Center for Democracy & Technology – Director

This is Deven. We would be interested to hear from the providers on the call, because my assumption is that if the summary of care document is the document that is the focus for transitions of care and making sure that relevant information is being shared among the care team, that that's the place where the care team needs to be listed, is in that document. But I don't know whether there's value or importance to having it required to be demonstrated in other parts of the record as well. I have no clue. I think it's important that it be in that document, but beyond that I'm not sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so here's one of the concerns. If you press a button, or you don't even have to press a button and the document goes for any transitions, that's one thing. The value of being able to see it in my face, just like the problem meds analyses, is that that's really accessible at that level and it contributes to coordination of care every encounter.

Deven McGraw – Center for Democracy & Technology – Director

Yes, good point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So right now if I practice in an integrated system I can actually having to do some filter and store, figure out who else has seen this patient in our health system, but clearly if I'm practicing and there's a specialist involved I have no way in my electronic record to know that, and yet almost every visit you would like to know, oh, so they have a cardiologist or they don't, or they don't have a PC. That information about the care team could be used at almost every encounter.

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, this is Michael. Actually, Deven, you anticipated the direction I was going. It would be as useful, as Paul describes, if it was available at the time of an encounter who was seeing my patient. Often it's inferred by, on paper records people have jotted down who I referred this person to, but in this case it would be great to have it present automatically, and also to validate that when the care summary is sent out that it actually has the most recent list of folks that are involved in that patient's care.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. Just listening to the discussion here I think that that critical information for the patient and their family as well, particularly again as we think towards the day when we actually have patient contributed information, that this is certainly a decision that should not be made for the patient, that the patient needs input as to who their care team members are, and so that information needs to be

accessible to them as well, and at least the way we've structured this particular criterion is that this is not a patient facing one, it's strictly in the transition of care between provider to provider.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, I think what we're doing is a cultural change again. It's analogous in that way to advanced directives. Providers already know they would love to have this, they just don't know how it can be possible to get this information. Well, interconnected EHRs is one of those, and to start having the notion of having this list and starting to make it more complete and actually, as Eva says, and the patients certainly can contribute, is one of those things that will start really contributing to coordination, but you have to start. Right now there's not even a field and it's certainly not one in front of my face, and that's where we're headed with this.

Eva Powell – National Partnership for Women & Families – Director IT

I don't know, Paul, is this a standards issue? Consistent with what Deven said, obviously this information does go in this particular document, and if we can get that as our foot in the door, that's great. But we don't want to do that in a way that precludes, as we've been discussing, the availability of the information in other places. So I don't know if that means that this is a functional requirement issue or a standards issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, it is a problem of interoperability, and now I believe we have NPIs, that's part of the HIPAA. It is more possible, it's still hard, but it's more possible to identify people and include that on this care team field, so whatever applies to the summary of care document certainly applies to this, but if it's available in the summary of care what we're saying is that we'd like it to be available up front in an accessible way. It's analogous to what we said with problem meds analyses. Then of course once it's in front of your face you are more likely to check on it, so we go through a med review every encounter to try to keep it up to date. The same thing with this, we can incorporate that as part of the ... to make sure that we understand who all is taking care of you. Okay, are we building any consensus here? Other people who haven't said anything, how do you feel about this being left in a summary of care document versus a standalone as we initially proposed?

David Tao – Siemens Health Services – Interoperability Champion

This is David Tao from Siemens. I think the rationale was that if you include data capture standalone for every piece of data that ends up in a summary of care document you increase the number of objectives and tests that have to be written and things, and so it seemed to them to be busy work that obviously if you wanted it in a summary of care document you would have to collect it somewhere. And if you collect it, it stands to reason you would display it without necessarily having to be told that you're not capturing it, having it go into a black hole and then only appear on the summary of care document and nowhere else. So I guess I would support it in that unless there's a real strong case why we know people aren't showing it except somehow they're sliding into a summary of care document, then it seems like having less could be more. You don't have to tell people to do the obvious in most cases. So ... team members on a summary of care document unless you captured them. If you captured them there's a UI of some sort that would record them, so it seemed to me like the principle was reasonable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Any comments?

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

This is Amy. In my mind it almost seems like a moot argument, because if you're going to have it there you're going to need to test it whether it's a separate objective or incorporated it needs to be there and done. So I don't know if it's splitting hairs or not. By making it separate you're clearly putting more emphasis on the importance of it, I think, so that it doesn't get buried. But if it's under the other objective and it has to be part of it, you still have to make sure it happens and works properly. I think I'm missing here the –

David Tao – Siemens Health Services – Interoperability Champion

In fact I think if you look at Stage 1, the tests that were created for summary of care documents, CCD at that time or whatever, tended to include enter the data, we're going to give you some data to enter and then we're going to show that it appears, so therefore it is in there, it's just that if you had a separate objective for it, it creates another test where all you're doing is capturing the data and then another one where you're generating the document. But it didn't seem to be a problem, because you want to know that they didn't hard code the data to appear on the document, where it was never actually captured, just ... in the system, so the test asks you to collect the data that you then show on a summary of care document.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me maybe give the provider perspective. An example from the paper world is you had to have a problem list in the ... requirement, for example, and so people would have a problem list and that was filled out once and therefore you would always have a problem list present What happens is it was at the back of the chart or whatever and it was there for certification documentation and was not used in ongoing care. So that's part of the difference between having it somewhere and having it in use in every day care.

