

**Meaningful Use Workgroup**  
**Draft Transcript**  
**May 1, 2012**

**Roll Call**

Operator

All lines are bridged.

**MacKenzie Robertson – Office of the National Coordinator**

Good morning everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please be sure to identify yourself before speaking. I'll quickly take roll and then at the end, ask any staff members to also identify themselves. Paul Tang?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Paul. George Hripcsak?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks George. Michael Barr?

**Michael Barr - American College of Physicians**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Michael. David Bates?

**David Bates - Brigham & Women's Hospital & Partners**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

David. Christine Bechtel?

**Christine Bechtel - National Partnership for Women & Families – Vice President**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

All right. Neil Calman? Tim Cromwell? Art Davidson? Marty Fattig?

**Marty Fattig - Nemaha County Hospital (NCHNET)**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Marty. Joe Francis? Leslie Kelly Hall?

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Leslie. Yael Harris? David Lansky? Deven McGraw? Greg Pace?

**Greg Pace – Social Security Administration**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Greg. Latanya Sweeney? Robert Tagalicod? Charlene Underwood?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

And Amy Zimmerman? And if any staff members on the line can please identify themselves?

**Josh Seidman – Office of the National Coordinator**

Josh Seidman.

**Michelle Nelson- Office of the National Coordinator**

Michelle Nelson, ONC.

**MacKenzie Robertson – Office of the National Coordinator**

Okay, thanks. I'll turn it over to you Paul.

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

Great, thank you MacKenzie. So, I want to start out this call by thanking a couple of people who have been sort of joined us recently and just have been hitting the ground running, and that's Michelle Nelson and MacKenzie. Both of them jumped in at a time when there's a flurry of activity, not that that isn't our normal state, but, I think it's just gotten more intense over the past couple of months, as we prepare for the Response to the NPRM. So, I want to thank both of them for ably keeping up with the pace, as far as their help. We do have a full agenda both today and as you know tomorrow we're meeting in Washington. The format for tomorrow is something that the Standards Committee did, and so we're trying to. . .it's mainly because of the pressure of time, so we have to get our transmittal letter in by May 7<sup>th</sup>, which is just a few short days after we meet tomorrow. So, we're going to try to keep track of the comments in real-time. We won't wordsmith during the meeting, but we're essentially going to go line by line through the Meaningful Use objectives, and we'll have a separate feedback from the Certification and Adoption Workgroup. Quality Workgroup, Mary Jo or MacKenzie or Michelle, how are we handling that one?

**Michelle Nelson- Office of the National Coordinator**

So, there is one objective that they have a comment on, so that's included in the document that we're going to review today. But most of their other things kind of fall into. . .there's a other comments category and then Measure comments, so that's for. . .

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

So, we'll be going through that after our Meaningful Use objectives, at least tomorrow?

**Michelle Nelson- Office of the National Coordinator**

Um hmm.

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

Okay. So today, what we have left to do is we had a couple of small groups going off to help solve some of the details from our conversation last time; one was Clinical Decision Support and the other was Public Health. So, we'll start out with those two topics, then we'll pick up where we left off, which was Care Coordination and HIE. Then we'll go back and all of the other workgroups have been meeting as well, and up to the last minute, like this morning for example, Information Exchange Workgroup had a meeting and Micky was kind enough to share their final conclusions with us. So, we'll go back and try to reconcile some of the things that we deferred to them, there are a couple of things that they deferred to us, so, we'll try to reconcile and have the least amount of surprise as we can for tomorrow. How does that sound?

**M**

Good.

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

Okay. Let's get started and actually, this is on the PowerPoint that was sent out. This is on page 4, and this has to do with the CDS small group, and just to remind you, we started out. . .stage 1 was implement 1 "CDS rule." Stage 2 we had proposed going to a flexible approach with saying hey, instead of proposing oh you've got to do a rule and you've got to do a reminder, whatever those different types are, why don't we just describe what the attributes of a clinical decision support intervention is, and that is what came back in the NPRM. There're a couple of things that differed and wanted to just address those two and open up for discussion. So, with the five attributes which came out in the Certification NPRM, one of the things that got added to was attribute 1. We had said, make sure that the source of citation supporting that CDS intervention is made available to the user, the clinician, and the NPRM had other attributes in there, one of which was like. . .see, I don't have that one in front of me. . .is that handy?

Anyway, there were additional attributes and so we were suggesting, up for discussion, to just go back down. We didn't want to burden the user, the healthcare organization with having to post a lot of things and add to the reading burden of the person that's trying to make the decision, like answering CPOE. That's why we were narrowing back one of the proposals, to narrow it back and then we can have discussion today. The second is there was an additional special call out for linked references. Now in fact, in that call out, they even refer back to the other attribute, so, it seemed like that was a little unusual in the sense of it was calling out for a special one type of CDS, i.e. linked references, and we were trying to avoid that, that was our original philosophy and just to describe what attributes would apply to see this intervention. So, we're thinking to propose for this group's discussion, not having a special call out for one specific type of CDS. So, those were the two changes from the NPRM that are more consistent with our recommendations. Let me just open that up for discussion. We could start maybe with the source citation for the CDS, and if I can. . .if somebody can find what was in the NPRM quickly, so we can read that out. . .

**Michelle Nelson- Office of the National Coordinator**

I can read it. So, with source attributes, enable a user to review the attributes for each intervention or reference source for all clinical decision support resources, including video graphic citation including publication, developer of the intervention, funding source of the intervention development technical implementation and release, and if applicable, revision date of the intervention.

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

Okay, comments?

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Michelle, this is Leslie, may I ask a question? Was there a reference to context at all in there, so that there was the thought of passing patient specific context in order to query information for the clinical decision support?

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

I can answer that Leslie. It's part of the other five attributes, so we. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

. . .okay, I thought that. . .great, I just wanted to make sure. Thanks.

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

So, we're only talking about the source attribution right at this moment.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Wonderful, thank you.

**Marty Fattig – Nemaha County Hospital (NCHNET)**

Paul, this is Marty. My concern with this whole thing is that if we get too much verbiage in there, physicians are not going to use it, they're not going to take the time.

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

That was part of our thought in terms of, is there a minimum necessary, is there a critical few that is important, without overburdening either the visual or the amount it takes to implement this. Any other comments about this?

**Greg Pace – Social Security Administration**

Can we have all this information available by another click or something, rather than when initially popping up with the decision support statement, or. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

. . .this is Leslie. Generally, it is in the background as a reference click.

**M**

Wonderful.

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

And one of the considerations, let's say, looking at some of their additional attributes or subattributes, a funding source, I think this doesn't refer. . .the funding source of the intervention development technical implement. . .that's a lot of words, but, it sounds like it's not the funding source of the trial, which as you know, most of the international journals subscribe to having a disclosure, so that's sort of built in to the publication criteria. Maybe this is referring to other things and I suppose if there are other funders of a particular intervention, just like in the published literature, those should be transparent. So, whether there are organizations receiving funding for a special type of intervention, or, I don't know, maybe a vendor's receiving funding, whatever it is, those should all be transparent.

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

So Paul, this is Charlene. Are these like all require. . .I mean, from a certification view, we're required to do this, but if it's not. . .like, if these are developed internally, again you can kind of say the funding forces the organization, but some. . .

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

Correct.

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

. . .times it's not relevant. So, are these kind of option. . .as pertain. . .ask each. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

This is Leslie and generally when they're self-developed, the attribution is just as clear, because there has to be the sense of how to go back and change it if there's a change in medicine, so they have the source and they have that information, whether it's internally developed or not.

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

I wonder Charlene, to address your question, whether the language is something like, um, the funding source other than the healthcare organization that's implementing it, because everybody understands all the salaries are paid for the folks that are implementing in your organization. If there are external influences that would be germane to the person receiving this intervention, then that should be transparent. So, maybe we can word it so that it is, you know clearer to say exceptions to normal fund. . . you know, normal external sources other than the healthcare organization implementing the rule. . .the intervention, should be transparent.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Sound's great.

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

Okay. Good. Let's move on to the second one that the small group talked about, which is the special call-out and the recommendation of the small group is not to have a special call-out for "linked references." Any objections to. . .suggesting. . .

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

No, otherwise it gets workflow cumbersome.

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

Right.

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

Yes.

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

Okay, are we agreeing on those two suggestions from the small group then?

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

Okay by me.

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

Okay. And then, George has some additional comments that we've put into the comments in this PowerPoint under public health, so we'll turn to them when we get there, how's that?

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

Yes, public health, we're going to get there later, at the end of the slides, right.

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

Correct.

**M**

Right.

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

Okay, so let's move on. Where we left off was under care coordination, and it was with HIE testing. And the question that's posed in the NPRM is whether. . .they're suggesting in the NPRM is that because of the complications, really complications in interpretation of what does a test mean and who do you have to test with and, even though they said you could pass or fail, it sort of became very complex. . .you know, there was a lot of unintended negative consequences from what we intended, which is, just to have the systems being capable of exchanging information. So the proposal in the NPRM was to actually drop the criteria altogether for Stage 1, and then to pick it up in Stage 2. So, our. . .when we went through. . .and they offered four options. So the IE workgroup, which is who we deferred to, came back and agreed with dropping it, and selected option 1 that was presented in the NPRM, which is to drop it completely. And

we had talked about taking option 4, which is not to drop it, but to have instead of just a test, to have an example of one successful transmission. So, further comments on that? With a bit of the bias as we sort of are deferring to the Information Exchange Workgroup, for their opinion.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Paul, its Christine. I guess at the Policy Committee meeting, when Micky spoke, we did talk about that, and I think there was. . .it almost sounded to me, and I may have not totally heard him correctly, but it sounded to me like the workgroup thought about the fact that the test wasn't effective, but didn't look at the other options around, you know, having one case example. So, I wasn't under the impression that they fully even considered that, and when we floated that with Micky at the Policy Committee meeting, he seemed to be okay with that. Do you have a different recollection?

**Michelle Nelson- Office of the National Coordinator**

Christine, this is Michelle. I've sat in on the IE workgroup meetings and they did resurrect that coming out of the Health IT Policy Committee. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

. . .oh, afterwards, okay. . .

**Michelle Nelson- Office of the National Coordinator**

. . .and they still came to this conclusion.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Do we have a sense of why?

