

**HIT Policy Committee
Meaningful Use Workgroup
Draft Transcript
August 7, 2012**

Presentation

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

Good morning, this is Mary Jo Deering in the Office of the National Coordinator for Health IT and this is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. It is a public call and there will be a chance at the end for the public to make comments. And, I would ask all the members to identify themselves when they are speaking. I'll begin by taking the roll. Paul Tang?

Paul Tang – Palo Alto Medical Foundation

Yes, here.

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

George Hripcsak?

George Hripcsak – Columbia University

Here.

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

Michael Barr?

Michael Barr – American College of Physicians

Here.

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

David Bates?

David Bates – Brigham & Women's Hospital

Here.

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

Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

I'm here.

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

Good. Neil Calman?

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

Here.

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

Tim Cromwell? Art Davidson? Marty Fattig? Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

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

Yeah, I thought you were there. Thank you, Leslie. Yael Harris? David Lansky? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

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

Greg Pace?

Greg Pace – Social Security Administration – Deputy CIO

Here.

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

Latanya Sweeney? Rob Tagalicod? Charlene Underwood?

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

I'm here.

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

Amy Zimmerman?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Here.

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

Good and would staff please identify themselves.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

Emma Potter – Office of the National Coordinator

Emma Potter, ONC.

P. Jonathan White – Agency for Healthcare Research & Quality

Jon White from AHRQ.

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

Okay, back to you, Paul.

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

All right, thank you very much, Mary Jo. We have two major agenda items for today, one is to review the feedback from HITPC from our presentation on August the 1st and the second is to begin planning our HIE hearing, that as you know is a top priority for ONC and for everyone, this is something we're trying to concentrate on for Stage 2 and as folks brought up at the Policy Committee meeting it's still something where there are still a lot of challenges and we probably should understand some of the feedback from the field and have a hearing on getting some proposed solutions to that or at least ways to address that. And we have some initial ideas to run by you, but at any rate, we want to start that planning process because we wanted that to happen in the September timeframe, a mere few weeks away. So, that's how we'll spend the second half of our conversation.

Okay, in the first half, Michelle, probably Michelle and Emma put together a wonderful debriefing from our Policy Committee meeting on the 1st and slide by slide pointed out the comments we got back from the Policy Committee. So, that begins...do you all have that, it's marked the HITPC feedback?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yes.

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

And in green are the comments that came up, as I said, slide by slide. So, if you go to slide 4 the first screen notation has to do with our guiding principles which were largely excessive, so fitting the supporting new models of care, addressing national health priorities having broad applicability and promoting advancement of the initial roles be achievable. Now in the achievable what was included or at least how that was annotated had to do with standards which has been certainly a big factor in our considerations what was pointed out and I think we included that in achievable bullets but it's worth making a separate notation about is reasonableness, sort of a feasibility from all parties point-of-view whether it's the products or the organizational capacity nationwide to absorb the changes needed with each stage that we also want to consider, and we have been considering that, but we wanted to make sure that shows up on our guiding principles. Any comment about that addition or overall about the guiding principles?

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

Paul, this is Charlene, just clarification, it's been challenging, you know, because they're pushing care coordination, we've been again, getting great feedback and there's been a lot of work being done by the S&I folks, but it's sometimes really hard to discern where these standards are in the process. So, are they expecting implemented proven standards, are they expecting standards that are... I mean, these standards are in different status, so even though it's reasonable or does that mean implemented, so, I think that's where I get a little bit challenged in terms of trying to understand the expectations, because we are trying to push the bar to some extent, but on the other hand, it gets a little unclear where some of the pieces are in the process.

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

That's an excellent question and it did come up, fact Judy Murphy, representing Farzad, asked that question and we all recognize that it's always a tension. If we could leave it to the market we would of course, because that may be a more efficient way of doing this, but it hasn't happened in the past couple of decades or 3 decades, so that's why we decided, not we, but congress, decided to move forward. So, but we face those same kinds of decisions and tension and on the one hand you can't push something where if everybody stood up...the function we'd have a bunch of silos and create in a sense more hardened silos. So, that's the danger if there's no standard and particularly... you know, ideally if the standard exist and it is widely adopted. On the other hand you get to a point and HIE is one of those points where it's just not moving the way it needs to and so you actually may force the hand or certainly strongly influence the hand by showing a deadline that's in the future and gives people enough time to adapt. So, I think that's where we are. Our preference is to have at least standards available if not widely adopted and that they're accepted to be good standards or good enough and then we start moving the whole industry to adopting that.

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

Paul, this is Neil, I have a question about the standards piece too.

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

Yes?

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

And, I'm sorry; I missed my very first meeting last month, this month.

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

...

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

So, on the standards piece, like the one thing I don't want to do is have standards become an excuse for not moving forward on things and sometimes we talk about them that way, like if there's no standard for how you, you know, how you capture certain types of information then we shouldn't be capturing it at all, and that's come up around problem lists, it's come up around progress notes, it's come up around, you know, functional status stuff and so I'm just, I guess a guiding principle is fine, but I wouldn't want it to become a hard and fast rule that if there's no standard it doesn't mean that we can't move forward on certain areas.

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

And, I think everybody shares your sentiment.

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

Okay, great.

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

So, these are all guiding principles not absolute hard requirements. But we need to talk about them because, you know, you do get to where it's either a thousand flowers bloom and we still have a bunch of silos, so, you know, we understand there's a tension, but part of the reason we're doing this, this early, if we conclude this in time the whole industry should have 2.5, now the industry means both vendors but also all of the healthcare organizations, should have 2.5 years to prepare for the 2016 introduction of Stage 3 criteria. So, that's why we're moving this quickly. Any other comments on that?

Okay, let's move onto the next slide which is slide 6 and then slide 7. And there are a series of questions that were asked and some of the answers I might have provided and why don't we take just a moment to look through those and then we can go through them to see if there is any additional amplifications. Some of the questions I think we handled in our process and it's just a matter of bringing it forward to the Policy Committee.

Christine Bechtel – National Partnership for Women & Families

So, Paul, on the first...do you want to talk now about this?

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

Yes, yes.

Christine Bechtel – National Partnership for Women & Families

So, on the first piece about health disparities what I said during the meeting was... and I... that I still... I do think need to be addressed is the use of the data, right? And, so that we're collecting demographic data but the way the objectives are written it doesn't quite get to using them to like report from a dashboard that you've looked at your patient population not just by condition but by disparity variables. So, I think that's a piece that's missing and then, you know, being able to stratify quality measures as well and showing that you in fact are doing that. So, I think that is a gap that needs to be addressed.

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

And, as you know, Christine, we've been trying to do sort of the functional objectives which turn into certification criteria on the objective side and use a combination of the measure of objectives and the CQM as a way of assessing use and effectiveness.

Christine Bechtel – National Partnership for Women & Families

Right, I understand that, but I think, you know, the functional piece that we talked about in the meeting was some way to take that patient dashboard functionality and ask for its use as a function. And, then, you know, the other piece that I would say... so, I think that is a gap. But, the other thing is, you know, we've been talking about stratifying quality measures like disparity variables for a long, long time and it's not making it in anywhere. So, I understand the division but I think there's a problem in the process that's it's not really moving forward.

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

Okay, let's keep that for ONC, Michelle, and let's keep that on the table in terms of, one of the things I think we might want to pull "integrate" more closely... is David Lansky on the line? Are to see how quality measures line up with things like this. I mean, it's... if you... I think people who've gone through for example JCAHO requirements as kind of accreditation requirements a lot of... some of the times you may do things to fulfill a requirement but it doesn't actually get used or its value doesn't become apparent. That's one of the reasons we try to move towards the CQM where you're actually looking at your performance and assessing it versus putting out something from a piece of functionality.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, Paul, this is Leslie, and one of the things that we talked about was using an existing CQM measure but allowing a patient to view with a measure that was consistent. So, I think that one of the CQM measures in Meaningful Use 2 recommended was how many or measure the number of patients with diabetes the number of A1c tests they were receiving per year and there was an indicator of what that number should be.

So, an example of a patient facing response to that would be, you as a patient, have had 3 A1c tests as compared to the national standards which is 6 and I don't know what that national standard is, but that would be a very small, very skinny example of a patient facing view of a quality measure so that patients can start to see what it means to them.

And, so by using an existing CQM, an existing measure that's already being gathered in Meaningful Use 2 or it might even be 1, forgive me I'm not sure, and then saying, and you must be able to present this in a patient facing view is not a huge stretch. So, the Subcommittee that we had working on patient engagement felt very strongly that it was as a patient you needed to know what it was about you that you needed to change, what were the quality measures as a patient participating, and we also heard this in our care coordination team around accountable patients and how do we make sure patients know what it is they're expecting.

So, I sense a suggestive language around this, but the measure would be the patient facing view or reports would be provided and choose an existing CQM measure that you are already doing and provide one patient facing view or report. And, I am just using this as an example.

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

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But, that way we're moving that agenda and not burdening beyond what's already being collected and that the provider gets to choose of the CQM measures which ones do they want to provide a report to the patient.

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

That sounds like an interesting idea; I don't know... is that covered already in category 2?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

What was covered in Meaningful Use 2 was that all of the CQM measures that were being reviewed and look for public comment, we don't know what the final measures were...

Christine Bechtel – National Partnership for Women & Families

Leslie, I think he's asking if we covered it in Subgroup 2 and we... I think it was actually one of our referrals elsewhere.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It was and then in our last meeting you asked me to come up with a measure and example I forwarded back to the group and used that example.

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

Okay, let's put that... it looks like new work; it's not exactly the feedback we got from the Policy Committee. So, let's put that on the table and when we get to category 2 we can see if that fits in somewhere.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Thank you.

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

So, as far as your topic, Christine, if we can put that on our CQM or measure parking lot then let's make sure we can get that covered.

Christine Bechtel – National Partnership for Women & Families

But, what about in turn, you know, using the dashboard functionality to display... does that make sense?

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

To me it would be interesting to see what other people think, we've been trying to avoid being prescriptive to say it must... many of the times when you say this is what the report has to look like you'll get a report that looks like that but it won't necessarily be used. We've always... I mean, it's nice to rely on other programs, it could be what you need to do for accountable care or these other programs that you have to do and now all of sudden you have a tool that can do that, it tends to be far more effective in terms of how organizations make use of this.

Christine Bechtel – National Partnership for Women & Families

Which, I completely agree with except I don't think that in accountable care or in medical home or any other place that there is a requirement around looking at disparity levels. So, I think it's something we at least need to get some public comment on, you know, we should just... a very simple ability to look at that dashboard and, you know, slice and dice by, you know, whatever your disparity variables that are relevant to you are and report.