The other piece, analogous to problems in meds, is we plan to build on it, so one example Eva cited what would be good about having the care team in front of you all the time, well, gosh, it would also be in front of the patient and the patient can say oh, I don't go to this person anymore, or I'm now seeing such-and-such, that up to date information the patient contributes to. And in fact, we do that with our immunizations and meds, etc., we accept information from the patient to try to make sure we have the most up to date shared summary information as possible. So because it, one, can be used in something that's really hard to do, i.e. care coordination, it really should be in front of your face and we plan to do something more with it in later stages, that's the argument ... for separate objectives. I believe it was George that also mentioned, well, if it's there somewhere then why don't we just put everything in the summary of care document and then we're just done with it. That's the other extreme of saying, well, gosh, if you just want to make everything in the summary of care document then we've finished with all the requirements and yet we haven't changed what influences care decision every day. So I'm just giving you some of the background and thinking from the provider perspective.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Paul, this is Leslie. In the clinical summary definition on page 79, at least for the clinical summaries going to the patient, it indicates provider's name and also referrals to other providers, but I don't see a field that says specifically team members. Now maybe that's implied by saying the provider name is actually on it, but I don't see the other members. If we're going to put it in the clinical summary document then we just need to ask that that be specified as part of the requirement.

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

This is Amy. I'm fine leaving it separate. Again, I would support that recommendation, and some of the comments I've heard is that while this tries to make it look like there are less objectives and a little bit more flexible, in the end if you count what's been merged it doesn't really do that. I think this is just making clear what we want to have done and not trying to get it buried, so I support keeping it separate. I'm fine with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other people?

Deven McGraw – Center for Democracy & Technology – Director

I agree with Amy. This is Deven.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Tao – Siemens Health Services – Interoperability Champion

This is David again. Even though I said what I did, I don't think it has to be separate, but I don't object to if the committee wants to make it separate to emphasize it's important. Making it separate won't necessarily mean that it's in someone's face, however, they could still hide it, but nevertheless.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

David, this is Leslie. Do you think that the most meaningful place to have it is in the clinical summary?

Deven McGraw – Center for Democracy & Technology – Director

Why wouldn't it be in both? I didn't think this was an either/or conversation.

David Tao – Siemens Health Services – Interoperability Champion

No, it doesn't have to be an either/or, but I think we said that there are two extremes. One is, only one requirement, clinical summary has all the data, you don't have to do anything else. That's one extreme. The other is you state every element that you want in the clinical summary and you state an explicit data capture requirement for it, which gives you a much longer list than we have, because I don't think we listed everything. So I think you're trying to find middle ground where you're saying, well, clinical summary catches a lot of stuff but if there's anything we really feel is important that we want to say is important we'll make separate too, so that's the middle ground and that's okay. I think the point of the clinical summary was it's, in a way, a very strong incentive because now the clinical summary is going to other providers and the patient and you're basically exposing your data to others, not just yourself, so you can't game the system anymore by putting in a bogus problem list with one problem that doesn't mean anything, because that's now going out to the world and they're going to see that you do that problem list. So that's the strong incentive of the summary that's shared, which is the enforcer in a way. If now you have to really exchange stuff, you're going to show everybody else your stuff, and you'd be embarrassed and maybe even liable if you put out stuff that's junk. That's the argument, I think, to try to reduce it. I don't object to calling out a few because you feel like they're not normally being captured or people tend to skirt around them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That last phrase, David, I think is the spirit behind which we have both for the care team and the care plan. Neither of these is actively involved in the workflow, though we would benefit, and particularly under care coordination, by having those now, in a sense, a new part of our workflow. That's why we originally did it that way.

David Tao – Siemens Health Services – Interoperability Champion

Yes, I think it's good. Maybe later when they become commonplace and well shared, maybe they won't need to be separate anyway, they can be merged.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Any other comments about this, and see if I can get a sense of the group.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Paul, this is George. I just got disconnected for a second. What did you just – because it sounded like you were about to make the same point that I was about to make. The reason we separated is because in the future there's an idea that the care team is tied in with HIE and there's some automated mechanism of adjudicating them and everything, as opposed to other items in the summary of care record, the care team is the more dynamic care plan, so that's why we kept it separate, but I'm kind of neutral. I see the benefits of separating it, definitely, and then I see CMS' need to reduce the number of objectives, so wherever we end up I'll vote for.

Marty Fattig – Nemaha County Hospital – CEO

This is Marty. I agree with what George just said.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we're going to have to decide one way or another, and we might as well wrap in the care plan as well. Let's go ahead and do a vote, and really we're all recognizing the importance and it's we keep it

as a separate requirement, a separate objective. and actually from a certification point of view it can end up with the same thing, but as a separate objective we can build upon it as part of active care. Let's just go around the room and say separate or contained in summary of care. George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I was the one that was neutral.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm sorry, you've got to pick.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I guess I'd just leave it as is because I'm neutral. But if people are in favor of separating I'm going to change my vote.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Eva?

Eva Powell – National Partnership for Women & Families – Director IT

I too am neutral because it seems to me like this is more of a market issue as to the design of the system and how certain information is shown. But if the group is for separating, I'm good with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Marty?

Marty Fattig – Nemaha County Hospital – CEO

I would leave it as it is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Which is together?

Marty Fattig – Nemaha County Hospital – CEO

Together.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In the summary of care. Leslie?

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Well, I struggle with this one because if it's not specified in the care summary document ... so I'd support separate. But if it's specified in the summary document then I prefer it there because it benefits more parties.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, great. David?

David Tao – Siemens Health Services – Interoperability Champion

To answer the question, it is specified in the summary of care document.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Tao – Siemens Health Services – Interoperability Champion

But I will actually reverse and go ahead and vote for separate just for the spirit of supporting its importance, because it's new.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Deven?

