

Meaningful Use Workgroup Transcript October 15, 2012

Presentation

Operator

Ms. Robertson all lines are bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everyone; this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there is public comment built into the agenda and the call is also being transcribed so please make sure you identify yourself when speaking. I'll do roll call. Paul Tang?

Paul Tang – Palo Alto Medical Foundation

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. Amy Zimmerman? Art Davidson?

Arthur Davidson – Denver Public Health Department

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Art. Charlene Underwood?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Christine. David Lansky? David Bates? Deven McGraw? Latanya Sweeney? Leslie Kelly Hall? Marty Fattig?

Marty Fattig – Nemaha County Hospital

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marty. Neil Calman? Greg Pace? Sorry, was that Neil? Okay, Greg Pace? Joe Francis? Robert Tagaliod? Tim Cromwell? And Yael Harris? And are there any staff members on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy Zimmerman and I just joined.

MacKenzie Robertson – Office of the National Coordinator

Oh, great, thanks, Amy. Okay, Paul, I'll turn it back to you.

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

Okay, thank you very much, MacKenzie. This is the Meaningful Use Workgroup call and we have an hour and a half to go over our agenda. I think they're in three pieces, one to go over the comments we had from the full Policy Committee on our proposed RFC, the second is we can go over an e-mail that I believe has been redistributed from Friday from Tom Frieden who you all know is the Head of the CDC and third is to look at some questions that Charlene is bringing as far as how do we understand the public feedback on care plans as phrased in the public comment period. Any questions or additions to that agenda? And we have one more call before our November meeting. Okay, why don't we start going through the Power Point, which Michelle has kindly put together and she has called out some of the Committee comments in yellow and you want to just advance to the first question?

Michelle Nelson – Office of the National Coordinator

I think that's slide 6.

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

Okay, so one is Farzad talked about some of the public meaning like in the media comments about documentation and particularly coding and some of the implications it has had for billing and I think that documentation is a rich area in and of itself, it has everything to do with – it has a lot to do with the actual efficiency of the providers and that's driven by a number of things, some have to do with medical coding, what's needed to take care of the patient, some of it has to do with billing and compliance, but it also takes a lot of time, so it's really an important topic in EHR adoption and effective and efficient use. So, it's something I think it would do us well to actually concentrate on and potentially even have a hearing or a listening session to delve into some of the issues and talk about it more generally. I don't think that's what we're going to do today, as you know in Stage 2 it's the first time we even had documentation enter into the Meaningful Use requirements but we probably can do well to think about well, how can the EHR support us in doing effective and efficient documentation. So, as I said, I think we'll plan for taking that up as a special topic.

The other thing that Marc Probst mentioned was how the level of effort works into the objectives and certification criteria and there it's level of effort by both the vendors in developing functionality as well as the level of effort to comply with its use by the providers either during the implementation process or actual day to day use. I think we actually had that in one of our matrices in earlier time and maybe you recall, Michelle, or maybe it predates you, we had a face-to-face and we talked about prioritizing, it may have been a year ago, prioritizing each of our proposed objectives and saying, well what are the benefits of course and a number of the principles we talked about, exemplar and you know a big gap, etcetera, but also the "cost" of implementing those. Is that around? Is that something that was around when you started, Michelle?

Michelle Nelson – Office of the National Coordinator

I'm not aware of it but I can go through and try and find it.

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

Okay, it was during a face-to-face meeting and then we had it filled out during one of our subsequent meetings, but we just probably need to resurrect it and it's just sort of a qualitative thought about...I mean, it's part of every cost benefit analysis so that would be helpful.

Michelle Nelson – Office of the National Coordinator

Paul, do you remember if it was a Meaningful Use Workgroup meeting?

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

It was a Meaningful Use face-to-face.

Michelle Nelson – Office of the National Coordinator

Okay, thank you.

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

And then what happened is afterwards we did put that matrix together and used it as far as part of our initial proposal and I believe that was for Stage 2. Okay, you want to advance to the – any problem with let's say working on documentation as a separate project and then going and resurrecting some of the matrix as far as the level of effort required?

Arthur Davidson – Denver Public Health Department

So, Paul, this is Art, are we talking about having this done for the next meeting?

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

No. I think it's just we used it at one point, we probably can refer to it again or incorporate that thinking again into our development of our final recommendations for next May, so it's worth thinking about the level of effort it takes to put into some objective that makes sense and we're just calling up some old Workgroup items. Does that makes sense?

Arthur Davidson – Denver Public Health Department

Yes, thank you, Paul.

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

Good.

Christine Bechtel – National Partnership for Women & Families

Paul, it's Christine, I just wanted to add kind of one other lens that I think came out last week when folks at RWJ released the Open Notes Project study results and it was – there was a big sort of tension, this was a project where they opened up these progress notes to patients so that they could view them and in some cases contribute to them, but the big tension that sort of came up was, I think as you're pointing out, you know, how progress notes get used for documentation and coding and billing, but sometimes that means that they really miss the narrative that's important for the care team and for patients, so I just wanted to make sure we sort of have that lens as we move that work forward, which I agree is important.

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

Exactly, I think there's a lot of good that can come out of "documentation" I'm not sure we're realizing that right now in the current state, which means it's a good topic to look at and there could be a better way of just approaching it all around to make it a win/win. Okay, could we move onto the next set of yellow then please?