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

So, and that sounds exactly like a CQM or a measure. So, let's figure out how to write that, the choice you offered is a good one, I'm not sure I'd build it right into the objective though.

Christine Bechtel – National Partnership for Women & Families

All right, I think we're missing the ballgame, but I'll let it go for now, let's keep moving.

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

Okay. And we talked about the notion of how high is... when we talked about, remember one of our principles is that it's not topped out and the question was asked well should any of these things be 100%, the answer I tried to give is to reflect our discussion was, you know, we sort of stopped around 80% thing, there's always going to be reasons why it can't be 100% or there is going to be legitimate reasons why we can't get 100%. The closer you get to 100% the more documentation there has to be and auditing has to be about, oh was that reason good, I mean, and people don't stop and say let's not go beyond 80, it really almost reflects it topping out. Is that agreeable with people? That's sort of how we've been acting anyway.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, that makes sense to me.

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

Okay. The stages... oh, the last comment has to do with...I think this has to do with Marc Probst's argument about saying, hey look one of the biggest challenges we have is interoperability everything from the lack of standards to the lack of acting on the standards, incorporating them and should we almost say, let's just do that and focus on that alone, that generated a lot of discussion and it was a legitimate point to make and I think we just need to...in fact this is one of the things we'll touch on when we discuss the hearing for HIE. So, that coupled with the notion of how do we assimilate the feedback we're getting about HIE and see if we can't come up with some recommendations to advance the ball forward again. Okay, I think we can move on then if people don't have objections.

And the next one, we had no changes requested for the next slide, which is 7, the same with 8, 9 and then in 10, this is the up-to-date problem list, part of the question was, hey one of the issues was are there too many things on the problem list, that hasn't been my experience with these things, it's more that something is not making it to the problem list and we have a bit of a chicken and egg. In theory the better approach for quality measures is to use the problem list as a denominator rather than trying to get proxy for whether somebody has a particular condition.

David Bates – Brigham & Women's Hospital

Right, I think, this is David Bates, that's where I think we need to go and there are tools to make the problem list more complete now.

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

Yes, so that's what we're trying to leverage.

David Bates – Brigham & Women's Hospital

Yeah.

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

And, I think that's what this group agrees with. Okay, no changes on slide 11, 12. I'm going now to 13 and this has to do with clinical decision support and one question is, you know, one of the things we raised was can we go back, we did this actually in Stage 1 and it's never been picked up, that is addressing the efficiency part of healthcare practice and a couple of things we've picked on before because they're known to be high cost items and known to have a certain amount of ordering that doesn't necessarily meet the guidelines, one area is in high cost imaging and we talked about that before, the question was raised whether there are guidelines and ACR has a number of guidelines in terms of indications for tests and particularly for high cost imaging. So, that's a good source for some of these guidelines.

Another area we targeted was formulary tracking including the use of generics where that's available and equivalent. One of the ones where we wanted to see some progress was renal dose checking, the thing that might get in the way is a lack of structured sigs. The instructions... so sometimes EHRs accept free text in the sig. Sig is the instructions on the prescription and if you have free text that the machine can't understand then you can't calculate a dose and you can't check against the appropriate renal dosing. So, that would be the barrier. So, the thought is we'd go out with that and see what comes back in, in terms of comments. Yes, did somebody make a comment?

David Bates – Brigham & Women's Hospital

And Paul you're expecting us to discuss this some more in our group?

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

Correct.

David Bates – Brigham & Women's Hospital

Yeah.

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

So, this is an area we've always identified it from the... I mean, EHRs really a lot of the weight is around CPOE and the support made in the ordering process. So, while this is one of, you know, a number of functional requirements we wanted to spend more time honing in on this one and so Subgroup 1 was going to spend some time looking at how to expand it.

George Hripcsak – Columbia University

So, this is George, Paul, so what... I mean, I think we have to be explicit about what question we're asking Subgroups when we ask a question.

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

Right.

George Hripcsak – Columbia University

So, are we looking to change our Stage 3... to modify our Stage 3 recommendation or not or look forward to the future after that?

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

I think this particular one is we, the whole Workgroup, but Subgroup 1 having do a little pre-work, is an area where we've intended to... we've made many comments and we've intended to beef up and we've just been using... we haven't spent as much time specifically on this and that's something where we could use some extra time, extra attention.

George Hripcsak – Columbia University

So, the plan is for the Subgroup to talk about the Stage 3 recommendation modify it.

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

For CDS.

George Hripcsak – Columbia University

And then present that in October before the Request for Comment?

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

Well, it's presented back to us. Our next call, Michelle is?

Michelle Nelson – Office of the National Coordinator

It's on the 23rd.

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

Okay, so present it back to us so that we can digest it before presenting it in October. We also had a question on the... first of all, it looked like the committee and I think ONC, including Steve Posnack, who is an expert on these Regs, liked the idea of splitting up in certification only, that notion was appealing to many. So, we don't necessarily have... when we want new functionality and maybe functionality in advance of use requirements it's very helpful to have that kind of criteria.

So, one of the questions I was asked, was we talked about tracking CDS triggers and how the provider responded, it wasn't so much designed to be a big brother looking over the use of it by physicians so much as how do we make sure that we get better and better CDS interventions. There are some seminal Utah work that showed how poorly you get it right out of the gate and you overlook certain things that, oh we should have taken that into account, or, oh we didn't intend for these effects, you know, unintended consequences to happen and that really helps you improve so that you get intervention very quickly, so that's what we meant by that, that was the spirit with which we had this objective.

David Bates – Brigham & Women's Hospital

Yeah, I actually think it's some of the... you do find some individuals who are behaving in a really unusual way and it's helpful to be able to identify them, but the much more important one is the second point that Paul made.

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

Okay. Okay, people agree that this is an area where we want to spend a bit more time and even get it into Stage 3?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, and I'd say, yes and I do think that certification criteria is a good model for us to follow.

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

Okay. And, so there's a number of steps, it maybe just even bringing some order to all of these subparts we have in here, so we've called out things that of the 15 for example we wanted one to deal with appropriateness of labs and rad orders, another thing that people might propose is something to do with prevention, which is where we have a lot of data and how effective it is. In other words a little bit more...probably a better way of organizing this requirement might be helpful.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Paul, this is Amy, I know when we get to it there were a lot of comments about immunizations, did we decide and when it was presented to keep the immunization algorithm discussion separate from this CDS discussion?

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

We did, because, one we decided... we'll get to that, but we did decide to look at immunization as a special high priority high value area and then break it up into both what people have gotten and also what's recommended, so that we cover that in immunizations.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I just wanted to make sure, I just was trying to remember that we kept it separate and we'll come to it.

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

Yes.

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

Paul, this is Neil, I have a question too.

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

Yes?

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

The CDS stuff, when we're calling out like, you know, implementing 15 clinical decision support interventions, are we taking any kind of position on trying to establish criteria for those clinical decision supports or are we basically, you know, going to sort of let... like a decision support around, you know, around something sort of be evolve in a thousand different places, in a thousand different ways? Because the... what I'm talking about are the actual criteria for the decision support.

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

So, it's a good point, Neil. So, the approach we took in our recommendations for Stage 2 and they were at least largely accepted in the NPRM, we'll have to see what the final rule says, was to give attributes of clinical decision support interventions without specifying, oh, it has to be a rule or it has to be this or that. The second point you're raising, Neil, is, is there any movement toward guidelines that would help us share the actual knowledge contained in these interventions and that's one of the areas I think, David's Subgroup could look at to see if that's appropriate.

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

Right, because right now I know there is a framework, I forget what it's called, to sort of share information about how these things are designed, but that's not really at a user level where...

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

Right.

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

Anybody except somebody who is an IT person can work with that.

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

Right.

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

But, I'm just thinking that, you know, these things are evolving all over the country and they go through 10 iterations before you get them right, and just from a resource point-of-view and being able to allow people to really look at something and say, wow it really is important for me to refer people, you know, whose creatinine has gone up at least 0.5 in the last year to make sure that they've had a nephrology referral, gee I wonder how I design that instead of having a thousand people trying to figure that out at the same time, you know, to be able to create some format where that could be... where the criteria could be developed that could be... and I don't think they necessarily have to be computer interoperable but at least that the standards are available in a useable format for people to implement.

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

Right. David, is that something you would cover in your discussion with your Subgroup?

David Bates – Brigham & Women's Hospital

Yes, you know, the challenge was really to come up with a statement that is sufficiently broad to cover everyone, because, you know, which decision support will be clinically important for an individual, you know, will vary depending what their specialty is and so on, but, I agree with what's been said and we'll discuss it some more.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, this is Amy, and just for clarification and it goes back to Neil's first question, when we talk about clinical decision support interventions are we talking about the use of a clinical decision support tool as being the intervention or the outcome of what that clinical decision support suggest as the intervention or either?

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

I think the target of this objective in the measure is the tool, the capabilities for organizations to have interventions that the system provides, particularly around CPOE. The outcome would be measured either by the driving function, the forcing function like CMS programs or just the whole notion of ACO like delivery systems as...

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, the referral to a procedure based on some clinical decision support is not the intervention, the fact that you use some... you have something in the computer pop up to say, you should have this patient go get this procedure is what we're looking for, that's what I'm trying to distinguish.

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

Correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay, that's what I thought; I just wanted to make sure I was correct.

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

Okay.

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

Paul, this is Charlene.

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

Yes?

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

And I participate on David's Workgroup, but I am chatting with the vendors on Monday, this one seems like a pretty high list, because there's a lot in it and there's a lot of new stuff in it.

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

Yes.

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

You know, the work on the... for instance radiology codes I think are just... will be just coming out maybe 2014. So, what kind of input would you like from that process? And, I'm sure from the provider's side too it's going to be, you know, a stretch to even do what's on the list and get measured on.

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

So, I think that's part of the discussion by the Subgroup and remember that this is 2016, so hopefully, if there is something available in 2014 that certainly could be ready to implement in 2016.

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

Yeah, I just... most vendors probably haven't seen it yet, so...

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

Yeah.

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

I'm just saying that there's a lot in this one. Well, I will get some input in terms of where the vendors are at and their feedback on it.

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

Right, because it seems like current systems probably can do interventions about these topics, it's more, for example in renal dose checking is the sig structured and in your case you're saying radiology orders are the codes standardized, I mean, it's more of that rather than actually functions that the vendors have to program.

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

Right, but embedding the rules, doing that checking... I think doing the piece on the certification is non-trivial, because it's... again, what that means is fairly complex, because what the interactions are with providers... pretty complex, so...