**Michelle Nelson- Office of the National Coordinator**

So, I can read their discussion points. . .I don't know. . .Josh, is that appropriate to read here and go through that?

**Josh Seidman – Office of the National Coordinator**

To read what they stated?

**Michelle Nelson- Office of the National Coordinator**

Yeah.

**Josh Seidman – Office of the National Coordinator**

Yeah.

**Michelle Nelson- Office of the National Coordinator**

Okay. So, their discussion points are, according to CMS statistics , the objective has not been widely chosen by EPs or EHs to date. One contributing factory is likely confusion about the intent and requirements of the objective, and this was a comment the workgroup made in Stage 1 recommendations. Another point they had, is while we understand that removing this objective will eliminate the only care coordination measure from Stage 1, this measure is not well enough defined to result in an appropriate escalator towards exchange. Next point is, we do not recommend replacing the objective because relatively few providers will be affected by it, as the Stage 1 cohort diminishes over time, the intent of the objective is achieved by Stage 2, interoperability requirements; we want to minimize the number of changes made to Stage 1 requirements, to reduce market confusion. And the last. . .do you want more?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

No, that's fine. I guess the concern that I have about that Paul, is one, and the group was confused about this because we had some discussion about it in the Policy Committee, that Stage 1 doesn't end, I mean, anybody can pick up Stage 1 for the next several foreseeable years, so, you know, everybody starts at Stage 1, that's the escalator thing. Now, I think the big difference is that if, let's say, you begin Stage 1 in

2015, the software that you buy will have to be. . .it won't be just Stage 1 compliant, it would be Stage 2 compliant as well, so, it means that it will have the transport standards that are currently, assuming the rule. . .it does stay in when the rule is finalized, but it will have the capability to extract information and everybody will have the same two sets of standards, even in Stage 1, they'll still be Stage 2 compliant software, so I don't understand why we would not ask both to, you know, begin to think about. . .I would actually argue for more than just one actual transmission, since the software is capable, but, we have to begin to get folks thinking about the workflow changes inherent in doing care coordination and I have a very difficult time supporting removing the only objective that is about care coordination from Stage 1, given that Stage 1 is going to be in place for several more years.

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

Well, let me try to paraphrase what I heard Michelle read from their comments. They're basically saying. . .well, first of all, the folks who have been dealing with this in detail, CMS and ONC, said wow, there's been a lot of confusion about this and it became more effort and burden to everybody trying to implement this criteria, than was worth it in terms of what they, both the healthcare organization and ONC got out of it. So, they're just saying, withdraw it. Now, I think what the workgroup is saying is, and why would we come back with something else that could be confusing, when in fact everybody is going to get to the place, exchange of information, anyway by Stage 2; and people are not limited saying oh, I'm not going to do any exchange until I have to do Stage. . .it just doesn't make any sense for people. When they have a need and they have the software and the community agrees to exchange, it seems like they will do that, because it's a very valuable function. But, I think the workgroup is saying, why replace one confusing requirement with another, let's just add this piece because it's going to come anyway.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Which I agree, you don't want to replace it with another confusing one, but as I understand it, the reason it was confusing is because there was absolutely no guidance given to what is the content of the data that you have to exchange, and there weren't transport standards that were in the Stage 1 certification rule. So, we're remedying those two problems, but I think where the major driver of the fact that people just couldn't achieve the objective, they didn't know what counted for what and what data to send; so, if we clarify that and we know that the software is going to be capable of it, then I think the burden of implementation is absolutely not the same, as it definitely was in Stage 2. And given the. . .you know. . . we constantly hear the low number of providers who attested to Stage 1 in year 1. So, there're going to be far more people who haven't attested yet, and who, you know, need to be able to have this capability and demonstrate that as a core part of Meaningful Use. So, I just am not convinced that if we do address the burden of implementation issue, which you're raising, but there's a real issue here given that you can technically start in Stage 1 and you could stay in Stage 1 and avoid a penalty. So, you could get to a point where you can be using an EHR for like, you know, it sounds like ever without having to do anything on care coordination. And, yes I agree, my hope is that the market shifts with ACOs and medical homes, and we have a different payment system. But I think we are a long ways off from that.

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

Other comments?

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

This is Leslie. I agree. I think that because we did a poor job of defining something that was still new, does not mean that as it matures, we don't get better at it and we don't push for it to be done. So, I think it's just that giving up is not acceptable when we're on a reach. . . .we're trying to get people to reach and go beyond the norm.

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

Paul, this is Charlene. Again, the feedback from many of the customers, again, has been that by having to do this reach, and help them understand that they needed to collect the data. . .one comment was, as we're trying. . .what's really important in care coordination is that the data about the care is collected. So, the question starts to come up as you're starting to implement these systems, okay, you have to achieve 50%, well, the whole process drives you to collect a greater percentage than 50% because you ask, okay, what 50% of patient's aren't I going to collect the data on?

**M**

Right.

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

So, it does start to really drive what we need to have happen in Stage 1 which is to start to get the data collected.

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

Wait, and that's relating to this HIE test?

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

Yeah.

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

So, as a vendor you're saying that this is useful?

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

We're not the. . .again, you know, the customer's aren't what is the test, that's the stuff that comes up, but. . .and they're not typically intimidated by doing a test. But, the fact it's on the list, they have to think it through, they have to make it part of their project, starts them down that path of understanding what it's going to take to have exchange.

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

Uh huh. Okay, anybody else?

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

It's not easy. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

This is Leslie. I do think an implementation guide with something that's active, ongoing for people to make tests against, is an important part of whatever testing we come up with, someplace that people can actually do a real-time test against the system with a response required and not just a one-way pane is important. And, I think if there were a testing mechanism with which any vendor could certify against a standardized test, then we would get further along, not only in promoting interoperability, but also having a standard implementation test set for people to use so it's not as difficult or as cumbersome for both the vendors and the users.

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

Okay, so the sentiment I'm hearing is we'll present this to the Policy Committee tomorrow and we'll have to come up. . .maybe it comes down to a vote of which way we go, but, we'll come up with some resolution so that we have a position to respond back to CMS and ONC. Great. Okay. The next one has to do with med reconciliation and the IE workgroup, we sort of deferred to them, is that they would recommend exclusion criteria for certain either specialty or clinical situations where med rec would not be warranted. Now the trick of course is to define that, but that's their only change to this recommendation. We did come back thinking that it should. . .the threshold should remain the same at 50% for reasons we've talked to before.

**Deven McGraw – Center for Democracy & Technology – Director**

Paul, are you on the slides, because we're not following the slides. . .

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

Yes, could somebody advance the slides please. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Well, I mean, I'm on the slides, but we went from CDSS to like a bunch of slides forward on exchange and now, okay, I think we're on. . .

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

So, what we're doing is, we're going to where we left off, sorry. So, could someone advance the slides to. . .

**Michelle Nelson- Office of the National Coordinator**

It's slide 18.

**W**

Thanks.

**W**

Thanks.

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

Thanks Christine. Trying to look at things in front of me and the paper. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Oh, I got you, yes, all right.

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

There we go. Okay, so that's what we're looking at, the bottom section. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, go.

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

So, we had previously commented on, we think the threshold should remain 50% and the other point is that actually when we're talking about a denominative transition, somehow, someone has to indicate that a transition is about to occur. That's an interesting new, unfortunately, documentation requirement. Any comments on the IE workgroups recommendation about exclusive criteria for specialties and clinical situations?

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

I guess I'd have a. . .so, are we saying for orthopedic medicine for example, is that a specialty where you wouldn't have to do med rec because it doesn't involve medicines typically, or I'm not sure. . .anybody else who participated on the call understand?

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

Well, I don't know. . .like chiropractic umm. . .there may be some that literally don't, but it was literally not relevant. . .

**M**

Okay.

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

Well, you want to know what the medications are probably anyway.

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

So, that's one approach, is people who do not prescribe medicines, so that seems clear.

**Michael Barr – American College of Physicians**

Paul, this is Michael Barr. The other issue is requiring specialists to manage the details of medications that are not prescribed in their normal scope of practice. So, it might not be that they never, but that, you know, to use your example, orthopedics, and there's a bunch of cardiology related medications, do we want them doing reconciliation when that should be the cardiologist, the internist or so on.

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

Good point. So how would we define those situations?

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

This is Leslie, you asked a question? So, when the patient is moved into the specialist, the specialist does need to know the drugs that the patient is on. . .

**Michael Barr – American College of Physicians**

. . .that's different than the reconciliation which includes the frequency, the dosage, all those things. I agree, the medication list, but reconciliation goes beyond that; at least that's our understanding. So, it really should be. . .there should be some clinical judgment involved here and not just be automatic all the time. Because if the orthopedist is going to prescribe a pain medication, clearly they want to know what's going on; but medication reconciliation involves a lot more than just what the list of medications is.

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

For example, are they on other pain medications for other. . .illness. . .

**Michael Barr – American College of Physicians**

Right, yes, I mean, that's the clinical judgment issue, but if they're not going to prescribe anything, do they really need to do a whole medication reconciliation?

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Wouldn't they do it for preop?

**Michael Barr – American College of Physicians**

Well again, that's where the clinical judgment comes into play, you can't have one rule that's going to guide every single clinical situation. And that's what this sort of implies, that it's an all or none. I think what we're calling for is let some clinical judgment reside here; obviously a physician's not going to want to prescribe something without knowing the medications. But, let's say a primary care physician, after a hospitalization definitely wants to do medication reconciliation for everything. Likewise the cardiologist, after discharge for a surgical procedure, is going to want to see that patient's reconciliation, did they continue all your cardiology medications, did any get changed? The orthopedic who's seeing you for a broken leg, is going to want to know if you're on any pain medications, if you have any renal insufficiency. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Right.

**Michael Barr – American College of Physicians**

. . .and that kind of stuff. So, there's a lot of judgment involved in this, that doesn't get picked up by the way it's written.

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

The NPRM is pretty vague. . .I'm on page 104 in the NPRM, the original version. It's pretty vague about what does it mean to perform medication reconciliation.