Okay, here was – okay, it was Gayle's comment about the PDMP and this is a database set provided I believe, Michelle, to help watch out for drug ... abuse of drugs and abuse of prescription drugs and prescribing is that correct?

Michelle Nelson – Office of the National Coordinator

Yeah, so I don't know too much about the pilot work that ONC is doing, but I did quickly have a conversation with Steve on Friday and, you know, ONC would be happy if the Meaningful Use Workgroup asked questions about it in the RFC and I could possibly loop back with him and maybe he could join us on our next call if that is something that we're interested in.

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

Okay, so the point that Gayle was raising is we talked about, gosh, you know, actually it's still pretty hard in the private sector to know exactly what plan an insurance company has many plans that an employer may sign up for and knowing what formulary applies to that plan for a particular patient is pretty challenging and that's the reason why we had initially put this as a placeholder for Stage 4. What Gayle had brought up is in the Medicaid Program they already, I guess, for all the states have a database with formularies and that's active and so her request was that we consider that in Stage 3. I think what we might want to do, as Michelle is suggesting, is try to understand more about, you know, the prevalence and the use of that as we prepare for making our final recommendations, is that a Stage 3 or is that a future stage? So, maybe we could use some help in putting together the questions in the RFC that would say, well how are states doing and how are providers doing in accessing that database. Does that make sense?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, Paul, this is Amy, the Prescription Drug Monitoring Database is a different issue, I just want to make sure, that is one issue and then Medicaid formulary is a different, correct?

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

Yes, that's correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services

They're not the same issues; I just want to be clear about that, they're two different issues.

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

So, is it true that it's one in the same database that would help us both with the drug monitoring as well as formulary, is that true?

Amy Zimmerman – Rhode Island Department of Health & Human Services

No.

Arthur Davidson – Denver Public Health Department

No.

Amy Zimmerman – Rhode Island Department of Health & Human Services

No, that's what I'm saying, that is not necessarily true at all.

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

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, most states, I don't know if all states do, but most states have or are moving towards or have a Prescription Drug Monitoring Program and that has – like in our State in Rhode Island that's in the Department of Health that's so that pharmacists and providers can go on and look at for controlled substances.

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

Right.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You know, Class 2s and Class 3s and whatever, you know, whether someone receives something and so that's really around, you know, the abuse.

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

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

The Medicaid Formulary is probably, you know, in a completely different, I would say in many places, you know, it might be part of MMIS or something else. So, that's why I'm clarifying they are not one in the same.

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

Does anybody know whether the Medicaid Formulary is alive and well in every state currently?

Amy Zimmerman – Rhode Island Department of Health & Human Services

I actually don't know that, I don't even know that for my own state and I should, so I apologize.

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

Okay, so I think we have a little homework to do. It sounds like we're not going to change our recommendations as far as what's mature and ready for Stage 3 so we could have homework on both of these issues and thanks for clarifying Amy these are two different ones, one is whether we already have Medicaid Formularies because if there are at least there are only 50 of them or 50 plus territories versus 100s of private sector plans and the other is whether there in future stages should we consider accessing the PDMP. So, those are things that perhaps ONC can at least clarify the issues for us and then we can think about where we might place it, but it doesn't sound like it's ready for Stage 3.

George Hripcsak – Columbia University

Well, so Paul, do we want to put this in the...so are we doing work on this on the side or we're put this in the RFC? The RFC isn't an efficient place to find out the answer of Medicaid-based, maybe it is, but ...

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

I suspect ...

George Hripcsak – Columbia University

... not an answer.

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

Yeah, so for example if a Medicaid Formulary does not exist in a publically accessible way, in a standardized publically accessible way in every state that sort of answers our question. If either of these two things are available and already have a public ACI then we can ask the question in the RFC how many people are using this. Do you see what I'm saying? So, a bit of a – it's staged.

George Hripcsak – Columbia University

Do you think we're going to find out about all the states before we have to generate the RFC?

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

Does anybody at ONC know whether it's a findable answer?

Arthur Davidson – Denver Public Health Department

It should be available from CMS.

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

Yeah.

Michelle Nelson – Office of the National Coordinator

Yeah, I mean, hopefully, I'll be able to, this is Michelle, I'll be able to get the answer before our next workgroup meeting.

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

Yeah and actually you can distribute that in e-mail once you confirm so we'll know.

Michelle Nelson – Office of the National Coordinator

Yes.

George Hripcsak – Columbia University

Well if it's a moot point it's a moot point.

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

Right, right. Okay, so does that make sense for folks? Okay, next yellow. Okay.

George Hripcsak – Columbia University

I'm looking over my notes on this one.

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

Yeah, I'm not getting it exactly from the yellow comment, but I think it's still a question; maybe we're still not clear on what our intent was in terms of maintaining the accuracy and completeness of these lists. So, the idea is these are well known to be high leverage, high value lists but they're also well known to not be always accurate or complete, probably the best of these is the medication allergy and one of the reasons is people generally ask about it almost every time certainly when you're going to prescribe a medication.