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

So, this is complex, which is why, one it's sort of broken up, but also of course it's a real big part of the payload. So, that's why we thought it would be worth drilling down on this in this...

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

Okay.

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

Thanks, Charlene. Okay, next page, the notion here was, when we use the term real-time our notion was instead of waiting for a report to be run, you know, and it's a retrospective and it's sort of... it's sort of out of the face of the provider, our goal here was to say, the provider should be able to call up this current dashboard on demand. So, the objection was, gosh if you have the same CPU that's running your EHR you could bog that down, so that wasn't really our intent, so that's why people talk about near real-time.

Okay, the next one, no change on 116, 117 there was clarification requested about, well what do you mean by mismatches and how are they tracked and what do you do with it? So, it's true, I think that wording is... we know what we intended but it probably could be edited for a bit more clarity.

George Hripcsak – Columbia University

Wait, so this is?

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

The mismatches on the eMAR, so mismatches of how the medication order doesn't necessarily match exactly with how it's administered and there are lots of reasons for that. How do you make sense of that is what we, you know, give tools for the provider to make sense of it so that they can improve any policies or practices they have.

George Hripcsak – Columbia University

Okay, so who are you saying will rewrite it?

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

I guess that's Subgroup 1.

George Hripcsak – Columbia University

Okay.

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

Next, page, 16 there are no changes, 17 no changes, 18 no changes and that brings us to the end of Subgroup 1 or category 1. Is that fair? So, our major emphasis really is we tweak a bit like we just talked about the editing of eMAR, but major time spent on CDS and perhaps even a little framework on how do we deal with CDS? How do we make sure that we have functional capabilities to use it effectively in care? Okay, moving onto Subgroup 2 feedback or category 2 feedback, this is on page 20.

The question was do we really mean... I think auto Blue Button is not something that's well understood, the notion here was, is there a way to continue to get... so if you pass some information to another party is there a way to have that... it's almost like a subscription so you get ongoing updates. And the second part of this is and then what's the functionality, what's the process, what's the workflow for a provider to receive these continuous updates, because there is a notion of well, gosh if the information is there does somebody have to look at it and with what timeliness, etcetera. So, those are areas where, and probably one of the things we could do is tease out the questions we're asking in the RFC around these areas, because these are big deals. Does it make sense?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Paul, this is Leslie.

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

Yes?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I did send on some further information about that and would be happy to work on that wording a little bit more.

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

Okay, great, thanks. So, on page 21, this essentially is patient..an outcome of our patient generated data hearing and our intent, I believe, was when we used the word provide, just like we've used it in previous stages it essentially says make available, it doesn't mean that we force people to use it, but make available this kind of capability. In the future, obviously we hope that this new data will be used; it could even be incorporated in CDS, but be used in decision making and the systems understanding of what's going on at home. Some of these have standards that are adopted, some of them don't and that was one of the questions as well.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Paul, this is Leslie, and I've done some research and the Rhode Island Quality Institute is already piloting Direct as a way to communicate medical homes with medical devices and their pilot will be in glucose, blood pressure and weight. So, we will have some...

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

Well, that's one data point, as you know; Direct doesn't necessarily mean that these data elements are standardized.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

...just added some of those rehab and asked for... do we have standards. We do have some standards...

Christine Bechtel – National Partnership for Women & Families

Yeah, Leslie, you're cutting out a bit, but I think what she's trying to say and what I would say is that, you know, we did get some feedback from standards folks on the device side, that there are some standards there and then we've got value sets for the others but what we really need is to understand more about what the best way to architect it is, because I think we all worry about having to kind of code for every single one of these versus code a functionality that can be adapted so that's what we're hoping to get public comments on.

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

Okay, and someone working in their kitchen or something if you could go on mute. I think that, to George's point for each Subgroup, if they could respond to some of these... a lot request for clarification in the wording that would be helpful. So, I don't know that we want to... we don't want to add new things.

Christine Bechtel – National Partnership for Women & Families

Right.

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

This is what we have with the Policy Committee, if you would come up with... and this comment, you know, I mean, just because there is something let's say a certain general... had a family history App doesn't mean that's necessarily, you know, widely adopted, so...

Christine Bechtel – National Partnership for Women & Families

But, Paul, this is... I keep getting confused over this, because we keep having this discussion about standards but this is the Policy Committee. I cannot tell you the standards for this stuff and we got, you know, some quick feedback from John Halamka, can we take this more in a more considered way and ask them more formally...

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

Yes.

Christine Bechtel – National Partnership for Women & Families

Give them a little time to...

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

Yes, that's exactly...

Christine Bechtel – National Partnership for Women & Families

Okay, because the Subgroup is not... I'm not equipped to do that, Leslie probably is, but she keeps saying the same thing and either we're not listening or whatever, so it's getting frustrating a little bit in that regard. So, if we can get standard folks to really consider how can this be done, not like, you know what I mean, and give them, I think the same caveat that you stated up front and that Neil I think did a good job explaining too, which is, you know, it doesn't have to be a perfect standard right now but it does need to be able to be ready.

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

Yes.

Christine Bechtel – National Partnership for Women & Families

And tell us what we need here.

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

So, that's one of the things we have permission to go Workgroup to Workgroup and we do have enough time now. So, between now and when we represent in October we need to have sort of settled these questions to the best of our ability.

Christine Bechtel – National Partnership for Women & Families

Yeah, right.

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

And so that's exactly right, Christine.

Christine Bechtel – National Partnership for Women & Families

Okay, but in terms of my Subgroup I just want to make sure I take the action items back to get completed. So, we don't need to do anything on the standards side because they will?

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

If you would pose the question and it could be the same question we posed to John who was kind enough to... you know, what's the current lay of the land as he knows it, will give them more time to come back to us.

Christine Bechtel – National Partnership for Women & Families

Okay, and so we can ask the standard kind of questions?

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

Yes.

Christine Bechtel – National Partnership for Women & Families

But, I think we have to explain the sort of architectural question as well, because they feed in. So, I'll have to write something up to do that.

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

That would be great.

Christine Bechtel – National Partnership for Women & Families

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, and I would be happy to launch that standards patient engagement group again to answer these questions and to keep the communication between the two.

Christine Bechtel – National Partnership for Women & Families

Great.

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

Okay.

George Hripcsak – Columbia University

So, Paul, this is George, so I want to... we should be clear... I was hoping we could actually reword some of these things now as much as possible, but I don't want... and this is not an answer to this last one, I know that this one had specific questions from the Policy Committee, but I think we need a very specific charge of exactly what we're fixing and not fixing, so, for group one it's specifically to look at decision support and slight rewriting of mismatches and that's it, right?

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

Yeah.

George Hripcsak – Columbia University

As far as I can tell. In group 2 so far we have, in 204A, it's rephrasing the... changing the phrasing so we don't have to refer to Blue Button but instead just say what we intended. And then there's a request to clarify team members and that's what's being fixed on that?

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

Yeah, and thanks for doing that, George. I think at the end of this call we should have exactly this list of what's coming back from the Subgroups and it's really answering the HITPC questions and clarification not coming up with new things.

George Hripcsak – Columbia University

Okay, so then on the one we just did, what's the charge on this one while we're here?

Christine Bechtel – National Partnership for Women & Families

I think I have to write up the question to pose to the Standards Committee.

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

Correct and then we'll pass that onto the Standards Committee and try to get, you know, give them a little bit more time to come up with a... it's still an informal answer because it's not being taken up through the committee itself.

George Hripcsak – Columbia University

So, we need to clarify the word provide, I guess, right?

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

That, I think, unless someone is correcting me, I clarified what we meant by provide, which is makes available.

George Hripcsak – Columbia University

Okay.

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

Okay, we can move onto page number 22, no suggested changes, 23, this, you know, I think our option 1 was a little bit confusing; it was confusing when we talked about it.

Christine Bechtel – National Partnership for Women & Families

Paul, can somebody advance the slides on the Webinar though?

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

Oh, I'm not watching that at all.

Caitlin Collins – Altarum Institute

We are currently on slide 22, that is correct, right?

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

No, 23.

Christine Bechtel – National Partnership for Women & Families

No.

Caitlin Collins – Altarum Institute

No problem.

Christine Bechtel – National Partnership for Women & Families

Thanks, okay, sorry, Paul.

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

Thank you, no problem. I think perhaps the Subgroup... option 2 sounds like a very clear and easy to understand and accomplishes something; option 1 is pretty hard to understand the implications. The Subgroup might want to entertain the notion of like picking one of these.

Michael Barr – American College of Physicians

Paul, it's Michael Barr, I thought what we discussed earlier was based upon some other entity standards about a certain percentage of the practices population speaking a particular language and that being the criteria for which they would have to provide the materials in that language if available.

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

Yeah, it's just defining the numerator, denominator and which locale and is it national or is it local, which I think is where... every time things are complex or open to vague interpretations it just doesn't work as well, it creates a lot of angst and extra work, which is why I think option 2 is easy to understand and everybody will have somebody that, you know, a population for which English is not a primary language and where there is information that's publically available, that's why it seemed just so very clear and it's certainly pushes people in one direction and obviously the system.

Christine Bechtel – National Partnership for Women & Families

Yeah, I just can't understand the comments on the right as they're written. I understand what you're saying Paul and that's fine but I just don't get what the comments mean.

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

Yeah, I mean, I think what I said was a reflection of the confusion.

Christine Bechtel – National Partnership for Women & Families

Okay, well, I mean, Charlene and Neil and Leslie are all on the phone, so, I mean if everybody's okay with going and getting comment on option 2.

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

Yeah, how does that sound to people?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, I did send... you asked me to put out a recommendation and I did send that, I sent it back to you again. One of the questions that came back is that one, you know, Spanish is prevalent and do we want to name Spanish at least as one requirement for patients who speak Spanish as a primary language in both eligible provider and eligible hospitals, so that was one recommendation. And, so, I'll just, I'll leave it at that.

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

Yeah and I didn't understand... can we answer Christine's question is, does option 2 sound like a good objective to go out with for comments?

George Hripcsak – Columbia University

Sure.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

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

Okay, great.

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

And, Christine, I'll try and get some other input for our call on this one, you know, from the vendors and also I'll run this...

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

Well, yeah, but this isn't a vendor requirement, I mean, I think this is what we're... we're going after language capabilities in these systems, so I think we're asking for comment for the broader community.

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

Yes.

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

But, is there a reason that we can't put both options out for comment?