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

So, I wonder. . .so, either we or CMS, has to come up with precise wording, or one of the approaches we've used in the past is you make the threshold low enough so that it will catch all these other times

when it's not appropriate, or. . .it's, I don't have those conditions in my specialty. It almost. . .I wonder if it's closer to the latter, which is have a lower threshold so that all the appropriate reasons for not doing med rec would not penalize an individual, yet, like we've always said, it it's 50 or whatever it is, you're not going to say, oh, yes, I think this is one of the. . .you know, half the patient population where I don't have to do this, that's not what people think about.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

But isn't it worth defining it well, because, I mean, depending on where you're sitting, someone might consider just getting the med list, reconciling it, because they are using clinical judgment to determine whether or not that impacts their current care or whether they need to do further action. Because, as we look at the goals, trying to improve quality and reduce cost, one of the key areas in transition is medication management, test management and so forth. So, I agree that clinical judgment has to be accommodated, but maybe our comments are both "or" or "and," a stronger definition of what reconciliation is, that accommodates clinical judgment and a threshold that matches that. But. . .

**Michael Barr – American College of Physicians**

Hey Paul, this is Michael. I mean, maybe I'm. . .I think it was George who said it was on 104, it's also on 105 of the PDF and it says, I'm assuming we're talking about the same measure, 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital as the CAHs inpatient or emergency department. Those are specific cases that aren't really picked up on the slide here. Am I looking at the right place and reading it correctly?

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

Yes.

**Michael Barr – American College of Physicians**

So, I mean, those are cases where I think generally there should be good. . .the full transitions medication reconciliation. But the slide makes it sound like it's a lot more instances where this should take place.

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

I think that's a good point. Um, can you read that phrase one more time?

**Michael Barr – American College of Physicians**

Sure, it's on page 105 of the PDF, the proposed measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospitals or CAHs inpatient or emergency department. So, they're specific situations where they're saying that should happen.

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

That's very helpful Michael. So, if we went with that definition, then I think we'd be: 1. It feels more precise, it doesn't mean you don't do it for any other times, but at least you know what's being measured.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

And so would you then take it back up to a higher threshold?

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

What do people think about that?

**Michael Barr – American College of Physicians**

I guess. Paul, this is Michael, it depends how well we can measure when those instances are.

**David Bates – Brigham & Women's Hospital & Partners**

Yeah, I'd rather leave the threshold here and then. . .and going through how we've done, just measuring locally, it's really tricky to find the right instances.

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

Yeah.

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

Paul, this is Charlene. From the vendor community, we feel like at least on the EP side, you've got to like say, this is one of those situations, this is a transition. . .

**M**

. . .correct. . .

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

You're going to have to acknowledge it, because there are situations where it's just not relevant.

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

So, this has an additional documentation requirement on the part of the EP. . .

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

. . .on the EP. Just so there's. . .so you get that baseline.

**Michael Barr – American College of Physicians**

Charlene, this is Michael. I believe in the subgroup we talked. . .Meaningful Use Workgroup, we talked about there'd have to be sort of a check box or indication by the EP, that this in fact meets whatever definition of transition that we're accepting, right? Because that's how it would be placed into the denominator.

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

We're trying to get away from this, this idea. . .

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

. . .I know, I just feel like how we, from the vendors when they talk this through, they kind of came to that conclusion, that was just a feedback from them.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Eventually we'll have, with more interoperability, we would have order to referral and order for electronic preadmission messages going back and forth, so it becomes a little bit easier with that automation in the future.

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

Okay, so let me try to. . .

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

Paul, can't we. . .this is Charlene. From the customers too, I think, as you're doing. . .at least in the hospital side, the process is still really tough, so, as you start to work through, and then working it through, which is the goodness of it, but, starting to look through the coordination from the admission process and in the specialist change of orders and that type of thing. So, a lot of things happen, actually, you know, while the patient's receiving care too, which makes the whole process more complex. So, you know, I think it's still a struggle on the implementation side, so I'm a little concerned. . .I can listen to David, I'm a little concerned with 65% and I think most of the feedback is coming that it should be lowered a little bit for Stage 2. I recognize we're the Policy Committee, so it's hard for us to say that, but. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

On the hospital side, they're doing this anyway. So, it's really the eligible provider part that the concern exists.

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

You know, it's actually, I think, on both sides still.

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

Let me try to recap what I've heard. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Paul, can I just say one other thing, it's Christine, which is, and I'm not arguing on a threshold issue at all, but, it does seem to me that wouldn't this objective be supported by and potentially enabled by, the next objective on providing a care summary for 50% of transitions? Because that care summary should have a med list in it.

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

Well the process though, it's more than having the med list exist somewhere. The process is really a comparison process and the reconciliation. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Right, right, but at least they've got that some path with a comparison.

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

So, let me recap where I think we've gotten and I think this makes sense, and I think Michelle that we'll have an MU Workgroup comment in here when we review tomorrow. . .

**Michelle Nelson- Office of the National Coordinator**

Yes.

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

One is, we've already captured the fact that we. . .there is a documentation criteria associated with this that is a transition, either is about to or has occurred. Two, that we. . .and we might put that language, the numerator language in there, that we agree with the definition of a transition as proposed in the numerator definition and three, that we would recommend that the threshold remain at 50%. I think that's what we've had out of this discussion and we'll just enumerate that in the comments that we'll present tomorrow.

**M**

Right.

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

Okay, let's move on. The next one has to do with summary of care records, and so, this has to do with the so-called summary of care document that includes a referral, the reason for referral or transition, the results of the referral, i.e. the recommendations and we point out that in order to know that this is needed, that you need to put this information in the summary of care document, the EP would have to indicate that a transition is about to occur, like they are referring somebody. We had previously said we would recommend that we like the part that it crossed organizational barriers that thought for a number of reasons, and I think all of the workgroups and committee feels that crossing vendors may have unintended consequences and literally not be possible in certain areas. So, the IE Workgroup. . .

**Michelle Nelson- Office of the National Coordinator**

Umm Paul, can I just interject that first item for the IE Workgroup, late last night they removed. So, it's just 2 and 3 now.

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

Okay, great. I was going to have to explain, I couldn't explain. Okay, good. So, remove that first one.

**W**

What slide are we on?

**Michelle Nelson- Office of the National Coordinator and Paul Tang, Chair – Palo Alto Medical Foundation**

Nineteen.

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

So, the second one we already agree with, that is, not have the cross-vendor requirement. The third point that they have, has to do with, and I think it's just sort of the fine points. So, it does not. . .you don't consider it a transition if you. . .if somebody else actually shares your EHR, now, it doesn't quite say that, so let me ask the people for comments on that. So, they said exclude from denominator if they have the ability to view or query. I think the point is. . .that's not exactly the same thing as saying you share the EHR, and that may be a point of clarification there. And then they had another one, and maybe somebody can comment on their motivation of excluding a provider if they have fewer than 50 referrals. Why would that be?

**Michelle Nelson- Office of the National Coordinator**

They were afraid in the few, you know, one-off situations that somebody. . . because right now, the exclusion is 0 and they thought that could cause an undue burden on somebody that does, you know, just a random amount, you know, less than 50, so they wanted to make sure that there was something higher than 0. Does that make sense?

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

Is that for. . .so, there's two pieces to this. One is the 60% have this summary of care record document and the other is, 10%, you know, are electronically transmitted. Are they referring to the first or second?

**Michelle Nelson- Office of the National Coordinator**

The electronic piece.

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

Okay, that makes more sense. So let's. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

But all they would have to do is send 5 electronically, so that's what they're trying to exclude?

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

Well the fact that you. . .so, if you only do some small number, let's just leave that for right now, then should this requirement force you to connect electronically?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Right, I mean, because it's a percentage, it's the lower your number, the lower the times you would have to transmit electronically.

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

Correct.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I mean, it's hard for me to imagine a provider who should not be connecting with others, at some level, electronically. So, I'm really glad though Paul, that you clarified, you know, are we talking about the paper or the electronic.

**Michelle Nelson- Office of the National Coordinator**

I think their point was that the math doesn't always work, so, if you only do 5, can you get to 10%, or, you know, they were playing around with the numbers a lot.

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

It is hard. I mean. . .if you're, I would assume that if you're a smaller provider in a rural setting, you may have a number of other small practices you refer to, but maybe none of them have more than, I'm just making this up, 5, and so, should you connect to 10 different providers to achieve the 5 referrals.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Well, but you. . .it's not. . .the denominator is the number of transmissions, not the number of providers.

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

I understand, but see, if you have, let's say it is 50, but they're 50 to 10 different providers, 10 different specialists let's say, then each of them only have 5, and are you. . .in order to capture the 10% of 5, you'd have to, let's say, connect with 5 different providers just to get that 10%. It does seem burdensome in certain areas.

**Michael Barr – American College of Physicians**

Paul, this is Michael. I could tell you that our internal ACPs committee was concerned on that very point about small practices being able to do that by 2014 or 2015, because of the challenges of connecting.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So what if you said. . .okay, what if the exclusion was if you've got less than 50 referrals, then you just have to do one electronically?

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

Actually, that was a bit of where I was going, and where we've gone in the past, which is. . .this is a case where people have an incentive to have the data move seamlessly and so, getting that to happen and enjoying how the benefits of that is our goal, and presumably then they would follow where the data really normally goes to, that is, their clinical trading partners. So, that might speak to having a small number, rather than a percent.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Right. . .

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

. . .to get away from this math problem.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

And Paul, this is Leslie. It would count, would it not, if I were to exchange through a health information exchange. . .

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

. . .correct. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

. . .with other partners, so in a rural area, whether we put in one or 50 or 100, the likelihood of people developing 10 different interfaces for their trading partners is not high. So, the opportunity will be for the health data exchange to act as an intermediary in those small areas, not just because of this requirement, but because it's not affordable otherwise. So, if we take into account the health data exchange as an intermediary, does that change the concerns?

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

It doesn't change the concern because of the same reason, there are very few providers, there are very few health information exchanges, so, we get into. . .so the theory's correct, in other words, you know, that might be a much more efficient approach for the entire community, it's just that there's not a whole lot of them around these days.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Well, and I think that's why the direct, you know, standards are also in the certification rule too, because that's a little bit less costly.