The other two I think everybody would appreciate assistance with maintaining the accuracy and completeness, and our request which is certification only is to have tools and we're leaving it up to innovation in terms of what kinds of tools that would help prompt providers or clinicians to...whether something could be missing, so what's an example? So, there is no diabetes on the problem list yet there is hyperglycemic medications or even insulin on the medication list. So the question the EHR could ask is, hmm, we have insulin and metformin on the list does this patient have diabetes? It wouldn't do – it wouldn't put it there automatically but it would prompt the clinician.

Similarly, if there is an, let's say an antibiotic on the medication list and let's say it's – and it's been there for a year could the EHR prompt and say, is this person still on this medication or should it be discontinued, again the clinician decides whether or not to but it sort of supports the maintenance of these lists. So, that's what we meant and maybe we can look at our wording to make sure that's crystal clear as we put it out there and maybe even use examples like I just gave. Do you think you have some guidance, Michelle, then to sort of tweak the words?

Michelle Nelson – Office of the National Coordinator

Sure, I'm going to have to go back and listen to the recording for this one.

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

Okay.

George Hripcsak – Columbia University

So, this, yeah, this is Judy's question or it's the first question we got, you know, now that she raises that question, because I'm looking at the slide here, like one way to go is to suggest, like I don't want to do this, suggest specifically, if you see diabetes in the problem list you should be seeing this in the medication list, like then we're getting to like designing the rules for them. So, you know, it's kind of an advanced feature, I don't know how to put this in, use of problems and lab results to support clinician maintenance of updated medication lists, it's a good idea.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy; couldn't you frame it in terms of clinical decision support? So, using clinical decision support algorithms and cueing to prompt providers to see if there's something missing based on other information?

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

Yes.

George Hripcsak – Columbia University

That's what I'm saying is yes, I agree.

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

So, in fact, I think if you just used the example which I think everybody can understand let's say diabetes and insulin I think it will be pretty clear, and what we're...the reason we haven't been really specific is we're trying to allow for innovation, you know, it's always been one of our intents and if we say exactly what you should do then it starts becoming a certification requirement and it leaves less latitude. We could even ask that in the RFC whether people would rather us do that. But, I can...

George Hripcsak – Columbia University

So, we have two choices, I think we can either leave this as is and try to clarify it, which I don't think it needs to be that much – I think it looks pretty clear to me, you may be using decision support could be the clarifying phrase or we could move it to decision support.

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

I think we can, so right now I see that we don't necessarily have an example and I think if we ...

George Hripcsak – Columbia University

Use an example?

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

Tighten this up and put some examples and say that one of the ways that you can view this is through the use of clinical decision support and you actually get credit for that, that would help. How does that sound?

George Hripcsak – Columbia University

In the supporting text or in the objective itself?

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

It can even be in the objective.

Michelle Nelson – Office of the National Coordinator

Well, it's not really an objective it's just certification criteria.

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

Certification criteria okay, right. So, we can be clearer even in the certification criterion and this is just an RFC so we can get advice on clarity. I can work with Michelle on, you know, the examples we just provided and help make it clearer.

George Hripcsak – Columbia University NYC

Okay and then this is just an RFC anyway, okay.

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

Okay? Okay, you want to move onto the next, okay here I think it's fair we've been calling it – we went from – so in Stage 1 we used the phrase clinical decision support rule and that really is fairly limiting, but we only required one. We tried to go to attributes in Stage 2 and, you know, I think that's a good idea. And so the thought here in changing the word to intervention, well actually it's an ONC/CMS change is to be broader in terms of what's required, it doesn't have to be a rule, it has to be something that is helpful to clinicians in making decisions. So, one of the words that Judy proposed instead of intervention is clinical decision support guidance and thinking that that would look less like it's a prescription or something. How do people feel about that?

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

To remove interventions and then just use guidance?

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

And substitute guidance, yes.

George Hripcsak – Columbia University

Actually what I have written down, Paul, was she said intervention or guidance that phrase quote.

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

Okay.

George Hripcsak – Columbia University

I might have misunderstood but I wrote down “intervention or guidance” as opposed to pick one.

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

Yeah, I think either is fine.

George Hripcsak – Columbia University

So, right now, Michelle, you’ve put in both, right?

Michelle Nelson – Office of the National Coordinator

Yeah, right now it’s interventions or guidance, but just let me know what you all prefer.

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

So, the only thing about having an “or” is then it turns out ...

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

Yes, you’re right.

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

Ironically it almost gives – it makes it more ambiguous, 15 clinical decision support interventions ...

George Hripcsak – Columbia University

Well you could make decision support into a noun, implement 15 clinical decision support so that’s one option, it’s not great.

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

You know ...

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

Here’s a suggestion, you know, they’ve already issued a final rule for Stage 2 that says clinical decision support interventions, what we might want to do is offer some supporting text that sort of explains that.

George Hripcsak – Columbia University

Yeah, you could put including guidance in parenthesis or something.

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

Yeah, I think that would – so what do people think about not changing the words from stage to stage, because that seems like it could almost add to the confusion, but explaining that intervention doesn’t have any specific connotation like it doesn’t mean it has to talk about let’s say a change in medication or any other treatment, it’s really guidance...

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

To explain the actions of what you’re saying then.

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

Yeah.