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

Well, I think it's more that people... it's very hard to understand option 1 and when you get right down to it, it could actually have no second language, because the majority of folks speak English, so it is just very confusing and putting out confusing language creates a lot of energy around something which isn't a good proposal in the first place, do you see what I'm saying?

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

Yeah, I guess I'm just thinking that option 2 sort of already has an answer and I guess the question... it would just be nice to know if there is more wisdom out there to figure out a way to ask it more generally, but I guess we'll get those comments when we put the option out there, so that's okay.

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

And, in our preamble we can also include the fact that, okay, so here's our best thinking right now, certainly if you have a counter proposal to any one of these things, you know, we're certainly willing to listen.

Christine Bechtel – National Partnership for Women & Families

So, I think for option 2...

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

I guess what...I'm sorry, go ahead.

Christine Bechtel – National Partnership for Women & Families

Go ahead, Neil.

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

I was just going to say the problem with option 2 is that, you know, if Spanish is available but completely irrelevant in a community where there's another language that, you know, 30% of the people speak, you're kind of basically... it doesn't really require somebody to look at the language needs of their particular population, but you could... but the, you know, the vendors could fulfill this very easily by just throwing in Spanish, which might not be relevant to the places where they are. I'm just not clear. I think the important piece here is for people to understand what they need to do in their community so it becomes relevant to the communities in which they serve.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

...

Christine Bechtel – National Partnership for Women & Families

That was the original, the original sort of construct and which I agree with because I think the concern about option number 2 is simply that you could have 3 people, you know, who are speaking, Non-English language and, you know, you just sort of got some materials for them and that's it, right? So, you know, we could... I could work on some language and send it back to the Subgroup that reflects more... in going back toward what we said where you've got to look at the predominant language is spoken and for any, you know, for the most predominant Non-English language if education materials are available in that language you need to provide those in that language.

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

Yeah, okay.

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

I would still like to get somebody on staff to find the Office of Civil Rights language requirement.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

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

Because there is a requirement, I'm quite sure, that's better than what we're putting out there.

Christine Bechtel – National Partnership for Women & Families

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

...Neil...

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

Hang on, let me... we're running short on time, but this is clearly an important point. So, if, Michelle, we could get some follow-up in terms of the...

Michelle Nelson – Office of the National Coordinator

Yes.

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

Yes, and then Subgroup 2 can come back and address Neil's point in the option 2, that would be great. Thank you. Now, page 24, no changes suggested, 25, we're talking about, so there were some questions about the query research enrollment system. I think this got in a little bit later so it's not as flushed out as some of the others and I think one of the homework that the Subgroup can do is to just flush this out a bit better. Do we know about these... do standards exist to query these research enrollment systems and are there one or are there a thousand and just a bit more about that.

Christine Bechtel – National Partnership for Women & Families

And that would be for the standards folks to do? Because, it's a standards question, I don't know it.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

I think we already said it's, we already identified, and we said if the InfoButton standard is there... the question can we use it if it's already being used to identify patient's specific education materials, so...

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

Well, do we know enough about the maturity of these research enrollment systems, is there... are there a thousand or hundred, or is a central? Do we know the answer to those questions?

Christine Bechtel – National Partnership for Women & Families

Leslie, do you? You had more interaction with the research community than I have. Did we lose Leslie or is she on mute?

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

I think we just need the answer to those questions before we pass... so if there are a thousand than it seems like that makes it infeasible already.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

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

And then we can go back to the standards but first I think we need to do a little bit more homework on is there really an organized enrollment system.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven, I think that actually there are multiple sort of private sector ones that exist but I thought that they all connected to clinicaltrials.gov, which is run by NIH.

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

And does clinicaltrials.gov have a web service that allows you to query it in the way that we're imaging here?

Deven McGraw – Center for Democracy & Technology – Director

I believe so, but this is a researchable and knowable question thing.

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

Yes, that's exactly right. So, if we could do a little research on is this even feasible from the research enrollment system's point-of-view then we can look at, well and do we have standards so that all the EHR vendors can comply with that standard.

George Hripcsak – Columbia University

Clinical, Paul this is George, clinicaltrials.gov has a list of trials, so if what you want is the EHR to return a list of all trials you can do that.

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

Well, do we want...

George Hripcsak – Columbia University

But as far as matching...

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

Yeah.

George Hripcsak – Columbia University

Search criteria, that is not what clinicaltrials.gov is capable of doing right now.

Christine Bechtel – National Partnership for Women & Families

No, this was...

George Hripcsak – Columbia University

There are some companies that do this like Trial X.

Christine Bechtel – National Partnership for Women & Families

Yeah, this was in the in between, George.

George Hripcsak – Columbia University

What's that?

Christine Bechtel – National Partnership for Women & Families

This was in between the two, it's not just give me a list of every trial in the, you know, United States or in the world, or whatever, it is, you know, specific to a particular condition, but it is not querying all of the criteria for inclusion or exclusion because that is not possible, so this is a simple, you know, way to say, give me the clinical trials, you know, that are the most appropriate or potentially appropriate for the patient, but it still will take human interaction to, you know, to go through it. So, this is just a, you know, capability, development piece only at this point.

George Hripcsak – Columbia University

And, so why isn't it, should it be in the Stage 4 column?

Christine Bechtel – National Partnership for Women & Families

Because, the idea was that if the EHRs became capable in the next couple of years that the research community would be able to build off that standard, that they need the EHR to move first so to... you know, to put it off for a couple of years doesn't get the research community moving.

George Hripcsak – Columbia University

Okay, I mean, I don't know that it will be feasible by then, but I don't mind having it go out for public comment, especially the certification part.

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

But, I just think we need to do a little bit more homework on this.

Christine Bechtel – National Partnership for Women & Families

Yes, we will, we will.

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

Okay, great. The next one, actually there was a comment, you know, in a sense, we already have the capability... for the things that have IDs, let's say people on certain drugs and as you know there's a device ID proposal out there, when you have an ID and you know that patients are effected, it could be a drug, it could be a device, etcetera, we already have the ability for example, secure messaging, to be able to notify folks, so it's not exactly clear what's the new thing here.

Christine Bechtel – National Partnership for Women & Families

There isn't anything new. So, because, remember... and I clarified it in the Policy Committee meeting, it's not a placeholder for Stage 4, it is simply a placeholder to make sure that if secure messaging stays in Stage 2 final along with the ability to generate lists of patients by, you know, condition.

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

Right.

Christine Bechtel – National Partnership for Women & Families

Then you would not need this at all and it would come out entirely. So, it's not a placeholder for Stage 4, it's a placeholder until we go back to Stage 2 and we know what's in there.

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

Got it, thank you, that's right and you're the one that's responsible for this great comment, so good, thank you. Okay, I think that wraps it up for category 2. So, moving onto category 3, we did have a lot of discussion about the maturity of HIE. One of the comments, this is on page 27, the third bullet came from Steve Posnack who was making the point to say, actually if you focus in on the concepts and not call out specific percentages then maybe you get people to focus on the policy more than the percent. I think... so there's value in that.

Another counter proposal we had in a side conversation is to just have categories of percentages, in other words, and sometimes we've used a low percentage like 10% and in a sense that's the introductory price, it's the introduction of this capability and to try to start moving it, however it works out for you locally, you might say, we'll start at this site, you might say we're going to start with this unit, whatever makes sense, because you know who are the... what groups are more amenable to change and accept new functions, that we don't want to like upset, but there is an introductory phase.

On the other hand, we talked about the topping out number, which is 80% and in the middle might be something you might call advancement kind of category, so you're trying to move from 30 to 50%. So, that's one way of handling this particular comment, which is as I said, did come from Steve Posnack, who basically writes these rules.

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

So...

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

Go ahead.

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

This is Charlene, but would we make that standard across all of the different measures or just for this measure, or... I mean, I think we would all welcome a framework to do this in.

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

Now, as you know this is only for sort of public comment.

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

Okay, okay.

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

But, it's just a signal. Okay, what we're trying to do is introduce the function. We understand that...

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

Exactly.

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

The standards might not be widely adopted, we don't, people don't widely understand summary of care document that's a new construct for meaningful use, etcetera, and that's why we choose a low number. I mean, we can choose to, you know, do it that way or not. I almost think the way we've been doing it is approximately that way, but at least it gives people the idea that, well what does it mean and then you can reflect back to your own organization, could I get 10% and how would I do that, any rate.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy, I'm still confused, as opposed to a percentage how would somebody measure that they're meeting this?

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

No, this is for comment.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay.

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

So, instead of... his point was instead of distracting people with the actual number and have people comment on that, have them focus on the...

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

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Ah, okay, have them comment on the functionality.

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

Yes.

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

Okay, all right, okay, all right, thank you.

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

Yes. Okay, moving onto page 28, I don't quite understand this, is MU enough motivation for this measure.

Michelle Nelson – Office of the National Coordinator

I think it was just a question that was asked and you answered yes.

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

Oh, okay. Oh, I'll stand by that then. Okay, the next page, this is the summary of care record and we moved it to 65, well kept it at 65 really and made it 30% electronically, and then had some "must includes."

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

Yes.

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

So, the question is, is this where the market is going? So, there are all kinds of questions. I think one way to summarize it is, what can be do that makes the capability there and then is it meaningful use that would drive it or is there a different way, like are people going to have to do this if they even want to attempt coordination of care, so isn't the market saying that anyway and what we want to make sure happens is that EHR systems talk to each other using certified standards, and so is that the bigger question and should we focus on that rather than let's say numbers with certain fields?

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy, I would assume that if the market is going that way it's helpful to have some standardization of how to do this, because again you're going to get a lot of sort of apples to oranges otherwise, and I would assume it would put a significant extra burden on vendors unless one looks at it as that's what becomes their distinguishing sort of features and factors for selling.

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

Okay, so let me pick up on that a little bit and see... so that might say let's make sure that the vendors use available standards and that should an organization want to transmit something they call a summary of care document they will figure out what's important in their best interest to provide for coordination of care for this patient and the less we are prescriptive, we need to say the fields have to be such and such or the fields need to accommodate such and such, but we don't have to say, oh and we're going to come back and say "oh, here's a summary of care document, did it have this, this and this?" Do you see what I'm saying? I mean, one way to take Amy's comment is to say let's make sure the vendors have the capability to use standards to transmit things that are important to summary of care.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, I would like to hear from the providers in the group, because at least in our state we have a required by law of what we call continuity of care form and, you know, we're struggling with the fact, you know, it's paper, some are ready to use it, some aren't and I've talked about this before, but the point is that we have a large number of providers that constantly go back to while they all have a perceived need for wanting slightly different data they still all want it in a standardized format where... I mean, they're going to the point of saying we need a common viewer so that our eyes can quickly scan where the information is and we don't have to look, you know, at 10 different formats when we get this. So, I'd be curious to hear from, you know, the providers on the phone what their take is in terms of what's useful when they receive this and how it's useful and whether it makes a difference or not.