**Leslie Kelly Hall – Senior Vice President for Policy forHealthwise**

Exactly. I think that we have to say. . .not looking at the most costly way that they'd achieve this, but are there opportunities of doing this through direct to a HISP, through an HIE, through the EMRs interfaces which would be most expensive. If we're trying to get the interoperability, we have to start somewhere.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yup.

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

So, and I think let's start with this "start somewhere" piece. Our goal is to try to help people connect electronically so they can enjoy, they can see and appreciate and enjoy the benefits of seeing the transmission of health data, where appropriate. And so, to get people started, maybe in this case, where we just talked about all these small numbers, should we go with a low number, and start that process? And, I mean, I might even throw out, just like our other HIE requirement, can we just start with one?

**Michael Barr – American College of Physicians**

Paul, this is Michael. I think that's a reasonable place to start and once they see, again, the value of it, hopefully would generate some more activity. I do want to make sure we didn't skip #2 on this slide, which is the cross-vendor requirement, because that might play into this too.

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

I think we're staying with our recommendation that it is not cross-vendor.

**Michael Barr – American College of Physicians**

Thank you very much.

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

That cross-vendor is not a requirement. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

But, what about the cross-organizational is still there, is that correct?

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

Yes, that's correct. Correct. So, let me hear other sentiment about starting with one.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy and I'm late, can you just clarify. . .so I apologize and I've missed a few calls on both the IHE Workgroup and yours as well, because I was traveling a couple of weeks. But, when you say one, do you mean one electronic transmission of a care summary?

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

No, one connection between two different organizations that there's and electronic. . . there is successful, ongoing transmission of the care summary. . .the summary of care document between two different organizations.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Okay, thank you.

**David Bates – Brigham & Women's Hospital & Partners**

This is Dave Bates, I'm just wondering if there should be some minimum, like 5, if you're below 5 you should get a pass, I. . .

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

You're still looking at even a pass, and exclusion I mean.

**David Bates – Brigham & Women's Hospital & Partners**

Well, I am. I mean, it seems like if you have one, to require you to do it electronically. . .

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

Yeah. . .

**David Bates – Brigham & Women's Hospital & Partners**

. . .it would be hard.

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

Yeah.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

I'd rather have the pass in that you can get the main group of people doing a lot more and allow for an exclusion for that small group, rather than lower the bar for everyone.

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

And Paul, this is Charlene, I think I'm on that page too because when. . .if we can get the business pace for some of these HIEs to start up and be sustainable, even though we've got direct, there's just a big public health value of going in that direction. So, it would seem like where it's potential to bring together synergy to get to move that agenda forward, I think that would help us.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

So, maybe it's 25 or less. . .

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

Twenty-five or less total referrals or transitions?

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Yes.

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

Okay, so, asking for one ongoing electronic connection between two different organizations unless you have less than 25 transitions or referrals in a year.

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

I still don't think it's just one, I was trying to say how do we have a pass and still achieve more penetration?

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

So is that greater than one, or how do we do that?

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

So, this is George. Now, remember that this is where care plans and teams and all that stuff went, so, we'll be eliminating care plans and teams for a number of providers.

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

No wait, we're just doing the electronic part, so. . .

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

All right.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Why. . .I'm not understanding George's comment, are we eliminating something from the electronic transmission. . .

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

No. No, no.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay.

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

Okay.

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

So I guess. . .in response to the, how do we get more to happen, our thought here is partly escalator. . .but we're constrained by the maturity of the market, which is not very mature.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Right.

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

So we're trying to get people to go through the learnings of how to make a connection, and enjoy the benefits of that connection and we're counting on as the market develops, well people are just going to want to enjoy more of the benefits. So that's why this being the escalator part, the beginning of the escalator, we're trying to move in that direction and it's clearly a tangible move. And yet we're. . .and the only reason for exclusion is to protect what just doesn't make any economic or even clinical sense if you only have 5 transitions, you can certainly do that easily on paper and effectively. So, let me just put that as a comment to vote on then.

**M**

Yeah.

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

At least one ongoing connection between two different organizations and the exclusion would be fewer than, what's the number David?

**David Bates – Brigham & Women's Hospital & Partners**

Five.

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

. . .fewer than five, you would be excluded from this requirement if you had fewer than five transitions, that means transitions between provider and transitions as hospitals.

**Greg Pace – Social Security Administration**

This is Greg. I'm okay with that except for one modification. I don't think we should penalize those that might want to make that connection using more than just direct, let's make it for both direct or some other exchange.

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

That's fine.

**Deven McGraw - Center for Democracy & Technology – Director**

Thank you, this is Deven. They just should have to use one of the approved standards.

**Greg Pace – Social Security Administration**

Agree.

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

All right, we have agreement on that?

**M**

Yes.

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

Okay. A couple comments now, I'm reading in the green section, the green. . .if I got this right Michelle. . .are some of the comments related to the. . .it came back from the HIT Policy Committee.

**Michelle Nelson- Office of the National Coordinator**

Right.

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

So, the first comment is critical to think about the technical capability to merge fields, I think that's the certification criteria, so, it's not specifically an objective that we're dealing with, is that correct? The point is, over time, we want this to be coming back as structured data, so, that each of the systems can deal with it; that and I think you deal with in certification criteria.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Agreed, the EHR should be able to both ingest or send.

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

Okay, second one I think we just covered, on is that direct counts, i.e. any accepted standard should count and I think among relevant providers, we sort of dealt with in our clinical trading partners.

**Greg Pace – Social Security Administration**

I agree with that change. Any standard should count.

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

Yes. Okay. And I think the third bullet is sort of tied up with the first bullet.

**Michael Barr – American College of Physicians**

Paul, it's Michael. I agree, but I'm not sure what it actually means in terms of changing the metric.

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

I don't think it's changing our objective metric. . .metrics about objectives, it would go into the certification criteria.

**Michael Barr – American College of Physicians**

Got it.

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

Okay. . .I think that's. . .

**Michael Barr – American College of Physicians**

. . .Paul, what about the last bullet, need to be able to send to non-MU EP and have the transmission count?

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

Where's the bullet?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I think that's the case already. . .

**Michael Barr – American College of Physicians**

Yeah, I think that's good too, I just want to make sure we didn't skip it.

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

Oh, it's not on my (indiscernible). Okay, fine. Okay. Then I think we're ready for Public Health, that would be slide 21. Okay. . .

**Christine Bechtel – National Partnership for Women & Families – Vice President**

What about. . .okay, so 20 is. . .that's all, your skipping 20 because we're all fine on those?

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

Yeah, I don't think there are any changes. George, did you want to walk us through the population public health?

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

Okay, so we previo. . .remember, that Stage 1 was a test of capability to submit to immunization registries, Stage 2 we recommend to actually move towards using the thing and so the NPRM talks about successful ongoing submission of electronic immunization data. They added the phrase, except where prohibited in accordance with applicable law and practice. Our first comment was that it may be challenging, remember, for public health departments to be fully prepared, so we felt if HHS, CMS and ONC decided that there had to be some prioritization, that immunization would be the highest priority. So, that's just a statement, it's not saying that they have to change anything, but, if there is a prioritization immunization would be the most important.

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

Can you explain the comment, it says, "We're concerned about the except where prohibited.

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

I haven't gotten there yet.

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

Okay.

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

And so now we need clarification on "except where prohibited." We're saying that there was, I believe it was inserted because the previous phrase, "in accordance with applicable law and practice," may have been interpreted to mean, you only had to do it if it was required by law. So, "except where prohibited" pushed it forward a little bit further to say, well no, it doesn't have to be required by law, but, if it's excluded by law, you shouldn't be doing it. Umm, so then we were concerned that in fact now the pendulum had swung to the other side, that participation should be encouraged beyond transfers required by law. So we agree with the sentiment, but we were concerned about unintended consequences. In other words, what role does the Public Health Department in saying no. We don't want to create a situation where cities are passing laws to prohibit transfer because according to Meaningful Use, otherwise their Health Department will have to. . .or their region, you know, their Health Department would have to transfer the data their not ready for, so they would actually provoke the passing of new laws just to prevent their doctors from losing out on Meaningful Use. So in other words, so basically what we're saying is, in the result, we're saying clarify what you mean by "except where prohibited," and to you literally mean every doctor who's in a state or in a city where it's not prohibited to transfer the data, must transfer the data, whether or not the Health Department can accept it, to qualify for Meaningful Use.

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

So where do you transmit it to?

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

You just would not be eligible for Meaningful Use, and that's what worried us about "except where prohibited." So we don't want to create a situation where people can't qualify, if it's not prohibited by law.

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

So, if you were able to transmit, and your Public Health Department can't accept it, how do we account for that?

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

I don't think you can hold them responsible if the Health Department can't accept it period.

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

So, how does this requirement allow for that?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I thought the exemptions is where that accounts for that. I thought that in the exemptions, just like now, you would take an exemption if your Health Department is not ready to receive.

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

Correct, because that's in the applicable law and practice. Yes, so the applicable practice for a Health Department that doesn't accept it, is that you can't transmit it.

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

So that's fine, so then what does "except where prohibited mean?" If it's in accordance with applicable practice, then why do we need the phrase "except where prohibited?"

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

Yeah, I think. . .

**Michelle Nelson- Office of the National Coordinator**

I think it was for the Sovereign Tribal Nation.

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

That they were. . .

**Michelle Nelson- Office of the National Coordinator**

That's what they specifically refer to in the NPRM.

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

Yeah, I'm looking at page. . .where am I. . .118-119, let me find it again.

**Michelle Nelson- Office of the National Coordinator**

So, there's one part where it says there are a few instances where EPs, EHs and cause are authorized or cannot submit to a state local immunization registry, for example, in Sovereign Tribal areas that do not permit transmission to an immunization registry or when the immunization registry only accepts data from certain age groups. That's what they . . .

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

So, I guess the question was, they felt that in accordance with applicable law and practice did not adequately account for where it's actually prohibited, is that what you're saying Michelle?

**Michelle Nelson- Office of the National Coordinator**

Correct.

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

Okay, so actually it's the opposite interpretation.

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

Well, the NPRM says, for Stage 1. . .actually, if you look at the Stage 1 section, because we proposed to add "except where prohibited," to the regulation text because we want to encourage all EPs, hospitals, CHs, to submit electronic immunization data, even when not required by state or local law. Therefore, if they are authorized to submit data . . . okay, so maybe that's the caveat, they should do so even if it is not required by either law or practice. There are a few instances where they're prohibited, for example, Sovereign Tribal. So, if they are authorized to submit, they need to do so, even if it's not required by practice.