George Hripcsak – Columbia University

Yeah, I like the idea of a parenthetical expression or an asterisk, whatever you want to do, asterisk, but leave it as intervention.

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

Okay.

George Hripcsak – Columbia University

Because, otherwise we've got to change it again next stage.

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

Exactly, right. And, I'm happy to review any sort of proposal that you have, Michelle, for like further explaining what we mean.

Michelle Nelson – Office of the National Coordinator

Okay. Paul, before we leave this one, you also wanted to loop back on the clinical quality measures piece of this.

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

Oh, correct. So, as you know in Stage 2 it says 5 clinical decision support interventions related to 4 or more clinical quality measures, it's to try to create a linkage and one of the questions is do you want to link on the one hand it's good to have here's your, you're measuring some change and hopefully and outcome, and CDS is intended to be one of the interventions that can be applied to get a better score on some outcome measures. On the other hand, you could argue that if you tie it then you basically almost limit, well it's not a direct one to one, but you limit people's thinking to only working on whatever happens to be the 6 or 9, or how many CQMs there are.

Our approach we have currently listed there is to say a total number 15 and that it must at least cover the four following domains, one addresses preventative care, another is to be able to use management, third is the appropriateness of lab and radiology orders and fourth is the medication related decision support, that seemed to be somewhat of a compromise and so the question on the table is do we want to – should it still be tied to CQMs? Thoughts?

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

This is Charlene, it got – as we up the number of clinical decision support it seemed like we might be able to, and again, I know we don't set policy so I get both sides of this one, you know, but it seemed like it would, especially increasing the number of rules, make it such that people could start to think through one of these conditions and more holistically start to approach it rather than be limited to CQMs because it does become very prescriptive from the vendor perspective, do we need a rule for each measure, dah, dah, dah, dah and this made it more flexible on the part of providers and vendors in terms of, you know, supporting our customer's needs, and again, we've got tools to let them develop their rules in this context, so that was kind of the rationale.

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

Oh, I see.

Marty Fattig – Nemaha County Hospital

This is Marty, coming from a hospital perspective I think it's important to not tie them all together to allow providers and hospitals to first of all see in fact if there is a problem somewhere and then tie it to a measure if indeed there is.

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

So, if you step back and say, what are we trying to do, we're trying to put what we think is – and it's not only important, but an essential tool in the hands of clinicians trying to take care of patients and we want to make sure it has the capability of providing at the point of care timely clinical decision support. The closer we get to prescribing things the more people chase the actual words rather than chase the actual objective of what we're trying to do, I mean, that's one way to look at it and I think that's what Marty is saying as well. We've got the tool in theory, we've got the tool in front of and in peoples' hands now we want them to let their local priorities drive how you use it, but just make sure they are using it meaningfully.

Marty Fattig – Nemaha County Hospital

Yeah, this is Marty and I do like the idea of having them chose one from each of the four domains that are mentioned.

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

Yes, so I think, so the standing comment is we did think this through and this seemed to be a good way of both getting the functionality and making sure some important classes of use are covered. Do people still agree with that?

Arthur Davidson – Denver Public Health Department

This is Art, I still agree with this.

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

Thank you. I think that seems to be a good compromise and I don't even think of it as a compromise in a bad way, I mean, I think it addresses the problems were trying to solve. Okay.

George Hripcsak – Columbia University

Yeah, I think we do what we planned and then we might have to circle back slightly after the CDC letter.

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

Yes, that's exactly right. Okay, so we'll come back to this when we discuss Tom's letter. Okay, next.

MacKenzie Robertson – Office of the National Coordinator

Hi, this is MacKenzie, can I just ask everyone to mute your phones if you're not actively speaking, because we're getting a lot of interference in the background, thanks.

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

Okay, two things going on here, one is the liability issues. I thought we fairly clearly laid out what we thought and I think there was a little bit of homework that Joy was going to bring back to us. So, I think we have two extremes that are fairly clear, under HIPAA a provider can transmit everything including the entire record to another provider in the course of care, let's say a referral that doesn't even require consent under HIPAA. Under HIPAA meaning it is not prohibited a provider can always share information with the patient including the entire record as long as there is no...except in rare cases where there could be potential harm to the individual. So, those are two extremes that are well covered I think in the current rule.

The one where there might have been a little question, but I think there's a way to interpret it, is if a patient requests a provider to send information to some other doctor, let's say it's not a referral, they say I want you to send my chart to somebody else, then a provider can comply with that and must comply within the regs of HIPAA meaning you can't just throw these out on the internet unsecured, you have to do all the things you would normally do when transferring to another provider but your responsibility for what goes is under the control of the patient's request and is no longer a liability to the provider. Does that make sense and does that seem consistent with our current laws and regs? Maybe there are no lawyers on the phone, but I think that's the question that was being posed I believe by Gayle and I think Joy was going to look into it further.

Michelle Nelson – Office of the National Coordinator

Yes.

Christine Bechtel – National Partnership for Women & Families

Paul, its Christine, I think that's correct. I think the challenge that I have with this is whether it's something that belongs in the RFC or not given that it actually applies to view, download, transmit regardless which was in Stage 2.

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

Okay, so it would be – so you're saying, let's not open this up because it is something that already exists.

Christine Bechtel – National Partnership for Women & Families

Right.