Deven McGraw – Center for Democracy & Technology – Director

I'm inclined to say that it should be – I want it in both, so if it's already in the summary of care document it seems to me since providers don't provide care on a day to day basis within their own facilities using summary of care documents I think it should be something that shows up on the screen for the provider to see, Paul, as you described. So my inclination would be separate. I think the challenge for us is that we're not going to get every ask that we make, and I'm not sure this is a priority ask among some others that we're really trying to push and get in.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. David Lansky?

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

I'm abstaining on this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Amy?

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

I actually am where Deven is. I could go either way. I think it's important to have it there. I'm fine if it's important to separate it out. In my mind I keep thinking it's a little moot, because if you have it as a requirement that the data has to be there, it's different than a requirement of where you have to see it. So the requirement isn't that you have to see it as a standalone or see it as a summary of care, the requirement is the data has to be in there, that's what's most important to me, unless we want requirements to say it has to be in two other places. But if it's in the system then it needs to be available where it needs to be. But I'm with Deven too, that this one I'm somewhat ambivalent on. I wouldn't go to the mat on this one. I don't know what the strategy is; ask for more and get less, or ask for less and hope you get what you want.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, I think there's a clear sense of the group and –

Michael Barr – American College of Physicians – Vice President, PA&I

You didn't ask me, Paul, it's Michael.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Michael, go ahead.

Michael Barr – American College of Physicians – Vice President, PA&I

I'm for separate, for the main reason is that data are going to be collected, so the data is there, it's a matter of representing it, so it's better for use in practice, and I think for the reasons you cited earlier, Paul, and what Deven just summarized I think having it separate. I agree that it's probably not a priority but I think it should be recorded.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So as I was going to say, in a sense where we have this amount of mutual ambivalence and the important part is that it's captured, there's no reason that we should propose a change from their NPRM. I think that's the sense of the group. And it captures a little bit of what Deven said, why try to make this another thing that we want to change. Okay, so I think we would be leaving both of these as the same, which is to make sure that it's in the summary of care plan.

Okay, so from my reading of this tab, that concludes, or did I get, what is this – what page is that? What page are you on, Michelle?

Michelle Nelson – Office of the National Coordinator

It looks like 16, I believe.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

If you can go to the objectives, scroll left so I can find that.

Michelle Nelson – Office of the National Coordinator

... and public health ones.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. The policy question, now it says bidirectional, so one of the questions is there are a couple of new menu items for entering information into the registry. The question is, what if the data elements that are required, and typically in these registries there are a large volume of data that's required, and what if no standards exist, is that still okay to have an objective even though it's menu. David Lansky, you might have something also to say about this. This is the question, that's one question, and the other question is bidirectional.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Paul, this is Leslie. I think that one of the ways to drive the standards is going to be asking for more information up front. The syndromic surveillance gives the 22 fields that are basic and then beyond that it wasn't very registry specific.

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

Yes, this is David. I agree with Leslie's main point. I think in some areas like cancer it's highly specified and that's not a problem, and in some they're working on it right now within specialty societies and this will be a good incentive to help them finalize those standards and specifications so that their members can qualify through this path, so I think it's a good signal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think what you're saying implicitly, one, we would only be saying this because there's still two years to work on it; two, they must be fairly close because two years is not a lot of time to get standards through; and three, that only if the standards are available in 2014 would this be an appropriate objective. Have I got those three requirements right, though?

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

Well, I think the burden is on CMS to define what's an acceptable registry based on the kinds of criteria you ... into that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is George. I think we're on exactly the right path, and I don't know how to phrase it yet, because there's not a lot of time in the sense that we have to define the standards, registries have to use it and vendors have to implement those standards, so I think cancer we're okay because it's fairly limited. For the other there's some kind of stipulation that you can only do this if the registry adopts the standard as well as the vendor, but we don't have meaningful use somewhat controlled on the other side, so we have to put a stipulation such that if we're going to suggest that we keep this new objective, it has to be phrased in a way that makes it clear that there has to be a lot of progress on standards and otherwise we can't really move forward on it and that the registries have to adopt these. I don't think it's fair to expect vendors to develop interfaces to 80 different registries that will each have its own method.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me try to summarize what David and George just said, where CMS can establish a standard then vendors should comply with that to submit data to various registries. It would be not the case, for example it would be undesirable to have what George just said, which is, oh gosh, now a bunch of registries have just come online and say vendors you need to comply with the data I'd like to be submitted. That would be really disruptive. So it sounds like the answer to this question is the specialty registries would have to comply with CMS adopted standards if they were expecting data to come from HHS ... EHRs. Did I say that correctly?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes.

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

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Did you get that, Michelle?

Michelle Nelson – Office of the National Coordinator

I did.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, thank you. Bidirectional, I think the question is do we want to move in that direction in Stage 2? We've already declared, even in Stage 1, our intent is as registries. Whether public health or specialty specific, registries become more mature we would love to incorporate that information, both for, say, QI, and benchmarking, as well as individual patient care, such as flu vacs and H1N1 and the things that change fairly quickly over time. Is there any sentiment about having bidirectional registries in 2014?

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

This is Amy. Again, I have a clarifying question. The bidirectionality in this case is meaning that the EHR can take back information that it may not have, or is this putting the requirement on the public health systems to be able to send back?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's back on the EHR, so the scope is only provider EHRs.

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

Right, okay. If you did that it's obviously, like the other things, all contingent on the fact that the registry at public health can actually send it back, which is I think the reality and potentially the bigger challenge perhaps than the EHRs taking it in. But maybe I'm wrong on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't think either have been done right now, so it would be development on both sides. But, yes, unfortunately the public health isn't supported by this incentive program.