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

Just to cite an example of what you just said, Amy, is ACOG forms for deliveries is an example where you're eyes go to certain parts of a form and you know where to look for this kind of information, that would be helpful.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, I mean we... I keep getting that all the time locally as we try to think about how to take our continuity of care form, have the hospital do it electronic, figure out how it's going to merge with this that we're talking about here and it's really a challenge and a struggle to try to, you know, figure out, but again, like you said, you know, we've heard from a number of providers that it would really help their ability to provide good care if they could easily and quickly know where to find what information and that they could rely on knowing that that information would or wouldn't be from... but that's actually from a viewing point, that's not even from a standards or a transition point-of-view, that sort of raises other complexities.

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

Other comments?

George Hripcsak – Columbia University

I mean, I thought, this is George, I thought that the main theme there with Judy was how do we push this harder and other than increasing our threshold it's other routes besides meaningful use.

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

So, the question is what to push harder, is it that it's there and providers just need to use it or is it not there, which is a little bit more of Amy's point for us to be able to... is there a structure for us to populate so that it can go to someplace else and in this universal viewer I know exactly where to look for what I want, what I need, is that the thing to push? And then, if that were available people would of course populate it with the information they need or is it that "oh, it's all there" and we need to push people to use it.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

The summary of care document, this is Leslie, under the consolidated CDA has all of the data elements we want and more, it can be used as the transition or the summary of care document, the question is what the team brought up was yeah we want to use that structure and we want to make sure it's clinically relevant, so the physician is selecting what's necessary for that transition of care.

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

So, and do EHRs all treat the summary of care document in a similar fashion?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

We hope so after MU 2 because it's been mentioned in at least 5 different measures.

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

So, I think... Charlene, this is Charlene, give us a standard that we're all working toward, so again, I think a lot of these elements... there will be more elements that are standardized for data sharing in MU 2, then we went a little bit beyond that to really look at some of the more care plan related elements that we wanted to make sure where there but not to add too many for MU 3, so we focused on a couple additional elements. So, it seems to give us the framework that allows us to support the information or the goal that we've been discussing here.

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

Okay.

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

I don't know other than... and I'll say, I think we have to put something in from the percentage perspective because the challenge here, and I think why we have to put some specifics in, is on the data capture side, what's going to make sure that those wheels are populated when that information is transmitted and that's the hard work.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, I'm looking at the consolidated CDA for instance and you've got results, encounters, medications, immunizations, allergies, vital signs, advance directives, procedures, insurance providers, pregnancy conditions and plan of care. Results, who provided the results as well ID, the time, the date, the stamp, the value, each encounter, other values, each location, reason for the visit and then medication history, those are all just what's been filled, what's been ordered, the expiration date, prescription of the provider, yada, yada, yada. So, there are a lot of the fields that are there and we're trying to use the same standard across multiple measures and then look at what percentage then do we want to make sure it's being utilized.

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

So, I think, although the fields are there, I don't know that they're coded and...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

...right? We've got summary of care document mentioned many, many, many places.

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

no, no I'm saying...

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

But, Leslie, Paul's right, in the standard there will be like 4 fields that are coded, we don't even have patient goals coded yet in the Stage 2, we have problems, medications, allergies, I think intolerances, so there is... and labs that... and I think that's a huge step to get coded in Stage 2. I would love patient goals coded for Stage 3. So, we have to be pretty parsimonious in those fields, because it's a lot of work to get those standardized mapped and coded.

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

So, let's folks... I think Charlene summarized it pretty well in terms of the goals for this objective is to say, let's take advantage of the consolidated CDA standard which is primarily fields rather than the coded fields for summary of care document, and ask for 65% of the transitions to have these 30% of which are electronic and include, as Charlene mentioned, these few extra things, the concise narrative, the goals, instructions and the care team members.

George Hripcsak – Columbia University

Paul, what... do we want to do this different than it's written here? See, my point is that we've done it, exactly this, we're trying to get this thing... to say that they should be... it's not our job in the policy to say that this field should be coded that way, that's the Standards Committee, we can put up an objective and we do that later on under reconciliation that says they ought to be coded so that you can reconcile them and so we do that in a specific one, but I don't see us doing something different than this unless you want us to start naming the standards in all our objectives.

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

No, I guess I'm saying we've had a number of questions because this is both an important one and also a hard one and is this group comfortable with what's written here, which we sort of talked to and said, well it seems to do what we think is needed.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, I mean, I'm still kind of confused by the comments in green, so I think what you're asking, Paul, is are we comfortable with what we originally proposed and then we need to send it to the Policy Committee.

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

Correct, correct. So, it sounds like with the discussion, the answer is yes.

Christine Bechtel – National Partnership for Women & Families

Yeah, I think, so Paul it's Christine, I think the answer is yes, but I think there was a big, you know, discussion as well about is 30% enough to drive it, because I think it was more a threshold issue, you know, it was more... you know, and it's that, I think piece came from my comment that it wasn't necessarily 30% enough across the board but it's such a sort of blunt way to do it, is there another way to think about, you know, if you're going meaningful user to meaningful user as ...

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

Ah, yes, that was an important comment, thanks for reminding me. So, the comment is... and we had talked about this earlier. Do you... yeah... so Christine is saying, right now it's the 30% across the board and then you have all of these other extenuating circumstances, is it better at this point, Stage 3 in 2016, to start taking advantage of the infrastructure we're laying that is there are a number of providers who have, who declare themselves meaningful users, have systems that are capable, shouldn't we look at the communication between those... when you're clinical trading partner as a meaningful user, maybe that's the time to take advantage of things, that was a good point.

Christine Bechtel – National Partnership for Women & Families

Right.

George Hripcsak – Columbia University

You mean if I refer to a meaningful user I have to meet this objective and if I refer to a non-meaningful user then I don't have to meet this objective?

Christine Bechtel – National Partnership for Women & Families

No, no, no, no definitely no, so what I was suggesting was, and again, I don't know the right number here, but the concept was if I'm going meaningful user to meaningful user, then 80% of my transactions should be electronic, if I'm going MU to Non-MU then maybe that's where you do the 30% or you do, you know, 10% or whatever the case may be, right? Because that's what we did in like Stage 1 and then potentially Stage 2. So, where...

George Hripcsak – Columbia University

Yeah, well, I understand it...

Christine Bechtel – National Partnership for Women & Families

George, let me finish real quick, where we...what Judy said was "yes, this is one of the areas where we want to push that" and what we said we would do would be to bring that question into the hearing on health information exchange before we try to, you know, try to tinker with this too much so that we could understand where is, you know, exchange right now, what's going on with Direct, you know, what are...and back to Marc's comments, what are the... you know, what's the one or two, or three things we could do in this context to really drive exchange given that we've now spent several years building an infrastructure.

George Hripcsak – Columbia University

But if their non-meaningful users I'm not sure I can get to 10% never mind 30% since presumably their not...

Christine Bechtel – National Partnership for Women & Families

Well, I think this is...

George Hripcsak – Columbia University

You know...

Christine Bechtel – National Partnership for Women & Families

I mean, but I think this is what we want to know about Direct for example and where is Direct at and how many... you know, we just don't know the answer right now is all I was suggesting and so I think the plan, as I understood it, was to take this question into the hearing with us and have this be one of the key drivers for the hearing was really how do we still take care coordination in a new infrastructure that we're imaging will be the case given that the, you know, quick trajectory of meaningful use in 2016 and then come back to this and not try to fight it out on the phone today or in the Policy Committee because we don't know.

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

Okay, so can I use that opening to say, so Michelle can we just put this as one of the questions we may ask one or more panels to address?

Michelle Nelson – Office of the National Coordinator

Yes.

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

But, this is Neil, I just feel like, you know, I sit on our state board as well and it's just... this always feels so disconnected for me from what is actually going on at the ground level, you know, with health information exchanges and fees being charged to providers for participating, and multiple things happening in the same geographic area and people not knowing what to do, I just feel like, you know... and I know that there is... ONC has got a whole process of funding state HIEs, so I feel like what we're doing is not well connected with what's actually happening and that this discussion is not well not connected with what's actually happening.

Christine Bechtel – National Partnership for Women & Families

Yeah, that was exactly why we talked about creating this hearing.

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

I know, but I'm not sure that the hearing is going to... I mean the hearing is going to tell us what's happening, but we pretty much know that already, you know, I mean, what's happening across the country is that a million different things are happening in different communities and the states all have different HIE plans and, you know, there's some state, multi-state consortia that are developing around standards and stuff like that, but the standards aren't even what's driving it, what's driving it are how to individual providers hook into whatever exist in their communities.

I just think that it's not going to inform... I don't feel like it's going to inform this piece of work that we're trying to do, which is to figure out how much of a requirement to put on individual providers. I think it's going to inform ONC in relationship to what needs to be done to help move this forward at a national level, but I think we're talking at two different levels here that aren't well connected.

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

Well, okay, but there are multiple levels that have to be addressed to have exchange happen. Now, is your comment that for the provider's centric view this is not an appropriate way to approach it?

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

I think the provider piece is... I don't think the providers can advance.

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

Okay, I see.

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

Can advance beyond the stage of their local communities and I think once the capability exist within the local communities for example through Direct or whatever for people to be able to exchange information, you know, meaningful user to meaningful user, people are going to do that because there is going to be no reason not to do it. So, I just feel like it's, you know, what's evolving in the communities is what's critical here and that we're sort of trying to push beyond that.

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

So, let me try to summarize, one way of addressing Neil's concern, in some sense the provider centric objective is to get... to acquire the data that's needed to provide a summary of care document for transitions and actually forcing them to do this for X percent electronically is sort of almost beyond their control because when the environment exist for that to happen the provider will be motivated and they have both the system and the workflow accomplished so that the information is there.

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

Yes, that's correct and the reason I suggest coordinating that with ONC's effort around the state exchanges is because a lot of states are getting lots of money to put, you know, processes in place and that should be coordinated with what we're trying to do.

Christine Bechtel – National Partnership for Women & Families

Right, Neil, one of the ideas though I think we also wanted to explore was, you know, is it possible if the right technical capability is built into the record and CMS were to create a directory of fellow meaningful users then could you essentially, you know, kind of bypass some of the challenges that we're seeing and so for communities who aren't there yet they at least can know in a very automated and very easy way, okay, you know, this, yes, my trading partner over there is a meaningful user and I'm just going to shoot a message because, you know, everybody has the capability to have Direct in their EHR or something like that.