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

What could be useful to everybody is let's have, it's almost like an FAQ, let's have a statement of facts and Joy can provide that and we can find...I mean ONC can find a way to make it public.

Christine Bechtel – National Partnership for Women & Families

Yeah and ONC and CMS I think have a number of mechanisms for doing that including, actually, I think CMS does call it the FA Facts, FAQ, sorry, they also have some implementation spec sheets and things like that. So, given that this has to be rooted in current law I'm not sure it's more appropriate for public input in an RFC as much as it is we need to keep this moving forward and make sure that we get the resources out through the RECs and CMS and ONC websites and all of that just to make sure we're doing it correctly.

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

Okay, so those are all internal issues though.

Christine Bechtel – National Partnership for Women & Families

Right, right, so I don't think it goes in the RFC.

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

Correct.

Christine Bechtel – National Partnership for Women & Families

I'm happy if somebody wants to disagree, but I just don't think it goes in the RFC.

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

Does that make sense, Michelle?

Michelle Nelson – Office of the National Coordinator

Yes.

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

Okay. The other thing and I don't think Deven is on the call, consent management issues, I don't remember whether it's only related to this topic of liability or I mean, you could think of as more generally how do you document these kinds of requests and complying with the requests. Do we understand that this is on the topic for the Privacy and Security Team?

Michelle Nelson – Office of the National Coordinator

Yeah, so, this is Michelle, I followed up with Joy and Joy's team.

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

Yes.

Michelle Nelson – Office of the National Coordinator

And so Deven is going to take that on within the Privacy and Security Tiger Team.

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

Good.

Michelle Nelson – Office of the National Coordinator

And just to kind of loop back it also came up as part of the IE Workgroup discussion around query.

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

Right.

Michelle Nelson – Office of the National Coordinator

So, they have some work to do, but not for this group.

Christine Bechtel – National Partnership for Women & Families

And it's Christine, I would just add that I think Joy also described the pilot that they have going on in the field now around eConsent that needs to inform all of that work. So, again I don't know that it's appropriate for the RFC.

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

Okay, but it's an important topic and we need to delve into it, we the collective we.

Christine Bechtel – National Partnership for Women & Families

Yes.

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

Okay, any other comments on this? Okay, we want to proceed to the next yellow, which I think is all the way on page 37. Okay, I think this is just a question of facts and we actually have discussed this before, in this category we talked about what we really like is not only to be pushing out information to public health departments but also getting information back particularly when it's patient specific. So, whether is this patient eligible for this immunization or this report, you know, reporting of this condition of a patient, that kind of thing, which we all agreed was very helpful but not ready for prime time in 2016.

This was a suggestion Josh Sharfstein had about saying can we have a general sort of messaging capability. We had, I believe in our discussion, tried to refrain from general messaging not that it wouldn't be useful, but it tends, you know, you then – the flip side is of course the spam nature. I know we've discussed this internally in our group, but what do other people think?

So, one of the ways to think about this is the whole false positive and so we talked a lot about drug/drug interactions and the more false positives, in other words, something that the system states does not apply to this patient, what happens is not only do providers get a little bit annoyed but it sort of decreases the value of the things that you really want them to pay attention to that's the main thing that would weigh against general statements coming across from the EHR.

George Hripcsak – Columbia University

So, Paul, so I agree, Paul, I think, this is George, there are two – so, for the general message, public health messages, I mean that – I don't know how we would do it. I'm not sure that the EHR is the right place to get general messages, but if we were they could be messages from the local, state or federal health departments saying what is going on; just you have to be smart about how you do it so you don't just get overwhelmed with each campaign. If it's patient specific that sounds good, it's a little bit further in the future though. There have been some pilots to, and then we have it as stage undetermined right now.

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

Yeah.

George Hripcsak – Columbia University

We have that exact rule in there as stage undetermined. So, I'm not sure there is anything to add. I don't know that we can add an objective that says the EHR should be able to deliver generic public health messages.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You know, this is Amy, and in the context of every time you open up a patient's, you know, record or something, no, I mean, I think, and I don't remember the conversation around this or maybe it a call I missed, but if there is a way to message out a general notice so, when you log on for the first time, you know, it pops up and there's a place that says public health alerts and messages, you know, I could see the utility, you know, and when you think about emergency preparedness or you think about H1N1, you think about the challenge of communicating, you know, if everyone had direct addresses and maybe you send it to a direct e-mail, but some sort of messaging out to the provider community on a generic basis I think has utility, I wouldn't want it every time you open a patient record unless it was as previously said, specific to that patient, and that I think is much more complicated.

George Hripcsak – Columbia University

Oh, so this – I agree there needs to be a mechanism the question is whether it's the EHR. So, if every time I log in, remember so the local health department is going to have a smoking campaign and the next level up the state might have a different campaign, the CDC maybe concerned about something, maybe it could be targeted to different geographic areas so that not everybody has to hear about an outbreak across the country, but, so my fear is you'd end up with dismissing a long list of messages every time you log into your EHR.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You know, I think we're sort of agreeing, I'm wondering whether there is more of a role in something like that for Direct depending on how widely it's adopted, putting it into a Direct, you know, message if that's fully integrated in the EHR.