Marty Fattig – Nemaha County Hospital – CEO

This is Marty. It seems like a bidirectional interface is a pretty aggressive standard for not having anything now.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, I reluctantly agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, I think that's just the state of the We established our direction in Stage 1 and I think it's not changed and we certainly can revisit this in our Stage 3 discussions, which would begin in 2016. Okay.

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

The only other option there, and I don't know that this is a good idea, but if you wanted to try to drive it would just maybe think about putting it in the menu kind of thing. I certainly wouldn't put it in the core kind of thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's pretty aggressive.

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

I agree. I absolutely agree. I know it’s important, so I’m speaking from the point of view that I would love to see it, but I know we’re not there yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Okay, let’s move on –

M

Paul, can I ask a question while I’m staring at these objectives, did we ever comment in our meeting on “except where prohibited?”

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We did not. Let me restate what I think the intent was, what I heard was some people were saying, so the original wording was where ... in accordance with, yes, so I think what CMS was concerned about is, okay, well, it may be acceptable, but it’s not required so people didn’t feel like they had to do it. So I think introducing the phrase “except where prohibited” meant that if you weren’t prohibited they were asking you to submit. Did I get that right, Josh?

Josh Seidman – Office of the National Coordinator

... . So my question is what about what the public health agency wants? What if the public health agency doesn’t want it, then what does the EP do, or the EH?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That’s, I think, where the other phrase catches it, where whatever it was –

W

In accordance with applicable law and practice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That’s right. So the practice part, so if they don’t want this stuff the applicable practice would be, well, it’s not like a lot of people are going to force it –

M

So then could we put a comment that we want that clarified, that “except where prohibited” does not mean that you don’t get meaningful use if you don’t send in all your immunization data, do you know what I’m saying? You can still get it if the public health agency either cannot or does not want it then there’s no one to send it to and you can’t meet the objective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think you’re asking for some clarification on the “in accordance with applicable law and practice.”

M

Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

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

This is Amy. I talked to a lot of folks, at least in Rhode Island in the Health Department, and that language is ... a lot of problems for the programs in the Public Health Department because it doesn’t even address the quality of data issues. There’s no addressing of once ongoing submission happens what if there’s a break in submission. There’s a lot of vagueness and I’ve been struggling with how to give the states the room they need but not be as vague as that, because that language just – I understand CMS now is trying to defer to the states, at least that’s my understanding, but I think the states are looking to say if they have a particular implementation approach, if it’s a little bit more standardized it may be more

likely to have it done across the board on vendors than making it different in each state. So I struggle with this a lot.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's useful feedback, Amy. Michelle, you caught the spirit of that?

Michelle Nelson – Office of the National Coordinator

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think what we want to do is provide that kind of feedback. And it's consistent with a lot of feedback from the ... which is when it is vague it's hard to interpret and that everybody's asking us to be as precise as possible so they know when they're

W

In practice, also because this is the lowest common denominator, if in fact they're still running a ... or COBOL-based system that can't communicate with anybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, so in some sense it's almost in accordance with the relevant public health agency's capabilities and practice, and that's not precise either but it's getting a little bit like well, who do you ask this? I think you ask the public health agency and they can spell out both the challenges and what they're capable and willing to accept right now. Anyway, so the main point is if they could expand on in their preamble both the "except where prohibited" as well as the "in accordance with applicable law and practice."

Okay, let's move on to the – have I done it, Michelle, are we finished with this tab?

Michelle Nelson – Office of the National Coordinator

There was one that we may want to go back to for ePrescribing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Michelle Nelson – Office of the National Coordinator

Let me get there myself.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

... getting the issue there.

Michelle Nelson – Office of the National Coordinator

Sorry, let me try and bring it up, if I can find it.

W

Paul, I'm seeing a note that there needs to be discussion about care plan goals and patient instructions. I know that we talked about care team members but –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I wrapped that into, it was the same principle. What CMS did was put it into the summary of care and I just applied that same principle to that.

W

Okay, sounds good.

Michelle Nelson – Office of the National Coordinator

Paul, I don't know if you want to go back to this one now or wait.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Where's that?

Michelle Nelson – Office of the National Coordinator

This is for ePrescribing, so our note was to clarify between 65% and 50% because at the time one of the slides that we saw had said –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Ah, yes, I believe I've even heard Rob Anthony say that it was intended to be 65.

Michelle Nelson – Office of the National Coordinator

Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, okay.

Michelle Nelson – Office of the National Coordinator

But I did want to bring up this objective was talked about yesterday during the IE Workgroup and they were very concerned about the 65%. They were going to go back to SureScripts to get some additional information, and they're going to discuss it during their next meeting. But I did want the group to know that as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good point. And they would be the appropriate party to weigh in. Personally I think it's also getting a little dicey when you get that high and most of us use SureScripts anyway and it's not always that possible.

W

I'm on the other group too and I think the issue has a lot to do with mail order pharmacy and needing more data to understand how that works in terms of how many can accept or not, and things like that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This group's thoughts in the past, once you're at 50% there's no inherent motivation not to go as far as you can and sometimes you can be prevented from doing that, and we wouldn't want to catch people that way. So does this group want to weigh in, or we just defer – let's put a special note so when I present this we'll defer this, we'll get additional input from the IE group, I guess.

Michelle Nelson – Office of the National Coordinator

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, thank you. All right now I think we're ready to move on, Michelle, then to the other tab.