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

So, Charlene, are you tracking this conversation enough to be able to work, you know, provide us some options back on this objective?

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

Yes, yes.

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

Yeah, so I think the major thing is how much to force on the "provider side" versus how much to really, in a parallel effort we've got to solve essentially the community exchange problem.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, this is Amy, and I just want to say, it very much becomes a chicken and egg.

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

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You can't do it on the state side if you don't have the providers having the capabilities in the EHR to send the data whichever model you're using and so, you know, even driving out Direct to providers has, you know, isn't always easy and their reason and rationale, and understanding for buy-in isn't always there, it will be when everyone is there and there's enough reason to use it. So, it really gets to be a circular conversation. We have to... at the hearing I think we have to look at this from a couple of different perspectives, because if we don't pull them together I think, Neil you're right, it does get very frustrating on all sides of the fence here in terms of how to get this coordinated and working properly and it is very much chicken and egg.

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

So, in the extreme, if we got providers to acquire the data that goes in these transition documents and be ready to pull the trigger that would be great on the provider's side and then we've got... so, Charlene, I think if you could give us a way of thinking about this and maybe a couple of options the bigger Workgroup could consider, that would be great.

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

Okay, all right.

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

Okay, moving on so that we can get to the hearing discussion, 30 and 31 have no changes as does 32. So, we're moving into population and public health.

Michelle Nelson – Office of the National Coordinator

Paul?

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

Yes?

Michelle Nelson – Office of the National Coordinator

Before we move on can... do you want to or do you want me to provide an update regarding the advance directive hearing?

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

Sure.

Michelle Nelson – Office of the National Coordinator

Because, we had talked about perhaps having this group also discuss advance directives.

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

Go ahead.

Michelle Nelson – Office of the National Coordinator

So, in a meeting that we had with Steve Posnack we discussed that it may be better to, rather than have an advance directive hearing make this another item as we talked about for certification, so it will have to be vetted a bit more, but we thought it might be appropriate for Subgroup 3 to vet that as well.

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

So, it's really to make advance directive a part of the summary of care document.

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

Is that going to be the question? This is Charlene.

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

I guess it is.

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

And, I think we we're holding off until the testimony, everyone was kind of just like, you know, we're trying our best, so will that just be part of the testimony or if there is an advance directive hearing I guess I lost that one.

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

So, the...

Michelle Nelson – Office of the National Coordinator

There won't be an advance directive hearing, sorry, Paul.

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

So, ONC was not... the question posed by ONC is this, of the amount of hearing dollars you have, is this the one that you want to have a hearing on? One of the things that you clearly want the EHR to be able to capture and transmit this important information where it needs to go, but what's the driver, is it an EHR incentive program or is it national health policy, that was the way it sort of came down to.

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

And, I think, in the minimum our intent was less, certainly knowing and being knowledgeable that an advance directive was available, but again, there is probably some elements around that, because there's a lot of aspects of that that are important.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, this is Amy, I have a suggestion. Is this... you know, since, you know, money may be an object or something, I mean, I think, our discussions were that there were a number of different implications state law, regulations, legal matters that were playing into this. Is it possible to do like a phone...?

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

A listening session?

Amy Zimmerman – Rhode Island Department of Health & Human Services

A listening session to learn what we need to learn and sort of like a hearing on phone like some of the Subgroups did, because that may be a way to get at both here and still, you know, be respectful of the dollars and the time and the travel and all that kind of stuff.

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

What do you think, ONC?

Michelle Nelson – Office of the National Coordinator

So, I guess it depends; maybe we could just do it for the Meaningful Use Workgroup, Paul?

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

Yeah.

Michelle Nelson – Office of the National Coordinator

I mean, we did listening sessions for Subgroups 3 and 4 anyway, so, you know, we could probably could follow the same format and see how that goes.

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

No, I think, Amy has a good suggestion. One, we want to be more informed about the implications and although it's a policy decision, the ability to access and however you might know what the current wishes are, the current advance directive is, it's still a question that is really hard to solve for which HIT could play a major roll and so I think, it's still something where this capability doesn't actually exist today but it could, we might want to be moving in that direction. So, that's our rationale for why it would belong in the Meaningful Use Program but in a more cost-effective way we could do it as a listening session as Amy suggested.

Amy Zimmerman – Rhode Island Department of Health & Human Services

And, I would suggest seeing which of the Challenge Grants on advance directives, you know, where they are and how they, you know, what... I don't know which states or which areas got funded on the Challenge Grants or how many were on that, but I know there were some, so I would think that that would be a few good individuals to bring into a listening session.

Michelle Nelson – Office of the National Coordinator

Yes, so we do have that information, so my only follow-up question is, Paul, do you want to plan that, do we want to do it in one of the Subgroups and then invite all of the Workgroup members or for the planning should we involve the entire Workgroup?

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

The planning to involve the entire Workgroup.

Michelle Nelson – Office of the National Coordinator

Okay.

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

So, it would be a Meaningful Use Workgroup call that had a listening session that included the kinds of questions we had planned for the hearing.

Michelle Nelson – Office of the National Coordinator

Okay, so we may not have time today, but we may need to schedule a separate planning call.

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

Yeah, I think we don't have the time urgency, so we don't have to spend the time today. We do have time urgency on HIE, so I'm still driving to try to get us to there at that point, but okay, so that's a good compromise, Amy, thank you. So, it's a listening session, same topic, we'll plan that later so that we can have it during one of our Workgroup calls. Great, let me move onto category 4 and this is on page 34 and 35. I'm going to try to sort of summarize the bottom line here.

In a sense, as you know, public health is extremely important, we would love to have bidirectional exchange with public health data and that public health was not funded, while they were extraordinarily grateful and happy to see that we're moving in this direction to make EHRs capable of not only capturing important data but transmitting it, it's almost like this last discussion we had, it's a bit much and we certainly had a lot of time expended by providers when there is really nobody home on the other side because of one, the different, you know, the fifty different states, but two the amount of money that may or may not be available.

So, the thought was... the thought is to focus in on something where there is more maturity across the different states and that is on immunizations and to try to make it a poster child for saying, what information can we get that's relevant to this individual and what information can we get in a timely way and we saw this with H1N1 that continuously updates us on who is eligible and who are the high risk folks for this particular public health threat. And work on that particularly in immunizations. And probably sort of not advance the ball on the others because it's just not a ball that broadly public health is able to receive right now. So, that's an approach and just really want to hear people's comments on that. I don't remember whether Art is on the line?

George Hripcsak – Columbia University

Art is away.

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

Okay. So, what are people's thoughts there on that approach?

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, I think, this is Amy, if you look at the... I mean, I think, that's fine, I think, we... the Population and Public Health Subgroup spent a lot of time talking about immunization and how that was one of the first places to go and try to push bidirectional. I'm trying to go back now and flip through the slides and see what else that means where we may have proposed some of that that we wouldn't move ahead on and whether it's sort of the case reporting for reportable diseases or...if I'm hearing you correctly, Paul, you're saying that prioritize immunization high and drop a lot of the other objectives out?

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

Right, don't push on where really it's beyond the provider's control, that's sort of just an approach. One of the... now registries is another one where, gosh it's still a great idea, there are so few out there and then we have complication with some of the providers here, the ones out there, not quite...just not pushing beyond what people can do now.

One of the ones that was somewhat attractive though is the adverse event, as you know that's something where we have extreme under reporting, there's a lot of good data that could be made available including states with EHRs. So, that might be one of the new areas where we want to start driving. But, anyway, the main thing is not to push further, I mean, we already have in Stage 2 there's some, you know, continuous, meaning it's not just a test, you connect and you do something, but public health departments are pretty strapped and it's frustrating to be pushing on something where we don't have a receiver.

George Hripcsak – Columbia University

So, Paul, I think, that's what we did is what you're suggesting, really the new stuff is under immunization and then HAI is new also and the rest were just maintaining what was there. Registries are a different kind of thing, connecting to the cardiac database is not really a drain on the public health system. So, if we go through, right, we have new objective for immunization, next page is new objective for immunization, next page is unchanged, next change is not Stage 3, next page is no change from current, next page is registry stuff, the next two pages, and then there is HAI, that was the other new one, which is kind of like you're adverse, and then adverse reports was another in Stage 3. So, really all we have new is immunization and HAI.

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

So, I think there's agreement but we didn't state it exactly as that and I'm just...

George Hripcsak – Columbia University

Well, that's how Art ended up with that list.

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

Correct.

George Hripcsak – Columbia University

As to why those other ones that are stage undetermined is...that's how we move them out, but he still wants to get comments back from the community about them.

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

Okay, so, I mean...

George Hripcsak – Columbia University

So, really for the other ones like externally... like knowledge in order to know how to do a case report that's on slide 38, he wants to leave it in there so we get it in the RFC but make it clear that we're not necessarily saying this has to be Stage 3.

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

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah.

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

Paul?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Thank you, that's what I was trying to say. I didn't think there was a lot else that really...so, thank you for saying that.

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

And, Paul, the HAI one seemed to be the reason we wanted to start to get it in there. And again, we were thinking 2016 is hospitals do this today and would love to do it electronically. So, it seemed like low hanging fruit to us. So, again maybe too many objectives and we respect that, but that was why it went there.

George Hripcsak – Columbia University

And this goes to NHSN not to your local public health agency.

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

And HS, yes.

George Hripcsak – Columbia University

So, that I'm not relying on the capabilities of the local health department.

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

Yes.

Bruce Gellin – Deputy Assistant Secretary for Health Director – National Vaccine Program Office - Health and Human Services

This is Bruce Gellin at the National Vaccine Program Office at HHS, let me just...this maybe beyond where you want to go, but I would just point out one thing that increasingly people get their or people are getting vaccines from a variety of places not just their providers more the case with adult immunizations and you know, you watch the flu season, you know, every drug store has got signs starting probably next week, was this going to allow non-primary care clinicians and particularly some of these retail outlets to play, because connecting those dots is actually going to make a huge difference, particularly on the adult side.

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

It's a fair question, they're not covered, but they can take advantage of everything that gets created so that people can be meaningful users. So, in particular that's of course of the standards and the openness with which people accept and comply with the standards for the interfaces.