**Michael Barr – American College of Physicians**

George, this is Michael. Does that get at your concern that the. . .

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

The authorized might. . .

**Michael Barr – American College of Physicians**

. . .but. . .

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

What does authorized to transmit mean?

**Michael Barr – American College of Physicians**

Would they all only be authorized if the receiving entity was capable of receiving?

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

That's a good question; I don't think they state that.

**Michael Barr – American College of Physicians**

Right, because. . .

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

We're just asking for clarification in that paragraph, on page 33 of the original PDF.

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

Okay, so I think our message is pretty clear about it being confusing and the only thing maybe that would help, Michelle, is in the e.g. on the slide, you said need to pass new laws, but we're not requiring them to need. . .our concern actually is the temptation to pass new laws that would prohibit in order to. . .you see what I'm saying?

**Michelle Nelson- Office of the National Coordinator**

Yup.

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

There may be just a word change, so that we at least can explain our concern.

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

Yeah, I mean yeah, we just want a clarification and this was the clarification on our clarification.

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

Okay.

**Michael Barr – American College of Physicians**

This is Michael. One other quick question, I mean, are we also stating that this is only applicable if those entities are capable of receiving? Correct?

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

In theory that falls under the applicable practice.

**Michael Barr – American College of Physicians**

Okay. In theory it is, I guess that's what needs clarification.

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

Well, that's the background for that phrase, and we might just be asking. . .

**Michael Barr – American College of Physicians**

The other key, I'll just say that. . .you know, just offer comments that I've heard, is there's an interest in having that be bidirectional exchanges, so the EP can be informed by what the registry already has about the patient, because that would be critical. . .

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

Correct.

**Michael Barr – American College of Physicians**

. . .communities. . .

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

So we were just. . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I think that's a conversation for Stage 3.

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

Correct, that's where we're headed. . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

. . . and the Public Health Group is, when we get to Stage 3, has started. . .this is Amy. . .has started to talk about that. I don't think we're going to be able to get there for Stage 2.

**Michael Barr – American College of Physicians**

I agree, I'm not. . .I'm just saying that that's. . .I mean, among the provider community, there's a great interest in that so they can help understand, particularly about adult vaccinations as an example.

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

Right, right. . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Yeah, sure. No, I mean, I agree and I think we've. . .I think that's. . .I think it is a Stage 3 discussion and should be part of a Stage 3 discussion.

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

Okay. Anything more on this one George?

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

So the need one stated to communicate with registry, that's a good thing. I think by registry, that was a comment by the HIT PC, they meant all 5 things, not just the registries, and so we can agree with that, but that standard . . .the original workgroup comment broadened the exclusion criteria to include circumstances where the immunization registry has designated health information exchange to receive information. I don't understand what that's saying, it means that if there's an HIE you don't have to send data?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy and again, I've missed some of those workgroup calls as well, but the way I read this and my understanding is, if the HIE were going to do it on behalf of the providers. So, my understanding is, and someone can correct me if I'm wrong, is right now, if there is no transformation involved, then the HIE wouldn't have to be a certified component and could, on behalf of the providers, send all the immunizations to Public Health.

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

So that would count towards this objective for that provider, no?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

So, I think what they're saying is, if you're going to send through your HIE all your immunizations, then you wouldn't directly have to send, because your HIE would be doing it on your behalf. I think that's the intent as I read it, but again, leave the caveat that I've missed a few calls.

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

So instead of exclude, maybe they could use a better word that means it counts towards your thing, rather than you don't have to do it, which is what was confusing about this statement.

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

Provided you have documentation that proves that your HIE is sending it. . .

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

Yeah, yeah, yeah.

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

Okay, so we can add that verbiage, but as George is saying it's not excluding you, it's saying here's one way to satisfy that. If you ultimately are getting your information electronically to the Public Health Department or an immunization registry, that satisfies this; but, you have to prove. . .you have to have that chain of proof that shows that it's getting there.

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

Now, I have not . . .the second half of the slide, I have not assessed. Michelle, do you have a summary of what they're saying in the second half?

**Michelle Nelson- Office of the National Coordinator**

Umm, essentially some of the things that you'll want to keep in mind is they want to uniformly use HL7 2.5.1 rather than permitting 2.3.1 and 2.5.1 as you could in Stage 1. And they're also proposing to grandfather in those who successfully tested in Stage 1; but, if somebody got an exception for Stage 1, they would not be grandfathered in.

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

So why is this a Policy Committee . . .

**Michelle Nelson- Office of the National Coordinator**

I was just putting in their comments overall, these are overall Public Health comments that they have. . .

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

Okay, I mean, it seems reasonable and they've softly discussed it, but, hopefully this is going somewhere in the HIT Standards Committee, yes?

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

Now there's . . . go ahead.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy. I think the more important part is around the defining successful ongoing submission.

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

Yeah, 10%, increasing by 10 points to Stage 2, that's the specific recommendation on the thresholds, I'm just looking. . . I'm not sure CMS really wants to implement a threshold that's changing like that.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

So my, and again, I missed some of those calls and I've just not been able to keep up like I wanted to, but, there is a lot of concern in the public health community about successful ongoing submission, that it's too vague and it needs more clarity. So, I think that there is clearly support and that came out of public health, saying there needs to, because ongoing submission, there are all sorts of vagaries that come with what that means. Although, I'm not sure actually, I mean I know I've gotten feedback locally that's saying that's sort of the actual . . . you know, that maybe where the state should make the decision is the percent of qualifying transactions to a maximum of. . . like maybe that shouldn't be standard across the board, but that's where the state could set it, but that there be some sort of more defined criteria. So, that's sort of, maybe, I don't know if that makes sense or not, but I'm just sharing some of the feedback that I've heard locally, in my community.

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

So, we could agree with more specific criteria. I don't know if I would do the sliding scale thing, but, we could agree with being sufficiently explicit. What do people think?

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

What's an example of wording to be more specific about ongoing transmission?

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

Is it 100%, is it 90%, is it 10%.

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

Oh.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

. . . and there were questions around time frame, you know, is it in 30 days, is it in 2 days, is it. . . you know, 5 months, which would make the. . . you know, render the data not as useful. There are also questions about interruptions in transmission, what does that mean? What if there's a period where the system goes down and isn't transmitting . . . so, maybe some of those could be applied to other things too, but I know these were specifically for public health folks issues that came up.

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

My suspicion is that CMS wants to be as general as possible and actually be inclusive and count delayed transmission and imperfect transmission, because it's the beginning of this thing and it's not clear what the Health Departments can handle. And so we probably don't want to rack it up to a very high threshold very quickly. Although to be useful, the data has to be nearly 100%, where we're talking about meeting the Meaningful Use objective, you know, doing this in a stepwise fashion. So, we don't have to comment on. . . this wasn't one of our comments. . . do you think that we. . .

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

I'm hoping that the Standards Committee will . . . (indiscernible) deals with some of these issues. They're very important ones and, as Amy was saying, it applies to more than registries, obviously, all of these HIE. . . exchanges have associated security and reliable delivery and we see all of those issues that need to be worked out. Probably it's in the certification function, which is more in the Standards Committee.

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

Yeah, most of that paragraph is Standards Committee, except the thresholds tend to be set by the Policy Committee.

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

Yes.

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

So the question is, do we leave it successful ongoing? Is our recommendation to leave it at successful ongoing or to say it should be more defined?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy and I would vote to say more defined, although I'm not sure I would make it the way it's defined there, but again, I missed the calls and weighing in on that, so, I didn't hear the full discussion of how they got to that.

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

So I think from the Policy Committee, it is successful ongoing and the additional comment is we recognize that the definition of successful ongoing needs to be further defined. But, it was our, you know, our intent is sort of 100. . . you know, once you turn it on, it's 100%. But, all of these other intervening factors, we need to be able to account for them. That was our code word for more than a test and more than just one. Okay, should we move on to . . . the next one is on slide 23, having to do with syndromic surveillance.

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

Well, for syndromic surveillance, we left it as above; the IE workgroup comment is that it supports the proposal to make syndromic surveillance core and menu for EPs. We obviously disagree with that; the as above specifically said that immunization was the highest priority and syndromic surveillance was lower, so this says that this should be your core requirement for hospitals. We're not particularly commenting on whether it should be core or menu, just that immunization is more important than this. So um, but we, you know, in general were pushing towards these becoming core, right, was our. . . our proposal was core, right. . . in Stage 2, by the HIT PC?

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

Yes, as a matter of fact. . .

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

. . . 3 should become core. So, this is not in disagreement with that, my point is just they seem to be highlighting out. . . highlighting syndromic surveillance as a critical one. . . oh, maybe they're just saying they should track-back EPs to menus, so in fact, they're agreeing with us, they're kind of ratcheting back and saying well maybe it should stay core for hospitals, but not so stringent for EP. So, I don't know their intent here. If they're saying this one can be ratcheted back, I guess that's agreeing with us.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

No, I think what they're saying here is that they wanted core for hospitals and menus for EPs. . .

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

Which is consistent with the NPRM.

**Michelle Nelson- Office of the National Coordinator**

Right.

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

So, are we. . .

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

Oh, I'm sorry, yeah. . .

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

. . . in agreement. Are we in agreement. . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Look at the first set of comments, that's exactly what they're saying, right?

**W**

Yes.

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

So, what are we saying?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I think we said the same thing.

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

We've gone further and said in fact, if you get too much feedback, that this is too hard to do or that syndromic surveillance does not have sufficient benefit to outweigh the cost to public health agencies, then focus on immunization registries. That's what we've said. If you look at the cost benefit of immunization registries versus syndromic surveillance, it's different; immunizations have very tangible, immediate benefits. Syndromic surveillance is also very important, but not the same as immunization registries.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Yeah, I would say for. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

This is Leslie, but where there is opportunity for data harmonization and retrieval I think we want to make sure that's included. So, whatever they prioritize, for instance the 22 fields that are in syndromic surveillance, we want to make sure that those field requests are the same that would be descending – or at least harmonize for immunization, if immunization is a top priority.