Michelle Nelson – Office of the National Coordinator

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We're working on comments, solicited comments, and one of the big areas has certainly been something that's requested and like most things you've got to be careful what you wish for because the devil is in the details, so there are a number of questions related in the first area on group reporting. But let me try summarizing, and, Josh, please correct me, I think the group reporting notion was that a group, let's say a tax identifying number group, can report their CQMs, their Clinical Quality Measures, as a group but they must report their objectives by individual EPs. Did I get that right, Josh?

Josh Seidman – Office of the National Coordinator

Yes, basically. So the proposal in the NPRM is on the reporting of the meaningful use measures that they can do something called "batch file reporting" which is that they can make one report for the whole

group but it needs to include numerators and denominators for each EP. That was the proposal. But in addition they sought comments on the other option that was proposed by the Policy Committee last summer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Go ahead. Let me make sure I understood. You're saying report CQMs at group level but include numerators and denominators –

Josh Seidman – Office of the National Coordinator

No, I'm talking about the meaningful use measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, the objectives?

Josh Seidman – Office of the National Coordinator

Yes, so the meaningful use functionality objectives. The measures for those, the ones that have numerators and denominators would need to be reported a separate numerator and denominator for each individual EP.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But the CQMs could be reported at the group level?

Josh Seidman – Office of the National Coordinator

Right.

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

This is Amy, I'm clarifying. So it's one report of the CQM for the entire practice without looking at what the individual variation among providers are within the practice for the CQMs?

Josh Seidman – Office of the National Coordinator

Correct, which is basically following the model of healthcare reform, you're in it as a team, your payments are bundled, and your quality

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. So you need all the EHRs to have functionality and presumably that's the rationale for having separate objectives, but you may decide to function as a team, as a group.

Josh Seidman – Office of the National Coordinator

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

How –

Josh Seidman – Office of the National Coordinator

... .

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Go ahead.

Josh Seidman – Office of the National Coordinator

So let's say there were a series of discussion points about the rationale for both options and there were a series of questions related to if the full group reporting option were being recommended by commenters to respond to a series of technical questions about how that should be, things that would need to be addressed in order for it to be administratively doable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's try, first, people's reactions or comments about the notion of having an option, it's an optional way of reporting of –

Josh Seidman – Office of the National Coordinator

In both cases, whether it's batch reporting or the other approach there's still the option for anybody to report individually if need be.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

What is the other approach? You said there was something we recommended on this.

Josh Seidman – Office of the National Coordinator

This was that instead of having an individual numerator and denominator for each EP a group could report one numerator and one denominator for the entire group.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But I thought that's what option one was.

Josh Seidman – Office of the National Coordinator

No, not on the meaningful use functionality metrics.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So you're saying in addition to reporting as a group for CQM also report as a group for the EHR objectives.

Josh Seidman – Office of the National Coordinator

Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Comments?

M

Josh, when you do that, what do you have to do as an individual in that scenario? So you have to have an EHR, do some of your doctors not have EHRs and they're still in the group or what?

Josh Seidman – Office of the National Coordinator

Well, I think these are some of the questions that were raised, so those are some of the things that you should discuss.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me separate them first. The CQM group reporting, so the notion there, as George stated, was we're encouraging people to act like a team when you've decided that's how you're going to function from a patient care point of view and you want to be measured as a group. So that I think is in common to both option one and two. How do people think about that? It is consistent, I think, with our previous discussions. Does that make sense, any issues there?

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

Paul, it's David. I think philosophically it's right. I have a pretty hard time imagining it working very well given the diversity of these groups, the ..., they're organized by ..., and that's an auditing question, if you like, I don't know, if you have a large group, what the representation of numerators and denominators really ends up meaning. But I think it's a matter of trusting that they're doing the right thing and maybe CMS will have some mechanism to validate it. I think we all agree it's the right principle. Whether we should raise any of the technical issues, I'm not sure it's worth doing that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think in these 20 questions they have for us the technical issues are buried in there, so they're probably looking for some guidance for something that we can offer. Okay, so your sentiment is, yes, it's obviously

where we're trying to head, but it could be very difficult to answer all these individual questions. Other comments?

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

This is Amy. I think philosophically working as a team and moving ahead is where we want to go and makes sense. I think there are, at least from some experience here looking at some of the data at patient-centered medical homes both at the practice and provider level, there can still be a fair bit of variation across providers in a practice. And maybe it's the choice of the practice what to do and we shouldn't be dictating it, but I'm just raising it from a learning and feedback and quality assurance, quality improvement feedback loop I think there is some value looking at individual provider practices within the same practice and variation across that to drive improvements to where you want to go as a group. I just wanted to put that out there. Whether that should be forced or not is another question, but I think to one extent if you require looking at it individually you're forced to look at it a little bit, and I think that there's probably sometimes, in some instances, more variation than realized among practitioners in the same group practice for the same CQMs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me respond a little bit to that, Amy. Nothing about MU prevents people from doing things on their own.

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

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And what you're talking about is QI, and what we're trying to do is set up the functionality in the EHR and the various reports so that you can do your own QI. So I'm not sure that we're trying to legislate QI in this particular point, do you see what I'm saying?

M

Well then what about that, Paul, what about accepting the opportunity for group reporting but saying that somehow it should be and that because an EHR should be able to tell a provider how they've done as an individual on those things that are purely electronic. EHR will have to have the capability, because there's always the option of individual reporting, so we actually already have it covered.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We already have that patient list, etc.

M

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think CMS has done the right – so what they've done is separate out, and you've got to make sure they're using a certified EHR, you've got to make sure they're using it meaningfully, and that's by individual, but not penalize people for what they're doing now, which is group reporting, or at least in one scenario. I think we have it covered, Amy, on what you said, which is we already have a prescription that you'd be able to produce patient lists by individual.