Amy Zimmerman – Rhode Island Department of Health & Human Services

It also may depend on the state and whether the... or whatever local or state registry at whatever jurisdictional level has the ability and the connections to take that information in or requirements to take that information in. I think it's very variable, but what this would do is if it got into some sort of a jurisdictional registry then it would be accessible because of the bidirectionality back out to the meaningful use providers even if the person administering the shot who sent the data into the registry was not. But, I think, if you're asking does this require non-meaningful use entities that are administering vaccines to submit it to the registry I don't think this does that, I think that depends on jurisdictional policies and regulations and law.

Bruce Gellin – Deputy Assistant Secretary for Health Director – National Vaccine Program Office - Health and Human Services

I think we can socialize it even if it's not a requirement, thanks.

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

Yeah. And, I'll bring up another comment which is similar to that, that was made by Judy Murphy representing ONC, which is even though we are... our task it turns out in the legislation is pretty broad in terms of... there are these 8 topics and then anything else that may relate. So, we have a fairly broad thing, broad scope and we could make a policy comment regarding national standards for immunization data that may help states sort of align and have more uniformity there. So, that's just an avenue so we could state something like that. So, if we focus our attention on immunization as a high value piece of data.

Let me move onto page 44, because we're just eating into our HIE time, to re-enforce, so these are some general comments from the Policy Committee. If you'll look even at the first three bullets about requirements creep, about concern about the time, money, will power and consensus to do all this and are we in danger of diluting what we're trying to do with too many objectives. As you know, that basically speaks to our parsimony principle, but it's just where it's... just like we just said in the public health, yeah we can defend each and every one of these things but if you add this much, especially if you don't have necessarily a receiver that's in this program you... providers will spend time on each and every one of these objectives, and that means spending less on overall objectives.

So, the more we focus the more we get the critical few, the better off actually we'll be in accomplishing our objectives and somebody added them up and currently we have 56 objectives and can't we get that to a smaller, it's not really the number, it's the smaller areas of focus. So, I think, that's a charge we should keep in front of us as we move towards even the Request for Comments because even the Request for Comments will dilute people's attention and we really would love to get the things that are necessary to do by a public mandate in the name of public good and stay away from things that are going to happen once we get things in place and so a little bit what Neil was saying in terms of it's not that we don't want to share this data, it's that we don't have the infrastructure and let's make that infrastructure, which isn't happening on its own, make that more possible.

So, that's the segue I want to use to going into the HIE planning. So, clearly, as you know, Stage 2 was supposed to be on HIE, that what we envisioned back in 2009, we know it's a heavy lift and it isn't simply technical but there is still actually technical challenges around.

How do we both identify and understand the challenges that are being faced in the field and when you hear about those all at once, including their ideas of making it better, can we come up with some policy levers that help move the ball, because we have a chicken and egg, you know, it goes back to the fax, which I guess it was invented in the late 1800s, but it really takes a neighborhood having fax machines for it to start flowing. How do we create the enablers to have the neighborhood have HIT that would allow this data to flow and HIT includes the standards.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Paul, can I... before you go on, this is Amy, can... how is this being coordinated this hearing or is the planning being jointly done with the Health Information Exchange Workgroup? Where are they fitting in?

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

So, we're going to, and I don't know whether you have the answer about the standards yet, Michelle, but, we're going to have a couple Subgroups plan this, so right now it might be a combination of the IE Workgroup and the MU Workgroup, if there is a standards partnership, Michelle do you know that answer yet?

Michelle Nelson – Office of the National Coordinator

I think, we... I thought we had decided that there is an Implementation Workgroup that's part of standards that they would probably be the most appropriate.

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

Okay, so the answer to your question, Amy, is there would be three Workgroups that are jointly conducting this hearing.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay, good, because I know I've got an IE Workgroup call I think sometime this week or tomorrow or something, so I'm just trying to make sure I'm cross breeding and connecting the dots.

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

Okay.

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

The IE Workgroup, this is Mary Jo, the IE Workgroup is tomorrow.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay.

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

And, Paul, I think you may get some additional input from Farzad this afternoon about the standards coordination piece.

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

Okay, great. So, let me just vet some, I'm just going to seat it with some of the topics that we've certainly heard about and get you're feedback on those topics or something you think is more pressing. The goal back is that what's the breakthrough here? It may be in several areas, we want it to be as few as possible to really nail the Achilles heel if that's possible.

So, some of the topics that we've certainly heard about, the data use agreement, every group in every state is going through this and it is a calendar time occupier, meaning years not just even months, and we're all reinventing the same thing having the same discussion. I think and you heard Gayle, you know, if we had a federal floor and the encouragement where it really would be wonderful to have a uniform floor, then all of a sudden we could bypass a lot of that work, we'd have to vet it, yes, but not regenerate it time after time, because that does take calendar time and it just isn't the time that we have.

So, that's one kind of... if we understood the challenges that are coming up and what's an approach... is everybody basically asking for the same thing, we actually had a panel, I don't know 2 years ago, where people were literally asking for us to do that, us meaning us to recommend that for the federal government. So, we might... and I can speak... and California experienced the same thing. So, we might actually have this uniform prior to this which would be why don't we just get this to happen.

The second piece is we've faced before, is this cross vendor transmission. Yes, everybody says they want to do it, but no it doesn't always happen, what's... is there something we can create in certification and test more importantly probably testing, can we construct the scenario where here's the test data, it's got to make it from system A to system B in the right fields in system B and produce a quality measure, can there be something that we caused to sort of unify the testing that really assures that when somebody... a customer gets one of these systems it truly is able to connect to another system and transmit the relevant data. Can we do a better job at that? What are the policies we which we could pull there.

Patient matching is another area, clearly even in one organization you have the labs returning, it was a different identifier, but it really gets even harder when you try to exchange with other systems. So, what are we hearing from the field and are there approaches, are there voluntary approaches to make things better?

Certification requirements, now that we're sort of on another path are there certification requirements that we can introduce without burdening the provider that really gets information to flow more smoothly. So, those are some of the examples. Comments about those and other challenges where we need some breakthroughs?

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy and I'll start, on the data use agreement I clearly understand the issue, I'm trying to understand how the EHR and the EHR functionalities tie into the data use agreement, in terms of meaningful use, you know, objectives and criteria.

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

So, you're right, it's certainly within the realm of what the HIT Policy Committee can make recommendations on; it may not be necessarily meaningful use.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay, all right, I just wanted to clarify; I thought I was missing something in my mind on that one.

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

Understood, that's good.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, the other thing and I'm trying to think about this again, I'm not sure if this is in terms of meaningful use or whatever, but the other challenge I think there is and it's more at an educational level and it's more maybe at a product level is how the data gets... where and how the data gets standardized and entered into the EHR so that it can be pulled and sent to the next provider and I don't know if that's appropriate for this. I mean, it certainly impacts the value of sharing data, because if data is in a wrong field then it's not getting pulled out to the CCD or CDA or whatever because that's not how the system works, then it minimized the value and I don't know if that's appropriate here or not, I'm just throwing it out.

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

Yeah, it's a little bit like the workflow issue we got into CQMs.

Amy Zimmerman – Rhode Island Department of Health & Human Services

All right, so it may not be appropriate for this. So, that's fine, I was like I said...

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

Okay, other comments?

Deven McGraw – Center for Democracy & Technology – Director

Paul, this is Deven.

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

Yes?

Deven McGraw – Center for Democracy & Technology – Director

We had an entire day of testimony on the matching issue and when I say "we" I mean the Tiger Team which then generated a set of recommendations to the Health IT Policy Committee that most of which haven't been acted on yet. It sort of feels duplicative to be asking people to testify on that issue again.

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

Okay.

Deven McGraw – Center for Democracy & Technology – Director

Versus going back through what people already recommended and what we recommended in thinking more strategically about how to implement some of those recommendations.

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

That's fair. So, subject to what we might hear... so, is it worth having any people talk about... I mean, of the questions that we submit to the testifiers, is asking them about patient matching a valid one? So, for example, let's say they raised something that wouldn't be necessarily... I think what you recommended was standardized data elements you used to do patient matching, correct?

Deven McGraw – Center for Democracy & Technology – Director

Yeah, we had a bunch of recommendations on this topic actually, you know, only one of which is sort of more tied to sort of EHRs and using EHRs, and that's the one that you just highlighted, which is, you know, standardizing the data fields that people typically use to match, but it wasn't limited, I mean, I'm not opposed to asking a question but I'd much prefer that the questions be more pointed so that we don't sort of drill down to the same old identifier or no identifier debate that I think is really paralyzed us from being able to move forward on this issue.

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

That's a good point. So, it may be a question but not a whole panel on it for example?

Deven McGraw – Center for Democracy & Technology – Director

Yes, fair enough.

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

Okay, fair enough, yeah.

George Hripcsak – Columbia University

I agree with Deven, but going even further, I don't know that we should be focusing on how because that's not what Meaningful Use Workgroups, have... I mean, we need the why not the how. So, I think, the question is in the... now it's 2 years later than the last time we went into detail on this as a Meaningful Use Workgroup, I think some of the other groups have been working on it all along, but, and so... is there a different question of what could we mandate that people will demand so much that it would push HIE to succeed. I mean, we're at or how it will improve the quality of care or something like that rather than what the Standards Committee I would think would be doing, which is how to get it done.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You know, one way to think about this maybe to think about sort of almost the way ONC has thought about it from the more, you know, from... or the way I think ONC thinks about it, which is, you know, you've got two kinds of layers of HIE, you've got sort of the Direct messaging point-to-point and then you have more sort of network systems, query and retrieve and I'm wondering if somehow thinking about structuring and I don't have this thought through yet, in terms of questions and issues related to those two levels, because that's sort of where the dichotomy comes in and some of the stuff that Neil was talking about before, about understanding how, what are the drivers to get... to make those happen together, to have them not compete and to get the incentives to have, you know, players on all sides of the exchange want to exchange and need to exchange.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, and one idea would be to look at how fax machines and the use of fax machines today are not covered under security under HIPAA. How does that existing infrastructure get in the way of a more electronic and interoperable infrastructure and are there policies that could be done that could help us move from the fax to the health information exchange.

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

Neil, you had raised this in the context of care coordination, do you have thoughts on, are we on the right track in terms of the kinds of things to deal with on this side, on the exchange side? Are you still there? Okay, other comments, since Neil is not...

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

Paul, this is Charlene, I think, you know, the... I mean, I think, where the concern is some of the cost of this, I mean that's what he seemed to be really be highlighting not only the confusion around it, but just, you know, the barriers on the ground, so I don't know, again... I know the Recs must be dealing with this in terms of getting their providers, so there might be some places that input harmonizes, but, you know, there...is it just awareness or is it, you know, so where are the issues that are really... I mean the data use seems to be a key one, because that seems to be what on the ground is occurring is this confusion, who do I go to and every single interface is going to cost me and where is the broad value of this, and that kind of item seem to be what he was saying.