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

Oh, I think it should be harmonized, yes.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

So, I don't think we should lose that.

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

I agree, and I'm not saying we shouldn't do this, we were just prioritizing. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Right.

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

So, let's go on then.

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

Okay, so the outcome is we stay with the NPRM, which is EP menu and hospital core.

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

Well, what we actually say is, the quote . . .so maybe, Michelle, maybe we should just repeat our comments, instead of saying as above.

**Michelle Nelson- Office of the National Coordinator**

Okay.

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

Because when we say as above, people think that means agree that's different. We should just repeat those comments that we had previously, like, needs clarification . . .like, if there's only one, do immunization, need clarification on "except where prohibited," and yeah, those are the two I guess. Do you see what I'm saying Paul?

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

Yes.

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

Okay. For the first registry one, which is for cancer, our comment was: "Need clarification on except where prohibited again, and then, further clarification is needed on what is an acceptable registry to qualify." If you skip down to the green, the Policy Committee asked us to step back and say, what's the basis for selecting a cancer registry; does that make sense in the long term to highlight that particular one? I believe our decision was made because of the more advanced standards in that area, but I welcome comments on that.

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

Well one of the comments were there weren't standards and I don't know who. . .

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

The way we got here in the first place was a report that if you're going to pick a registry, that cancer was further ahead of the areas.

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

So are there any comments, either from the IE workgroup or the Standards Committee about this?

**Michelle Nelson- Office of the National Coordinator**

Well, the IE Workgroup had Seth Foldy as part of the group and he recommended, you know, it was more for everything they talked about is in there and it was related to cancer registries specifically.

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

So, do they think that . . .their recommendation was to actually, for CMS to actually designate which registries, right? And presumably they would decide that based on availability and use of standards.

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

This is Charlene. I kind of have a simple question on this one. Typically those cancer hospitals, the oncology hospitals, I know there's other hospitals that do cancer therapy, aren't even part of the Meaningful Use program and, in many cases, it's pretty specialized oncology systems that are doing this today. So, I sometimes have to step back and, from the vendor community, they kind of agree with you Paul, like, where's the standard here, who's doing it? And mostly it's in the specialized system, so, the whole benefit of doing this, it seems to allude me just a little bit. And I just don't see the. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

This is Leslie, and, I would comment that even a Community Hospital is participating in cancer registries and, because if they are responsible for care in that community. I mean, in our entire state, there is not a cancer specialty hospital. And, so, that's. . .every hospital has to provide some services and actually, the registries become very important as a way to share best practice and communicate around a large geographic area, information about cancer patients in general. So, I wouldn't go there that it's only specialty, because there are many states without that, and still providing pervasive services.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

And if you look at the notes from the IE Workgroup, I think what they're recommending is taking out the reference to state cancer registry, if I'm reading this correctly, as being too limited, and talking more about public health or central cancer registries, meaning defined as what CDC and NCI fund.

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

So I think the main recommendation from them is that instead of saying the vendors have to work with every registry in the country, including hospitals, that CMS actually designates something that covers the country and they were going by state or territory. I think that may be the only out we have, since, one: there's not a uniform standard, across all registries, otherwise that would be, you know, the first approach was fine. But, lacking that, in order to make a start in something that's very important, like cancer that we start working with these centralized registries and that CMS would have to designate them. Does that make sense?

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Um hm.

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

So we're clearly in agreement with the sentiment. . .

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

Yeah.

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

. . . our statement of it was a little more vague, further clarification is needed regarding what's an acceptable registry. So, we agree with the sentiment, whether this is exactly the solution, I'm not sure, but we're not going to take back the IE Workgroup comment, so, I think probably we're more or less in agreement that something needs to be done and what the. . .but on the other. . .go ahead. .

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

In that case then, since this is an IE kind of a function, and we seem to agree with their sentiment, could we just defer to this being an example or will we defer to what they're saying here? So each of us is going to present. I think our position from this call is that we support the fact, you know, the rationale and sort of their compromise solution.

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

We haven't spent enough time assessing their compromise solution to say whether it works or not. We agree that further clarification is needed on what's accessible and then we hand it off to them to discuss their thought process about it.

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

Correct.

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

So, I would just. . .I don't even. . .I wouldn't call it deferring, with what the process is, we each discuss, you know, our comments and theirs and ours will be very short.

## **M**

I think we can go further to say we support what they've. . .

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

Well we support their sentiment, but I haven't sat here and looked up each of these choices to verify it. So, I'd rather have them, since they're the experts, comment on it, rather than have me comment to say that's correct. You know what I'm saying?

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

Not quite, I mean, because we're. . . I mean, the members of the Policy Committee doesn't each individually look through all of this, but we have the same concerns that they do, and their approach seems to be consistent with, you know, something that would meet our concerns. I mean, that's as far as I'm going, that's reasonable?

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

Okay.

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

I mean, how do other people feel?

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

Well, we're deferring on the selection of registries, were not deferring on the other question, right? For example, are we. . . they don't mention the "except where prohibited," that's still a comment we have. Two, do we agree with. . . that cancer is a reasonable thing to single out or not, they didn't comment on it either way.

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

Uhh. Yeah, and that's, in the sense, that's what the Policy Committee said too.

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

Well, the Policy Committee had that. . .

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

. . . why cancer?

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

. . . to consider, basically said, do you really want to do this with just cancer, and if we decide here that yes, we think it's a reasonable approach, then that's our comment back to the HIT PC. But maybe there's better standards and it's certainly pervasive. . . I mean, that was our comment today, this morning, is that it's. . . the cancer registries are fairly pervasive, so. . . that's why it's a reasonable choice. The use of cancer registries is pervasive, I guess.

### **Amy Zimmerman – Rhode Island Department of Health & Human Services**

But, this is Amy, I mean, cancer is one new optional menu set, as is other registries, right? So, am I missing something here, we've called off cancer as one, but, then there's the ability to say as a menu set, other types of special registries.

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

We could, I mean, they're just. . . CMS put forward an NPRM that does highlight cancer, one way or another, because there's cancer in everything else; so, that highlights cancer, and the Policy Committee said that that's reasonable it should just be folded. For example, you could say, let's get rid this objective and just have registries, and not do a cancer objective in parallel with it.

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

Well, that's an idea. . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

To call it out specifically, but, in the end it's the same because whether it's this registry or another registry, they're both menu sets.

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

Well, you suggest. . .

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

Not exactly the same because I could do cancer and, you know. . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

. . .and another registry, yeah.

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

(Indiscernible) so now I've met two objectives.

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

Right. When you're counting how many objectives you did, that's where it changes.

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

So, we're more or less in agreement with the IE Workgroup, we think, and then, except where prohibited and we remain supportive of cancer being singled out unless people feel otherwise.

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

This is Charlene. I thought when we talked about this originally we decided that the standard was more ready. In checking with the vendors, in general, and I don't have an analysis across the vendors, the readiness doesn't seem to be there, but that could apply to other registries too, because it's kind of across the board, depending on what type of practice you're serving. Do we want to just get going on registries and then make it such that, you know, just to start us up, the ability to report to registries or do we want to, you know, single one out?

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

Well, if we don't. . .Charlene, if we don't single one out, then everyone's going to pick a different registry. Now will have non-national registries. . .

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

It sounds like that's like from the vendor community, it seems like it almost has to . . . that's part of the problem anyway. . .

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

. . . well, wait, okay. So from the vendor . . .this doesn't help the vendor because they still have to do "all," but. . .

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

. . . But it's not a good scenario.

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

. . . it helps the nation in the sense that this encourages people to pick the cancer registry so that at least in one area we have national coverage. If you just do the second objective, then everyone is going to pick a different registry, potentially. . .

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

. . . Yeah. . .

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

. . . cancer's also nice because it covers many areas of practice, of course, they'll need to be many exclusions, but it covers many areas of practice as opposed to if you pick a different specialty that only that specialty can participate. So, if you want to pick one thing that everyone can be part of, cancer's probably not a bad selection.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

And also, this is Leslie, from the data standards point of view, I mean, cancer's going to be one of the more complex registries, we nail this, we nail many. So, I think that there's an opportunity to get, you know, more for the buck if we start out with cancer.

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

I think there were a lot attractive features, not about cancer, about cancer registries. What we have found out, because we weren't aware of before, is that standards in this area are not as mature as we thought, we're getting that feedback . . . I mean, that's the feedback we got from the Policy Committee and Charlene's saying that's what its turning out to be from the vendor community as well. So, it still remains a perspective area . . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

I think that's true that. . .

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

. . . But it's not as mature as we thought.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

I think what's mature is the use of them, what's immature is the standards, so, we probably have critical mass achieved if we develop standards to accompany this policy.

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

Yeah . . .

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

Why don't we do this, why don't we move to the next objective and see whether there's something we want to write back, because you'll see, the next objective covers this exact issue.

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

Right. . .

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

If we go to slide 24 . . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Well, so in the next objective, if you look down in the green, the Policy Committee's also making the comment that they feel selecting cancer registry is a disservice. Specifically they say that.

**W**

Is a disservice?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

If you read the fourth bullet down.

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

Yeah, that's what we were answering on the previous slide, that's to say . . . they made one comment, we just stuck it on both objectives.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Okay, sorry.

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

Because it's relevant to both of them, you know what I'm saying . . .

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Yeah.

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

So, we're in agreement with the objective. Our comment on the, this is now the general specialty registry, the non-specified specialty registry. We said we need to consider whether sufficient standards are available to support the interfaces between EHRs and registries, number one. Panelists at our hearing also expressed concern about the proprietary nature of some registries and then also, a number three concern, about this is for the vendor's sake, requiring all EHRs to interface to all registries, how is that feasible? And then we had our usual comment about in accordance with applicable law and what's an acceptable registry. The IE said the same thing, more or less, more specificity in qualifying registries, and then the Policy Committee commented, may not be paying enough attention to government registries; we agreed with that, that ended up actually, the state registries in the previous objective. No standard to describe data elements of registry so that's a standards issue. Advanced directive registry in Maryland was provided as an example, I think of a . . . must have been an example of the government registry; need to step back and look at whether cancer should be highlighted. The comment that other countries are looking to the US for setting the path and that more feedback is needed.