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

Yes. I just wanted to raise that point. I would hate to lose the momentum to drive that, because I think it is an important quality improvement and learning feedback loop component.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. I don't know how this happens in the background from a technical standpoint, but the requirement is just to generate the patient list, it's not in any way tied to any sort of quality improvement or quality measurement. I guess I'm wondering, does that come automatically? I guess I'm not trusting that it does. A list of patients by diagnosis is not all that useful if you don't include other kinds of information there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me try to – we're trying to make sure that EHRs can produce, and actually this is something we're working on too even in Stage 3, real time reports back to the individual about their patient, ... in whatever high priority conditions they're looking at, and over time that's what you're going to be paid against anyway. We're just trying to make sure the EHRs have the capabilities for you to do what's good for your patients and to respond to changes in payment policies. But we're not prescribing specific things outside of the CQM objective.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I'm just thinking –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

... if that was helpful.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... I'm not sure if the best model for quality improvement, if you have a group, that the best model is each doctor doing their own quality improvement. In other words, in a hospital generally you work as a unit and you don't have each doctor deciding which quality metrics to focus on. So it might be a tightly knit group, and maybe I'm wrong here, but I just don't know the answer, whether in fact encouraging group quality improvement is better in a 25 person group than encouraging individual quality improvement effort. So that's why, because we don't really know certainly what works perfectly ... giving CMS the option of opening up the option, I guess is palatable to me.

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

This is David again. I have to say the more I think about and look at this list, the more worried I get, because I think as George indicates, ... accurate, that would be fine, but there are a lot of groups under a common ID that are very diverse, they're business units, they're not really practice teams I think in reality. And that, and maybe Amy said, and even these questions identify a number of areas where if one individual within the group does "x" or "y" or has a different set of quality measures that are relevant and so on and so forth, I have a feeling we're going to end up with a mess, so we don't really know how to interpret the data that comes back from these I think CMS is already worried about the ... as a reporting unit because it doesn't have any clinical homogeneity to it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Could we say that we support an option but we think that they need to think about what comprises a group?

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

That would be good. I don't know if that's realistic, but I think it's accurate because they don't have any way to get the ... level at the moment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And you're saying implicitly, David, that like an IPA reports under a 110, is that the way it goes?

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

Or even a small group practice. I'll talk to groups with four or eight docs who they're all practicing basically solo under one –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes.

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

And I just don't know. And if they're multi-specialty group then obviously picking which 11 measures are going to report is going to be an interesting thing to interpret, and who, as they say on this list, which doctors opt out of which measures and pick which exclusions and so on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, and which EHR.

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

At the end of the day I don't know what we have back if I'm sitting in CMS' shoes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Could people look at, because as I say, there are probably 20-some things and they really are picking on the detail, I don't know whether they were thinking about the group – well, I know they got requests for group reporting, including one from us, so we may not have taken it to the next step that David was talking about and say, wow, in one scenario it could work really well, like at Kaiser it can work really well and that's what it was intended, and that's how the health reform was setting us up to be. In other scenarios it could be pretty hard to even know what's going on if you do this lumping without any true integrated group. If you look at these questions that are asked here, do they have to use the same EHR, do they even have to use a certified EHR? Actually they have to because even the CQMs required a certified EHR. Do they have to be the same one? What happens when they practice in more than one group? What about the 75% threshold? There are all kinds of questions.

Eva Powell – National Partnership for Women & Families – Director IT

Paul, this is Eva. I think from a consumer perspective the concern would be that ultimately somewhere down the road for reporting purposes we need to be able to use that information for patient selection and patient decision making and if it's only in a practice level it can be useful to a point, but unless, as David was saying, the practice is working truly as a team, you could get lumped with a physician who is not performing at a level that you were led to believe given the performance of the whole practice. And I'm wondering if we've got any information based on Stage 1 of the why's and wherefore's as to why people want this. I get that it's consistent with health reform, but I, like David, worry that this is more from an administrative simplicity standpoint, which certainly I would support if the net result is the same, but I think that's unlikely to occur if practices are really looking at this as a simpler way to attest to meaningful use and they're really not performing as a team. So maybe part of the solution is to keep this on the table for Stage 3 and ask for testimony or input from practices who would be doing this, and getting an idea of what their actual practice is like before we go down this path.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It sounds reasonable. Other comments? The one approach, and I think there is some momentum about the devil in the details it raised, is potentially to withdraw our previous recommendations, recognizing the complexity of this and making sure you do the right thing. And either CMS, once it gets its public comments, will decide the same thing, in which case we might go on and have a hearing about the desirability of group reporting and how you would do it, because that seems to be the really challenging piece, and in preparation for looking at Stage 3. Is that an acceptable way to respond?

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

This is Amy, and I support that. I think there's a lot of complexity here. I think we want to do the administrative simplification but we don't want to throw out the ultimate goal here of quality care by all providers and letting that get buried in here in some way. I support that. I think this needs more time to really get figured out.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

I agree. This is Leslie.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is George. A lot of these questions are outside of meaningful use scope, so I'm not sure that we're the ones holding the hearings. I think the Policy Committee would have to figure out how should payment adjustments for the group reporting be handled, that kind of thing. I don't know, I hate to reduce flexibility, though. I just wish there was some way of being supportive of flexibility. I don't have a simple answer.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. At least in my mind the batch file reporting is fine, as long as in all cases quality measures and functional measures, the numerators and denominators are reported by provider. So basically you could have a batch file sent and therefore reduce administrative burden that way, but the file has to contain provider specific information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a different question. And if that's the question, and maybe Josh knows the answer, if it's simply whether you can, through registration, submit a batch file that contains the same information but don't do it for all 1,000 people in your group, yes, that's an administrative decision. Is that what you're asking, Josh?