George Hripcsak – Columbia University

... structured you just don't put it in the EHR.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah.

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

So, I think...go ahead.

Arthur Davidson – Denver Public Health Department

Yeah, this is Art.

Amy Zimmerman – Rhode Island Department of Health & Human Services

We may not want to get into the how, but...

Arthur Davidson – Denver Public Health Department

Yeah, this is Art; I would agree with this that, you know, currently we use the Health Alert Network to do a lot of this.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Right.

Arthur Davidson – Denver Public Health Department

It doesn't go to an EHR it goes to a fax or an e-mail, or a phone call. So, you know, I think that associating with the EHR where it's patient specific makes no sense if it's a general message, because we don't want to, just as Amy said, we don't want to be inundated every time you open another patient you get the same message. So, that doesn't seem like we want to be using the EHR as a vehicle, we may use directories to help us get into the right people, but we don't necessarily have to send it to an EHR.

And then the second piece about, you know, patient specific stuff as they've done in New York City and other places that could be a clinical decision support based on something you present to public health to say, evaluate these data and tell me what you want regarding these data as they did in New York in the example that I've seen for New York City for Legionella's disease something like that. But, you know, for everybody, every time they open up an EHR to see that there is an outbreak of meningitis going on related to steroids it's quickly going to just be forgotten like George is saying.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, but it would be nice to have a way to, you know, somehow message out to those patients that got that steroid and get it right into physician's EHRs as they open that patient.

Arthur Davidson – Denver Public Health Department

And they did that in New York City around metronidazole when it was an inadequate dosage in a formulation. So, it could be, but that requires all the CDS that I don't know that we're ready to start putting forth...I don't know that the public health departments are ready to even create that.

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

So, I think, I want to...we came to the same conclusion, so I think we can stay with what we have here for the reasons everybody seems to agree with. Okay, I think, we're ready for the final ... let's go to ... since the next yellow is public comment, let's go to Tom Frieden's letter if we can pull that up. So, and let's look at how it compares to where we currently are and what are the policy or philosophical things we need to talk about. So, as I said, one of the things we have always said about our objectives and CQMs is that we do want to keep up with current health priorities for the country and at the same time we don't want to bake something in and have it go stale by the time it's relevant. So, in this case it would be 2016.

So, reading from Tom's e-mail, it has to do with two topical areas, one is smoking cessation and the other is immunizations. So, from a smoking cessation point-of-view one of the recommendations is to use the information available in the EHR related to hypertension because we already capture vital signs for example and we already have patient's list. So, can we, they propose look for people who don't have hypertension on their problem list yet they have "x" amount, you know, is it multiple readings above the national standard or the threshold.

Now, we just talked about actually that kind of capability in the certification criteria under problem list actually. So, would we consider that...well that certainly addresses the problem, the question, one question that's asked is should we make hypertension a specific target for a Meaningful Use objective or CQM?

So, I think that's a philosophy question and maybe we get people's initial take and as I say we might need to defer this – we're only at the RFC stage, so we may need to defer a more thorough discussion certainly before we come out with our final recommendations next May, but for another call, but let's see where people – what's on people's minds right now. It's essentially applying EHR functionality to specific health conditions as an objective for meeting Meaningful Use, for qualifying for Meaningful Use incentive. Thoughts?

Arthur Davidson – Denver Public Health Department

I think if someone is measuring blood pressure repeatedly and they're not making the diagnosis we should use the EHR technology to help them.

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

Well, that's a true statement, now should it be, should you say one of the 15 CDS rules has to be this rule?

Arthur Davidson – Denver Public Health Department

If they're – is everybody required to measure blood pressure?

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

You are in 80% of the time where appropriate.

Arthur Davidson – Denver Public Health Department

So, what does where appropriate mean?

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

If you're a dermatologist I think you're exempt.

Arthur Davidson – Denver Public Health Department

Right, so, I think for those where it's appropriate it seems like this is a reasonable request and that we would then say that one of the 15 should be this. If we're trying to leverage the EHR to support this Million Hearts Campaign and it is effective, it's a very effective measure to reduce morbidity and mortality it seems like this could be one of the 15, if they're measuring blood pressure.

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

Okay. Other thoughts?

George Hripcsak – Columbia University

Well, another approach would be to focus on the quality measure rather than mandating if it's specific decision support to fix it, you know, if you're 100% identification then do you need to add the decision support?

Amy Zimmerman – Rhode Island Department of Health & Human Services

I would ask how would you know if you're at 100% of ...

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

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I don't mean that in a critical way, I'm just saying that I think, I mean, you know, I would think that would be hard to know whether you're actually there or not.

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

So, let me offer a couple – so, in response to Art's suggestion there are a couple of ways we could tweak the current objective, one, we could, you know, we had 15 CDS interventions they have to satisfy ... there has to be at least one or more that are in the 4 domains, in addition we could require and 1 of the 15 has to be built around complete diagnosis of hypertension.

Arthur Davidson – Denver Public Health Department

Where appropriate.