So, I'm not sure that the . . . we've already commented on the cancer part, I'm not sure that the HIT PC comments change our comments. Do we want to vary our comments at all?

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

I think the only . . . one of the options we have is to combine . . . to recommend combining these and just talk . . . in some sense, there's a lot of attractiveness about registries, what you can get out of aggregated data if they were all comparable data, etcetera, and we keep getting faced with, but unfortunately it's not mature in either standards or the models for running these things, in this second registry requirement to talk about a standards and contracts and cost, etcetera. So, we don't quite have, despite the attraction of what we want to do with national registries, it's not there yet, it's sort of some of the push-back.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Well the other, this is Amy. The other thing is, and unless you've already had this discussion, obviously giving choice on registry, not every provider is going to be . . . is it going to be applicable to send to every registry, whether it's cancer or, I mean, the other common registries on sort of the government public health side, some states have birth defects registries, I know there's been funding from CDC to states on traumatic brain injury registry, so. No, but again, thinking about it, not everyone is going . . . not every provider is going to have a birth defect registry, have a need to report to a birth defect or you know, cancer's a little bit more broad, but . . . so, I struggle with sort of, how to define what makes sense for who.

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

So, are we helping in this immature registry by saying you . . . admittedly a menu, but, you must use two . . . I mean, not must, you may have the opportunity two, but then it does count against your, you know, I think its two out of four menu items or is the state of the maturity mean that we should have one category, one objective for registry, it'd still be menu, but you get to choose from a number of things that make sense for you.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I personally am leaning towards the second, because I don't know how applicable, you know, I don't know how applicable the range of registries are to the different types of providers.

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

(Indiscernible).

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

I mean Paul, you could do something where you say, if you want to cut it to one objective, say do cancer if its relevant and otherwise pick another. That way you encourage people to pick one thing so we have a national registry.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

This is Leslie, that's a great compromise.

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

Other comments? So the sentiment seems to be, we like the idea of registries, it is certainly one of the benefits of EHR and HIE, and we would strongly encourage the country to move forward in developing standards for some "minimal data set, you know, standards" that apply broadly to registries and as a start in that direction, that there be a menu requirement to Meaningful Use.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I have a, this is Amy. I have a quick question for any of the providers on the phone, in terms of the cancer registries as they may work today, and I don't know enough about the one in my own state, but, does a primary care provider report a diagnosis, along with an oncologist, along with a breast surgeon? Are they all reporting on the same case, and is it the same data or different data, and then does the cancer registry duplicate that? Like, what's the responsibility on who to send information to the registry.

**David Bates – Brigham & Women's Hospital & Partners**

I think it mostly comes from the oncologist. . .

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

Yeah.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

And, so one of the reasons this is, is because for . . . this is where I'm, and it's my lack of knowledge on how these work, so forgive me if I'm asking an ignorant question, but, does the primary care provider need to report to the cancer registry, in addition to everyone else? So, if we're making this, sort of pushing in this direction, I mean maybe redundancy, I mean I've heard a little bit that redundancy is a good thing, because when it comes to something like skin cancer, you know, you may go to the dermatologist who takes it off, you never, maybe it's basal cell, you may never be in a major, you know, oncology setting. So, it's even different across the cancers and I struggle with this in terms of, while I see and want the value, I struggle with what we're requiring of who for this. And I just don't know if there's been discussion about that prior.

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

Yeah, I think Amy brings up a good point, remember, this is a Meaningful Use for all EPs and I think David is right in the sense of, this is in the sense a specialty specific kind of contribution. In other words, the oncologist report it, it's not the PCPs that are doing this, and yet we're going to put this into things that touch the PCPs, which might argue for giving more latitude, which is combining the registries into one menu objective because of immaturity of the market, and try to move the market more quickly to standards; trying to accommodate and reconcile all the comments that have been made, which are all good. Is that a compromise approach that sort of moves, but yet doesn't penalize?

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

Well Paul, I guess, this is Charlene, can you re-clarify again? I mean, I think moving toward a general approach makes sense, but we know the registries are different today. . .

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

. . . right . . . so we're trying to give the most latitude for, if there's a registry that you can participate in and it provides your organization, your patients and the national good, benefit then, then do that, but we'll consume just one objective, Meaningful Use objective, as a menu option. Does cost . . . (indiscernible)

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

. . . And we won't care necessarily in this phase if they're using a standard or not, they're just reporting? Is that what we want? I mean, I'm okay actually with that, but, I mean, it's not longer term where we want to go, but, is that . . .

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

I think we're obviously promoting standards. What we're hearing is it's not that mature.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Right.

**W**

Because there's never been any batch or required, each registry today operates based on an asynchronous upload, you know, somebody downloads it from the EHR, compiles it and uploads it into proprietary registry. So, there aren't any standards for real-time interoperability today.

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

So somehow we want to certainly put it in the preamble about the need to go towards stand . . . the need to have standards develop for these across the board for registries.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Right.

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

And we'll have to think in our Stage 3, how to start moving it more aggressively in that direction.

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

Right. I mean, this also relates, you know, the feedback we get, even in the public health sphere is that it has been a struggle in Stage 1 where public health isn't ready to accept it in a standard, but, providers are doing reporting today, so they don't even get credit for doing reporting today because Public Health can't stand up to standard in time, so, sometimes I get lost in whether are we . . . is it important to do the reporting or is it important to do reporting with the standard, and should one, you know, it's the chicken and the egg kind of thing, in this particular space category.

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

Right.

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

So if we want them to do the reporting and they get the credit for it, independent of the standard for those . . . that's complex too, but . . . providers that are doing it, you know, that's, you know, that should be goodness, right? I don't know.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

It is hard, because the smaller hospitals . . .

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

This is hard. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

. . . might have been doing this for years, and you're right, it is the goal to have them report and then move to standardization and Meaningful Use 3, it is a chicken and egg . . .

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

So, let's try to close in on a recommendation. So one, we want to express our sentiment about the desire to have national comparative data . . .

**W**

Yes.

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

. . . in registries. Two, it can only be done if we have standards, and so, we really strongly want to push the levers that available to help that come in to being. Three, we do express concern that despite the fact that cancer is a widespread problem, and that registries exist, we're concerned about the lack of standards even there. So, let me have a vote between combining these objectives into one menu objective about registries versus leaving them as two, one being cancer and the other being "other." Umm, which does the group prefer?

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

Okay, so just . . . I'm going to ask a clarifying question. This is Charlene. So, would that apply as a vendor to get certified on this objective, that you have to do all the registries?

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

Well, that's the sticking point . . .

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

Now, I mean, then I'd have to vote no, right?

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

Right.

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

But, it would seem like it should be if you can report to one, you should still get certified even if you can't do all, right?

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

Yeah, but then you're forcing your customers to pick the one you've picked.

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

Right, based on . . . because, what vendors will do is they'll incrementally build 'em, right, based on demand.

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

So, does anybody know the answer to this question or how to get the answer? Is there any standard minimum data set for registries? I guess you'd have to think . . . unfortunately, I think the answer is no, even for demographics, so, I'm not sure how to deal with the vendor problem .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Could we encourage the use of the standards that we defined under syndromic surveillance, those that apply towards the registries, so that somehow we're building upon those standards?

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

I mean, Leslie, from the vendor perspective, if there was a standard, I wouldn't be, like as hesitant.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

I get it.

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

Right, that's all.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

I agree, so is there a way that we say, here . . . any registry that builds off the use of the existing standards as defined in syndromic surveillance reporting, at least we have 22 fields that have been identified. Now, there very baseline, they don't get into the detail required for a cancer or a cardiac or registry.

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

Exactly.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

It's completely absent any specialties to accept care. So, it doesn't meet the goal of cancer treatment, but at least it gives us a start. So, I'm also very conflicted upon this because we want to promote standards, we want to promote the benefits of registries, especially in lifesaving areas like cancer, but I agree with Charlene there's a chicken and egg here problem.

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

Let me try this with you Charlene, what if, since it's impossible to deal with all of the registries, with the lack of standards, what about if the certification criteria had the ability, you know, specified the ability in these products to construct documents that basically send documents to registries, and so the onus about, you know, what fields and how you define the fields that are really between the submitter, the health care organization, and the registry operator, but the ability to compose a document that gets forwarded on, I'm using document loosely, the ability to compose a file that is consumed by a registry, is a function that's in EHR. And that's far from where we want to be, but we're really coming up short if we say you have to interface to even X, the X's. Does that approach make sense, and I'm asking both the vendors and the health care providers on the call to say, hmm, is that a step in the direction?

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

So, Leslie, so this is kind of, I think, it's almost starting like using the consolidated CDA to start to be the beginning of that kind of, right? And then we'd have to start to fill it out accordingly?

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

Um hm.

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

Because it would be that, if you will, document? You know, so certainly being able to do that's something that the vendors could certainly do, but it's just, there are systems today that are reporting, not a lot, but there are systems today reporting and they've already got their own file structures in place and file transfers and those types of things. So, I just don't know the readiness of the registries to deal in that format yet, you know, so . . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

And are the registries all taking the individual patient at a time, or are you expecting to see ongoing communication of all patients every day? So . . .

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

I have another idea. How about if we take the approach . . . the CDS approach. In other words, describe the act if it's a registry and any provider registry connection that satisfies these attributes would qualify, and again, I'm . . . we're just looking for a step in the right direction. So, included in the attributes would be, it's an electronic transfer, and I guess you could say batch counts at this stage, that . . . and that there are certain attributes of the registry. So then we can go back into the issues that we've had, the proprietary nature, the contract restrictions, the extent. Maybe there are attributes that CMS can write up that would help address those problems at the same time we're saying, well just so that you are transmitting information electronically to registries that have these attributes, then you are meeting this, you are meeting this objective.

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

But Paul, that doesn't . . . it's different than CDS because in this case, you're still opening the vendors to the liability of having to interface to everything, as long as it meets those attributes. So, you're kind of saying, okay, here's a little registry, you know, a million miles away, look it meets those attributes so now every vendor has to be able to link to that theoretically. So, it's more about limiting the choices. Whereas to CDS, the vendor's not obligated to supply every imaginable sort of CDS.

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

Right.