Josh Seidman – Office of the National Coordinator

The proposal from CMS regarding the batch file reporting was that basically they could report individual numerators and denominators for each EP but that each EP had to meet each threshold in order to qualify for payment. It's basically just a way of creating one entry point into the submission of data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That we don't have any problem with. What about the CQM part?

Josh Seidman – Office of the National Coordinator

CQM is in a separate session that is proposing an option for actual group reporting of quality measures.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we can make the comment, Michelle, for the notes, I don't think there's anybody here that is in disagreement about batch reporting of the same thing just as an administratively simpler way of doing it for large groups, for example, but that we are reluctant to move forward currently with group reporting at the CQM level. And in that sense I think we're withdrawing our recommendations for that piece because we recognize that there's a lot of complexity in there and unanswered questions that we can't get to in this amount of time, and if they're not going to move forward with this in Stage 2 then we would do probably further hearings on this so that we can better understand the issues and the potential benefits, because we were interested in the concept initially.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva again. Sorry to belabor the point, but if the proposal is for the quality measures, the clinical quality measures to be reported by group with only one numerator and denominator, could we not split the difference, so to speak, and just say in order to promote administrative simplification that too could be done by batch file but the numerators and denominators have to be submitted by provider. I don't know how all of this happens, whether that would actually be useful or possible or what, but that might be a way to allow for better information with regard to the group reporting, but still allow for the administrative simplification.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

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

Based on that, Eva, then it sounds like you're saying still a payment is based on each individual provider meeting their own CQM.

Eva Powell – National Partnership for Women & Families – Director IT

Oh yes, absolutely.

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

And that’s where I think part of the issue, where the flexibility comes in.

Eva Powell – National Partnership for Women & Families – Director IT

Yes, but I think that if they’re each having to report individually through whatever portal CMS provides, and again I don’t know exactly how this happens, because this may not be useful, but it could still offer some level of administrative simplification and say they can hire a secretary to report all the quality measures in a batch file for each of the individual clinicians. I don’t know. It’s not worth belaboring.

W

I think the question is if the billing is generated by a provider ID which is a group provider ID then that’s one process. If the CQMs are actually reported by individual provider IDs, that might be another process. So I do think we need to know more.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay, so, Paul it sounds like people are supportive of batch reporting for administrative ..., so that’s a no-brainer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I wish we could put in some kind of caveat, in other words, what we’re doing is we’re encouraging the health system to stay the same, saying there are hospitals among the groups of doctors and there are individual docs, and that’s how healthcare should go forward and not encourage innovation in a sense of having groups of doctors that truly work together. I don’t know how to stipulate that in this rule, though, but the goal was that you work together, you get paid together, you do your quality together, and you all have to do well in order for your quality to be good enough. And we just haven’t found a way to do it yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think in our response back we would discuss how as we’ve thought about it more in terms of the details and recognized a number of challenges, we maintain the benefit side of acting as a group when that’s truly what you’re doing, and we need to do further work to come up with recommendations that would be feasible to implement as far as assessing their function as a group. I think, consistent with the spirit of what you just said, George, I think we need to do more work on it.

Okay, we have ten minutes left. I’m trying to look down at these remaining comments and see what we could tackle in that amount of time. That’s going to be a little hard. Let me just ask whether there’s a fairly consistent answer to ... question. I’m now on page two of the comments tab and I’m looking at a question that asks whether we should include “when applicable” functional and cognitive limitations as an extension to the problem list. I’m not exactly sure where that came from, but, Josh, if you have any clarifications I’d appreciate it.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. Could I just ask for a broader clarification on this tab and on this grid? It’s a lot longer than it had been, so is the intent that ONC staff has captured both the specific questions included in the NPRM as well as the results of our discussion thus far along with additional questions that we have asked?

Michelle Nelson – Office of the National Coordinator

Most of these items are things that have been asked within the NPRM, so they’re specifically asking for comment on them, and maybe this group will decide that it makes more sense for another workgroup to look at these. I’m not sure. Some of them we may have touched upon in our discussion, but the specific question is still noted on this tab.

Eva Powell – National Partnership for Women & Families – Director IT

And the right column, the Meaningful Use Workgroup comments, and on a number of them there are other workgroups mentioned. Is the intent there just to flag we need to touch base with this workgroup about this, or is the intent we're handing this over to them to figure out?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's more the latter, because there are so many corrections some of these are clearly we do have workgroups that are clearly working on this, for example, Quality Measures Workgroup, so we're not going to comment on them and actually the Quality Measures Workgroup in this example is going to present directly to HITPC their thoughts. They'll eventually go all into one letter back to CMS and ONC, but we've divided up the work.

Eva Powell – National Partnership for Women & Families – Director IT

Okay, and I need to read more on the detail here. It just seemed like there was an awful lot ... other workgroups and some of the ... that I thought we might have settled on an answer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Please look at that, Eva, and note where we either settled it or whether actually some of the things are referred to other workgroups, like the first one that we went through.

Okay, so what I'm looking at is row 11 and it's under the summary of care record, the definition of list, and there's a solicitation of comment on whether the problem list should include functional cognitive limitations. And Josh, if you have any further clarification on what the ask is here, let us know.