Amy Zimmerman – Rhode Island Department of Health & Human Services

But, I think, Charlene, to that point, I think its how do we get to the tipping point.

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

Yes.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You know, I mean, when enough is... you know, whether you use the fax example or Direct, or even if you use an HIE as a noun, a system, you know, no one is going to use it until enough of their patients have enough data in there that they're going to want to, you know, query and retrieve and have it integrated into their EHR.

And the other thing, you know, looking at this, I mean, you've got the ability to consume the data, to query it as well as consume it, I mean maybe that's another way to break down the exchange, because again, what I get faced with sometimes is we have a... you know, we have an operational health information exchange network system, centralized type of thing or noun, but the primary care providers are frustrated, they don't want to have to go query and retrieve and look up something outside of their EHR. So, if they were to do that how could they then consume the data that may get sent out of the EHR have it de-duplicated and put into their EHR, denoted where it came from if it wasn't originally theirs and put in the right data field so they can view it along with everything else.

To me, that is one of the core... you know, the how is a different thing, but to me that always... that has been a barrier even in the use of deploying a more centralized HIE and, you know, I don't... so that's just one other thought.

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

So, let me ask a chicken egg question. I think we spend a lot of time right now thinking about, oh, I have an EHR, it's a piece of software, it needs to do this and then when we say, oh we want it to exchange between EHRs we have to create another thing called an HIE noun and to say... and then we've got to pay for it, when so far I think we're missing the driver. So, what if... let's pretend tomorrow ACOs were just the fada complete for the entire country of private and public sectors, is that enough to make the market figure out this problem and in a sense it won't be how do we pay for this intermediary, it's how do we absorb the cost of getting data so that I can correlate the care better for my patients. Do you see what I'm saying? Are we missing the drive, is that the problem and if the drive magically appeared for everybody would the problem get solved on its own? Did I make any sense?

George Hripcsak – Columbia University

Well, Paul, my point was that it's... actually that is either true or not, but still our job, as the Meaningful Use Workgroup is to figure out how to drive it.

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

Well, no, I don't know.

George Hripcsak – Columbia University

Now if there's other stuff that needs to be done... well, I mean, because we have an HIE Workgroup as Deven said working on that, so I think we need to work on what drives it and that's what will solve it. So, what is the use case today that we can push forward on meaningful use that would actually create sufficient incentives that people will get over these obstacles?

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

So, that's my question, is: Can meaningful use drive this or does it really rely on the new payment model like the ACO? So, once it is in everybody's best interest and in a sense you get compensated for in your total costs of care, which includes the care coordination, one, is that the missing piece that's forcing us to try to push a wet noodle and two, once that's there do we actually have to push anymore, isn't it just making sure that it's enabled properly.

George Hripcsak – Columbia University

Well, maybe if health care reform ACOs go through that would push it, we would step back, even if that didn't go through I think there's sufficient need for it that it will go through it's just hard to get over the hump, but I think patients really have a need for their data to move around and they don't feel it yet so they don't really understand how to ask for it or their complacent with not getting it, but once they see it they'll appreciate it in a way that it will be worth the money even without the ACO model. But, if ACO comes through you're saying can we step back?

Amy Zimmerman – Rhode Island Department of Health & Human Services

My opinion is you need multiple drivers all, you know, converging to the same point, because there maybe, the more there is alignment in the drivers the more reason and rationale and not all of those drivers are going to get... you know, are going to happen at the same time. So, the more there can be convergence, you know, in whatever direction and I'm using this as an example, you know, so, you know, here in Rhode Island if we can get doctors to adopt Direct and that's how they send data to the HIE now, and that's how they send data to public health and they're required to do it for meaningful use, I mean the more you can give someone a reason to do the same thing the more you're going to get it done in my opinion. So, I think, we have to keep thinking about how we align multiple drivers to get to where we want to go.

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

So, maybe a different way of asking my question is are we... can we be successful driving it with these kinds of levers we have in the absence of, I'm just going to use ACO as an example? Is that what, you know, I don't know that we can actually pay people to exchange data when they don't have this compelling reason, which is the payment reform.

George Hripcsak – Columbia University

I think, yes.

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

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I kind of feel like we have to try at least.

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

Some of this I actually agree with the sentiment on the call, this is Charlene, about some testimony that we said we heard was actually, to your point, was without payment reform those that are really trying to use the system to, again where in care coordination, reduce re-admissions, make sure appointments are followed through, reconcile medications, and getting great results with reduces with bad outcomes can't afford to stay in business. So, you know, I think, payment reform is part and parcel of what we're trying to do, but I would agree with Amy that I think we need multiple drivers pulling us in directions because the implementation of this is so diverse and scattered.

The other thing that this process brings to the table is without IT driving it to some extent some of the questions about how to reconcile and report measures never get asked. So, this does force some of those...I know IT is not supposed to be the policy setter, but it does force decision making on some of those policies that we need to deal with.

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

Okay, so let me...we have just 5 minutes left, can I get some either support for some of the topics that I mentioned and/or new topics and then have staff work on proposing back to us some people. So, topics that I had mentioned were data use agreements, dealing with the cross vendor transmission, another area is what certification requirement levers can we pull to help with that? I did mention patient matching, but I think, Deven brings out a good point, we don't have to have a panel on that but we can include it in the question in terms of how are they dealing with it and what issues they have and what is the proposed solution. What other topics for panels would you like to see?

George Hripcsak – Columbia University

Are we doing anything on...are we hearing in the hearing how things are going from someone?

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

Yeah.

George Hripcsak – Columbia University

To get a status update as part of it, like there are a bunch of HIEs merging in New York, so I think more people would like to hear about that.

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

Okay, exactly.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I think, based on the conversation we had before with Neil on the phone, I wonder if some sort of provider panel or provider perspective and then sort of maybe juxtapose to the more sort of state either from a point-to-point Direct perspective and/or a more centralized state HIE. I mean, I think, that would give us like some comparisons and different perspectives to think about how to make this align.

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

Okay, so a provider, so maybe the topics I mentioned before are topics of questions but the panels include providers, a provider perspective, the state HIE perspective, what's another, what's another perspective you want to bring to the table?

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

I mean, and you might want to bring like, you know, there are a lot of HIE vendors so you might want to bring maybe a panel of one or two of those plus some of the people that have attached to the states to the table, kind of a vendor one, maybe not two but one, I don't know how you would choose, but I think, again they've got good cross cutting statewide or national perspective.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, and I would, going back to sort of the statewide perspective I would...I think what would be helpful would be looking at whoever we get to, you know, testify, you know, sort of a state that's heavy into more of a sort of Direct and HIE service type of model, and then maybe more of a centralized noun type model, because they're very different, you can bring them together but I think they present different challenges and different food for thought and how to break through here.

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

Okay.

Deven McGraw – Center for Democracy & Technology – Director

Agree, you know, Paul, this is Deven, when I was at that learning, at another, yet another seminar on the learning healthcare system and developing principles for it, Jim Walker from Geisinger talked about the consortium that some of the larger high performing systems had brought together and he said they were actually exchanging data and they are not all using the same vendor.

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

Yeah, that was like Kaiser, Geisinger and VA.

Deven McGraw – Center for Democracy & Technology – Director

Yeah.

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

And Intermountain I think, right?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

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

Okay.

Deven McGraw – Center for Democracy & Technology – Director

So, you know, I don't always like shining the spotlight just on the big guys but if they are actually exchanging data I'd love to know, like how frequently this happens, what were the obstacles, how are they doing it?

P. Jonathan White – Agency for Healthcare Research & Quality

Briefly, this is Jon White, the CCC, I can't remember if it's Care Collaborative Consortium or Collaborative Care Consortium, is still an active going concern, Jim says they're doing good work and I'm sure he or somebody there would be happy to talk to you.

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

Okay, any final comments on a panel? Did you want to say something about the... so the date, the 18th is now out and the 17th is now out?

Michelle Nelson – Office of the National Coordinator

I think those are just tentative dates that we had out there.

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

No, I mean...

Amy Zimmerman – Rhode Island Department of Health & Human Services

I was just raising that is was the Jewish New Year, both... I mean, depending on whether you celebrate one or two days, they're not ideal from my personal perspective or anyone else that may celebrate the holiday.

Michelle Nelson – Office of the National Coordinator

Sorry, I may have missed that.

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

That means both the 17th and 18th are out, right?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Wait, let me double check my calendar because I actually, I said it right the first time, I had it wrong in my calendar and then Neil corrected me.

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

Yeah, he said the evening of the 16th through the 18th.

Amy Zimmerman – Rhode Island Department of Health & Human Services

The 18th, yes, so, if we want to try to be sensitive to the holiday and a number of individuals celebrate both days then the 17th and 18th are out.

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

Okay, so let's go back to the drawing board on those dates, but, is it acceptable to the Workgroup to have staff work on panels that can address some of the issues that we've raised today and then we'll find people to address those issues, and then we'll find a way of organizing them into a panel, you know, that would make sense and run that by... I think we'll have to do this by e-mail and then our next call you said was, I think, the 23rd. So, we should probably... that means we're basically counting out, at least the first half of September in terms of when to have it. Maybe we move towards the second half or later.

One of the goals we had was can we formulate our thoughts enough to propose something for comments to be in the RFC and because we're presenting those on October, I believe even the 1st then we have to have the hearing before then.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, and Paul, while we're talking about it, as I'm looking at my calendar the night of the 25th and the day of the 26th is Yom Kippur so those would be the same conflict as the 17th and 18th.

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

Okay. So, if people would please when we send out the names, please send us e-mail back with either other names that come up in your mind or any comments you have on the evolving names that would be helpful, so we at least can have the draft to tweak and approve next call and we'll have to figure out when the hearing itself can happen. Well, thanks everyone for your vigorous participation in this call and for all the work that led to really a largely excepted set of proposals we had presented last week, really good work and thank you for that. And why don't we open it up for public comment then and while we're doing that any other final comments from the Workgroup members?

Public Comment

Rebecca Armendariz – Altarum Institute

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

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

Okay, Paul.

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

All righty, well, thank you everyone for your participation and we will get some information out for your feedback about the hearing and then over the next couple of weeks the Subgroups are meeting and they have specific and we'll summarize those, as we've talked about, we'll questions for each Subgroup so that we'll have those to present back on the 23rd as well. Thank you.

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

Thank you.

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Thank you.