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

Where appropriate, we thought about the same thing, Art. The other place this could appear is actually in the problem list maintenance and we tried to be non-prescriptive at all, but one possibility is you require something there. Now, it seems like we're introducing a requirement where it's out of the blue so it might be better to keep it in the CDS area, but, so what do people think about adding ... so there's two components right now, you have to have 15 and you have to meet each of these four categories, a third component would be that one has to be completeness of hypertension diagnosis.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy; I mean, I think in some ways I agree with Art from a, you know, from a public health perspective and a population health perspective, if we're trying to start to really get providers to think, you know, how EHRs can help, you know, on an individual yet population basis and we know this is, you know, a critical area which is undiagnosed and we can help improve the health of a population overall then I think it has merit, I think it does. On the flip side, I mean, I think then concern I'm assuming is that it sets a precedence and what would keep you from doing BMI or obesity, or, you know, other chronic diseases.

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

Right.

Amy Zimmerman – Rhode Island Department of Health & Human Services

But, you know, it could be a trial to see how it, you know, how it goes.

Arthur Davidson – Denver Public Health Department

Yeah, I agree with you Amy. I think this is a trial, this is not the end and hopefully there will be other important public health agenda items that are included in the future, but, you know, we're just trying to pick one that would be very population focused.

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

Okay, so consistent with these statements then could we add an RFC question in the CDS objective that asks about including CDS, including requirements around specific health conditions and go ahead and list this one for example, we can set up a little, a short, what's the problem to solve and so our – we are thinking about adding a requirement that 1 of the 15 be around the completeness of diagnosis of hypertension where people have elevated blood pressure, that may ...

Christine Bechtel – National Partnership for Women & Families

Paul?

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

Go ahead.

Christine Bechtel – National Partnership for Women & Families

It's Christine, I don't disagree with that approach I think for me it does sort of beg the question of, you know, we did try a very similar approach in Stage 1 quality measures and it does call to mind, for me, the importance of, you know, what are we thinking about for quality measurement in Stage 3 because given the wide array of providers, and we've heard these concerns before.

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

Right.

Christine Bechtel – National Partnership for Women & Families

Just the wide array of providers that are eligible for the program, you know, some of them will say, well this doesn't apply to me even though we can make the public health argument that look it really has to apply to everybody. So, I think it's a great idea to put it into some of the functional questions, you know, the RFC questions around the functionalities and whether you orient them around specific health improvement aims, but I also am wondering, kind of bigger picture, what are we doing to get feedback on the quality measurement approach?

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

Right now, so David Lansky is not on the line, I don't believe, David are you on the line? This probably would be a good philosophical question to raise with that group as well.

Christine Bechtel – National Partnership for Women & Families

Yes.

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

And as you said we did try some things but, you know, times have changed and maybe some of these initiatives are new since Stage 1.

Christine Bechtel – National Partnership for Women & Families

True and I mean, I think in Stage 2 we can look at how they fit into the quality measurement and, you know, are approached in that it has been reported in Stage 2, which is an evolved approach over Stage 1 and so I think we need to probably better understand how consistent this is with that, which I think it actually is fairly consistent, but I think we provided some or CMS provided some additional flexibility on the kinds of quality measures that folks could report that focus on particular health improvement goals.

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

Right, so they narrowed it to 6 domains, you can choose from 3 of the 6 but they still didn't get down to very prescriptive things. So, this next point in Tom's e-mail is also specific looking at, in fact this could be covered in a CQM, is improvements in hypertension control. So, that could argue for picking a quality measure and everybody has to, it's like a core/core, you don't even get to choose three of six – it is, you must look and then you get into I think it was Art's or maybe it was yours, Christine, as far as does this apply to every specialty question. So, it sounds like we should work in a question in the RFC to introduce the notion of and provide the rationale as well, here's an important public health issue and concern, and we're thinking about having specific objectives and specific quality measures based on a specific health issue, and get people's feedback on that, because I think we're crossing a previous line we had set, but, you know, we can do that.

Arthur Davidson – Denver Public Health Department

So, with regard to this last point, Paul, it seems like the second point might fit better as a clinical quality measure, I mean, it needs a clinical decision support rule.

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

Right.

Arthur Davidson – Denver Public Health Department

But many physicians who would diagnosis hypertension are not necessarily the ones who will be treating it.

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

Correct.

Arthur Davidson – Denver Public Health Department

So, I think the first bullet could be, if you measure blood pressure you should be recording whether someone has hypertension, it doesn't mean you have to take care of it.

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

Yeah.

Arthur Davidson – Denver Public Health Department

And then the second one would be more of the treatment model.

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

Yeah. So, in those cases ...

Arthur Davidson – Denver Public Health Department

But, I agree with Christine, we need to sort of sort this out with David's group.

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

Yeah. Okay and David and the Quality Measure Workgroup is participating in this RFC so we can ask his opinion and support for that kind of question. Okay.

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

This is Charlene, and Christine, you know, just kind of how we started to align the clinical quality measure one with the patient engagement one, especially on that second point, you know, we just need to make – because we started to say, you know, let patient generated data support one of these key conditions, this, you know, hyper, you know, blood pressure control could clearly fall under that category of patient generated data. So, just let's keep that in kind of the back of our mind as we work through these responses.

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

Right.

Christine Bechtel – National Partnership for Women & Families

Yeah, Charlene, that's a good point and it's not a bad idea that if we're asking, in terms of clinical decision support should we orient some of the decision support around particular health conditions, we could ask the same question on the patient generate health data to say, should, you know, should there be a range of data that is oriented around particular health improvement goals, we could ask that question in the RFC.