Josh Seidman – Office of the National Coordinator

I don't really have any further clarification.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's –

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

Can anyone share how functional and cognitive limitations is being defined here?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't think any of us know. Presumably – I don't know presumably. I don't really know where this came from.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie. I think we have to know more, because with a problem list is it either accumulative or episodic in nature and this might be something that carries forward inappropriately. So I'd sure like to know where this

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

If this is talking about developmental delay, that's one thing, or learning disabilities, there's a whole range here that without clarity it's hard to – it's important to have all that information in the context of giving care to the patient, but I'm not quite sure I understand what the issue is here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Maybe speaking as a provider this is what always happens, is where applicable you mention things that are important on this patient that you know about this patient's health condition, and if there were functional economies of limitations that are important for this particular patient we would have that ... problem list. It's hard for me to understand why this is called out separately.

Michael Barr – American College of Physicians – Vice President, PA&I

Paul, this is Michael Barr. I'm with you too. I was like, well that is part of the problem and I'm not sure why it's a separate question. I was just wondering if I was missing something. So I'm with you on this, I think that is, and should be, part of the problem list without any special calling out of it. If somebody has

dementia or anything like that it's going to be part of the problem list, whether it's short term delirium or longer term dementia it's going to be recorded, because the EPs and others need to know that the patient is either susceptible to delirium or has some cognitive impairment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so I think if there are no further comments, Michelle, we're saying this is like any other health condition of the patient and would appear when applicable.

David Tao – Siemens Health Services – Interoperability Champion

This is David Tao. They've always defined problem list as current and active diagnoses and so by using the word "diagnoses" they seem to have narrowed it down beyond what could be in it. Do we think that that is too narrow, I mean, saying that it would include at least those but they just –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David, actually, the provider definition problem is more expansive, it's not just a diagnosis. We don't have a great common definition we all share, but that's at least part of the teaching in med school.

David Tao – Siemens Health Services – Interoperability Champion

Right, so that's what we mean by them defining it more narrowly do we think that they've inadvertently excluded stuff that providers want to and should be putting on. Granted, it doesn't preclude you from putting it on, but when they say just diagnoses the EHR vendors may say, okay, that's all I'm going to put is "diagnoses." If it's something else I won't put it on. Should we comment that maybe they should be more broad?

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. I think that to the degree that we're talking about things that are diagnoses, it's probably fine just to go with what already exists. But I guess from my perspective I share a similar concern in that it's something to me that's really critical to know about a patient when you're developing a care plan and their own self-management plan is can that person read. And that, I suspect, is probably not among the list of things that are routinely recorded, and that would fall, to me, in the category of cognitive limitations that would be critical information as we're trying to engage patients more in their care. And there are a host of other things that are along those lines that my guess is that they aren't currently collected or aren't currently collected as part of that specific field and would probably need to be called out in some fashion beyond just a diagnosis.

Michael Barr – American College of Physicians – Vice President, PA&I

Eva, this is Michael. Let's not confuse cognitive impairment with –

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie. The –

Michael Barr – American College of Physicians – Vice President, PA&I

...with health

Eva Powell – National Partnership for Women & Families – Director IT

I'm sorry, Michael. What did you say?

Michael Barr – American College of Physicians – Vice President, PA&I

I said let's not confuse cognitive impairment with health literacy issues and those things –

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Yes.

Eva Powell – National Partnership for Women & Families – Director IT

I'm not talking about health literacy. I'm talking about literacy.

Michael Barr – American College of Physicians – Vice President, PA&I

If they can't read it might be a health literacy issue, not necessarily a cognitizant impairment

Eva Powell – National Partnership for Women & Families – Director IT

No, there's a difference in health literacy and literacy. You can be quite literate and be health illiterate. If you are –

Michael Barr – American College of Physicians – Vice President, PA&I

I'm with you. I'm just saying that cognitive impairment for clinicians has a very specific definition and it doesn't include literacy issues or health literacy issues necessarily. It's more along the lines of mental status issues, Alzheimer's, those kinds of things, so you're absolutely right, it needs to be recorded and we must be careful of the terms we use.

Eva Powell – National Partnership for Women & Families – Director IT

Yes, and I think that's ultimately the point here, is that what is the intent? Are we intending only to collect things that are of a clinical diagnosis nature? And if that's the case then we're probably good with the way things are currently done. But I guess I would argue that the broader read of this, at least in my mind, was what the intent was, to collect some critical information because it does have huge implications for patient engagement and the ability to follow through with care plans, and currently there's not really a good place to put that. So if we need to –

Michael Barr – American College of Physicians – Vice President, PA&I

Eva, those would be recorded in education history, social history, there are screening tools that can be used. In fact, there's a whole other – the problem list is a specific area of the record that ... so you're absolutely right, all those ... are recorded and there are places where they should be.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

This is Leslie. So the patient demographics and the certain status of the patient can be collected as part of the patient context I think the question on the table was does the problem list only cover that ... and if it shouldn't ... conditions and diagnoses it could be actual discharge or diagnosis, or other. I think SNOMED, the standard, allows for a lot of nuance here, so that's really good news. But I'd sure like to know what the rationale is behind those too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we're at the end of our time. And from a problem list point of view I think we have a response, and if Josh uncovers some other perspective that we're missing then I think we can revisit it. But I think it sounds like any other problem on the problem list. So we have another call, I don't know that we'll finish all these comments. If people could take a look at this tab before the next call and have some thoughts, we'll try to cover as much as we can then. We'll be able to prepare, Michelle, I think all of the responses that we've had today, and we've done a really good job of ... off of the objectives and probably most of the comments and questions and we'll just try to finish up some on the 2nd before our presentation on the 4th.

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

Paul, we do need to ask for public comment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, please.

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

Are we ready?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

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

Okay. Operator, would you open the lines, please?

Operator

(Instructions given.) We have no comments at this time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, well thank you very much. Thanks for your vigorous participation, and we'll continue at the next call and continue to make progress. Thanks, everyone.

M

Thank you.

W

Bye.