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

I think along the same lines, just don't call them attributes. I think . . . we're not at the stage where we can design this thing right now, and the meetings tomorrow. So, what we do is, we enumerate the issues, which are exactly the attributes you just talked about, and we just enumerate the issues and that may be all the Policy Committee can do for CMS in time. And they're going to be getting a lot of input from the public anyway, in thinking about this, we're just going to highlight the things we're concerned about.

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

Uh huh, that's a good point.

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

I mean, from the . . . from our customer perspective, they would definitely, even across public health, have one place to report in a consistent fashion. You know, and it's not so much the reporting, but it's just the variation that makes them crazy, so, the more standard . . . so kind of Paul where you were with, if there was a way to move and expand upon the consolidated CDA as a basis for some of the reporting, although I know some of them do it, not patient by patient, that would be something that would be aligned with, you know, what people are doing today.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

And maybe we give the options, this is Leslie, the consolidated CDA for patient to patient reporting and/or other applicable standards for batch reporting, like syndromic surveillance, and so that give the message that we really want to build upon existing standards, but not be prescriptive about which one.

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

Yeah, okay.

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

Okay, so, we had already enumerated, and I think agreed on our preamble. We can add to it the issues that George was alluding to, here's the issues that have come up, and maybe it sounds like we are still . . . we're consolidating into one menu objective and the reason is because we really up front, are finding it difficult to come forward with a precise way that can be supported broadly. So, one of the compromise is to have menu, that's obviously one compromise and two, to bring it basically into a registry objective and offer these thoughts about some of the things that would have to be overcome in order to make this more robust and able to go into core.

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

But I might still . . . would you still encourage cancer?

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

I don't know that . . . I mean . . .

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

. . . I mean, I might . . .

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

We're encouraging cancer just because it's a prevalent, important problem, but we don't have a better solution for it, unfortunately.

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

No, it's not better, but if we pick none, then we definitely don't have any useful data across the nation. So, if we highlight one, not making it mandatory, but highlight one . . .

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

Okay. So, you're saying make that one of the points we offer . . .

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

Yeah.

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

Okay.

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

And then Paul, I don't know, I mean if I qualify for reporting to the cancer registry, then I should be certified for that objective, not all . . . I mean, that should be okay, right? Because that's really what we want.

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

Yeah.

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

So, somehow the caveat has to be if we go into one objective that I can qualify to do a subset of registry reporting as certified. Because I don't have to do them all to get that check mark, and then, no one will ever get it done.

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

Yeah, unfortunately at this point, this is an exercise left to the reader . . .(laughter) . . . we're trying to offer our best thinking on this at this point, but it's unsolved.

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

Okay.

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

Okay, so . . .

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

There is the security one, although it's just a Tiger Team comment, and I don't see anything wrong there, other than missing a "C".

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

Okay, so we only have 10 minutes left, wondered if we could do one thing that another workgroup has made a recommendation on. I think really the recommendation belongs in this workgroup, as the major owner, but, that is in contrast to our recommendation and I just want to vet this so that we can have a position tomorrow, and that has to do with secure messaging. Umm, you'll recall that we went down . . . let's see, get that in front of me . . . we relaxed the . . .

**Michelle Nelson- Office of the National Coordinator**

It's slide 18.

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

Slide 18, okay . . .

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

16?

**Michelle Nelson- Office of the National Coordinator**

18.

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

Can you put it on the web please? For whatever reason, I don't have slide 18 on mine . . .

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

The slide 16 is secure messaging, no?

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

We're looking for secure messaging, right.

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

Yes, 16.

**Michelle Nelson- Office of the National Coordinator**

I'm sorry, yes, it's 16.

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

Okay, so, um, we thought that 10% was too high, it's 10% of people seen and so we recommended lowering the threshold to 5%, which happens to be 10% of 50%, for patient initiated. We did keep it as patient initiated and, um, and we had no problem with providers initiating some message that patients would respond to. The IE Workgroup talked about having physician initiated message as an addition to the numerator, so, I think the way I'm reading this is that not only would patient initiated, but also physician initiated messages would count against the 5%. I think we were staying with the focus on patient initiated, for one, that's the goal; two, recognizing that it is somewhat out of the control of the physicians, that's why we recommended lowering the threshold; but three, once you introduce a physician initiate, you can see how unintended consequences could arise.

So, this is sort of . . . our thought is to keep our eye on the prize, which is how do we make it convenient, to people, convenient and good access to their health team through electronic means, and so, that's measuring that, but recognizing there's all sorts of reasons, you know, that are in or out of the control of the physician and that's the reason for keeping the threshold low at this point, and also the maturity of both the products and the penetration. So, is there any comment about the IE Workgroup's adding a physician initiated message as part of the numerator?

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

Was, this is Charlene, was the intent that they would respond, or just including that?

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

As far as I can see, it's just adding that.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I think it's adding it because of the concern of how do you hold the provider accountable for what patients do. If they prefer to pick up a phone and call versus send a message, you're holding a provider accountable for that.

**Deven McGraw – Center for Democracy & Technology – Director**

Right.

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

I mean, that's my sense.

**Deven McGraw – Center for Democracy & Technology – Director**

I mean, this is Deven. I think as long as the message that comes from the provider invites a response back. I don't know how you test that, I mean, you know, it's essentially . . . because we, you know, the objective here was to prompt patients to engage, but, I'm in agreement with Amy that some people will want to do so by just picking up the phone and other people will be happy for the ability to sort of click on a link and respond back. But, if you're going to count that as a patient measure, I think at a minimum the provider should . . . that there should at least be an invitation to respond back.

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

But why don't we just focus on what we're shooting for then, recognizing that it's not 100% . . .

**Deven McGraw – Center for Democracy & Technology – Director**

. . . right . . .

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

And really just measure the response back, rather than allow . . . I mean, a physician can always write and that could be a stimulus for a response and that response would count. But if we add complex measures, it seems like we may not get the thing we're shooting for.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy. I mean, in my mind the goal is to start the secure email messaging and get people used to that. So, you know, if you never go to a portal, you're never going to see what your provider sends you, you're never going to send them anything back. But if you get in your email a message, because I know this is how a number of portals work, one that a couple of the places that I get care, you know, you'll get an email saying, "there's a new message for you," you're inclined to go in and look, even if you . . . so maybe it's just the result of your physical and everything's fine and you don't have a reason to send something back, but doesn't that count towards beginning to engage patients and families in knowing that the information, you know, that you can start to exchange information on-line.

I actually personally support the . . . I think as a beginning step, because I really don't know that we're at a point where . . . I think we, again, I feel like we can't hold the providers accountable, I mean, you know, they can push you to say it's easier for me if you send me an email versus call me, I may be able to get to you quicker, but, in terms of their own workflow, but I think there are some people, specifically older patients and others that just may not feel comfortable with that, they want a conversation if they have a question, but, even the fact that they're prompted to go look at something I think is a step in the right direction.

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

So that's already in another. . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

So if we do this both so that it's bilateral, both physician and the patient, then I think we should revisit the threshold as being too high at 10%, I think it's reasonable to go back up to that higher threshold if we're counting both.

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

So, so this is George. So first of all, remember, we're already forcing the provider to send messages to the patients, reminders, educational materials and there may be some things I'm not thinking of. So, we're already encouraging one direction and the idea of this objective was to see if we should measure the response, and so, we could say we shouldn't have this objective or we could lower the threshold to 5%, 2% or 25 messages or whatever, but I think having this message just say you can send messages, other messages, to the patient doesn't add much over our other two objectives that have providers sending messages to patients. So, I would decide whether we want this or not and not change it to be the provider . . . the other direction.

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

So, since we have to get to public comments now, and we're just out of time, let me try to call the question. We already agreed on 5% patient-initiated and let's just add the question of, does the numerator include physician-initiated messages or not?

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

Eh, I don't know, because then it's like we're recommend . . . remember, we had this exact discussion in person and ended up with this.

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

Well, that's what I'm saying, I don't want to really . . .

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

. . . we've objected . . .

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

. . . I'm just adding, just having a vote on whether we support another workgroups recommendation of adding something.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

I agree with George's comment. This is Leslie. This is the only place where we're asking for the patient feedback, participation.

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

So, I think you're agreeing with not adding another part to this, we're basically trying to measure . . .

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

. . . right . . .

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

. . . patients engagement and let me see. So, let me see what everyone . . .

**Michael Barr – American College of Physicians**

Paul, it's Michael. Quick clarification. Would a response from a patient to a provider generated email be counted in the numerator?

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

Yes.

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

Yes.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

Yes.

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

We already . . . we went through that . . .

**Michael Barr – American College of Physicians**

. . . just wanted to have that very clearly stated.

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

In fact, that's explicit in our comments, patient initiated message could be a response to a provider message.

**Michael Barr – American College of Physicians**

Okay, that's our comments, not in the NPRM, okay . . .

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

Oh, I don't know, I gotta check that. Good point.

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

It sounds like, everybody could agree, and let me ask it that way, is there anybody who would like to add physician generated message as part of the numerator for satisfying this requirement?

**Michael Barr – American College of Physicians**

This is Michael, I will go on record and say yes.

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

Okay.

**David Bates – Brigham & Women's Hospital & Partners**

Yeah, I don't want to.

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

I don't want to.

**Deven McGraw – Center for Democracy & Technology – Director**

No, Deven.

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

Sounds like everybody else . . .

**Greg Pace – Social Security Administration**

No, Greg.

**Leslie Kelly Hall – Senior Vice President for Policy for Healthwise**

No, Les.

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

Okay. Good. So, thank you, we have a clear statement in terms of supporting our original . . . and so that can still be over representing that. Okay, in this final minute, let's open up to public comment. Thank you everyone for being on point and getting us through this . . . all of the material we've been through and

so, we'll be reporting that out tomorrow, and hopefully get approval for the final recommendations. Okay, you want to open it up for public comment please?

## **Public Comment**

### **MacKenzie Robertson – Office of the National Coordinator**

Operator, can you open up for public comment?

### **Caitlin Collins – Altarum Institute**

Yes. If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We do not have any comments at this time.

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

All right, well thank you everyone and we'll see most of you tomorrow in Washington.

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

Very good.

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

Take care now.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks a lot everybody.

**W**

Bye bye.

**M**

Bye bye.