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

You know, one of the things that occurs to me is we wouldn't want to inadvertently put people into a position where they don't want to record blood pressure, because if you record blood pressure then you'd have to fulfill points one, two and three.

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

Yes.

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

And potentially four and you just wouldn't want people to get, you know, get, you wouldn't want to cause unintended effects. Okay, so we certainly can include questions in the RFC on both these points. The third point now is almost doing what I was suggesting, you know, right now you have three out of six, you have to address three out of six domains, now this is making this a core clinical measure that's mandatory in Stage 3. Again, this goes back probably to a Quality Measure Workgroup question, but it's being pretty prescriptive, well it is and so I think it's something we need to think through and also try to avoid the unintended adverse effect of people avoiding the issue to try to meet this requirement.

Arthur Davidson – Denver Public Health Department

Isn't the third point really just a method by which we achieve number two?

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

I think there is something implicit in them. So, the third point is the way you measure it. The second point their verb is to use EHR technology features to improve practice, so I think it actually overlaps with...well CDS is one of those methods, right? Having a registry is another method. So, there is a whole bunch and patient reminders is yet another, so I don't know that they've figured out, since they didn't suggest it here, how you measure that.

Arthur Davidson – Denver Public Health Department

Right, it seems like that the third is just a sub-bullet of two.

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

Yeah.

Arthur Davidson – Denver Public Health Department

But maybe their equal.

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

Yeah. And then the fourth bullet is not specific around hypertension, it's specific around tobacco and it's specific around the intervention.

Arthur Davidson – Denver Public Health Department

Right. So, this is Art and I think this is a really important area for us to try to explore. I actually have, and there are several others around the country who are working on methods to refer to quit lines from my state and working with the North American Quit Line Consortium to try to figure out the proper referral mechanisms for this. The real challenge here is that the quit lines need to be enabled to receive the referral, the eReferral.

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

Yeah.

Arthur Davidson – Denver Public Health Department

And I think they're working toward that and CDC is working on encouraging them through the funding mechanisms to get there as well. So, in the end I think this is just another type of referral like a provider directory that lists a quit line in your area and you can send an eReferral to that site, it's no different than sending a new referral to a cardiologist or a physical therapist.

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

So, the question is to use...and so I agree with you, now does this, you know, how ONC and CMS are trying to stay stable in terms of the number of objectives, you know, 19 to 19 and 20 to 20, what it says here is that another objective be created for this particular one. You know, as I look at this I wonder if there's a way almost to include much of the words here, both the rationale for focusing on something, you know, it's clearly a big issue, it's a big gap and we can do things about it, so that makes it a really good issue and maybe have this one section in the RFC that says and here is some specific things that an EHR can do to help tackle this, address this issue and here are the implications, here are some of the things we're thinking of that may be implications for the Meaningful Use Program and get people's comments on this whole approach, because it goes, it really cuts across functionality, measurement and specific use.

You might argue that two, three and four all could be done in a CQM and 1 is probably covered in our problem list maintenance objective. So, there are ways to work this in as long as you don't say and in each objective you must meet the following specific criteria. So, how do people feel about taking this whole body of work and saying let's get public comment on this approach? And I guess the alternative then is to ask questions on each of the features as they interact with existing CQM or objectives.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy; I think it makes sense to put questions into the RFC.

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

In like this, almost like this approach or by interweaving it with each of the objectives and CQMs we have?

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

You know, Paul, this is Charlene, I've been kind of working through this one too, I like the broader approach because hopefully by Stage 3 and 4 we'll have like the piece parts out there for them to figure out how to put it together, you know, to kind of become more outcomes and health improvement-based.

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

Yes.

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

I like the broader approach because that frames kind of I think where we want to go.

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

So, as you were talking I thought of a compromise.

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

Okay.

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

Really to set it up as a broader approach, because I think that's the big question we're asking.

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

Yeah.

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

So, that's the big approach and then for each of these questions we could give an example and the way this might show up in Meaningful Use is this requirement in this objective, do you see what I'm saying?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, I think that is good. I think that makes, it gives a broad but it makes it specific and concrete in terms of ways to do it.

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

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So people have something more tangible to say.

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

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You know, to react to, otherwise...

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

Right.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Who knows how people will interpret it and what their comments will be.

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

Right. Okay.

George Hripcsak – Columbia University

I guess, Paul, can you, I'm not quite getting exactly what we're talking about.

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

Yeah, okay, so in a sense, we're going to somewhat restate Tom's e-mail saying look hypertension is a – cardiac disease is a big issue, these are the number of people killed, here are the gaps that we currently experience, you know, like we don't treat everybody. One, we don't diagnose everybody with hypertension. Second, we don't have them under control. So, the question we're asking is should we have Meaningful Use objectives and criteria and quality measures that specifically target hypertension and smoking cessation and enumerate actually these 4 points, and then under each point say, and here's how it would show – here's a way it might show up in the Meaningful Use Program.

So, for the first point it shows up as a specific requirement in the problem list, maintenance objective. So, you have to show by whatever means you choose how you are capturing everybody with hypertension and so on and so forth. So, it's really laying out this policy objective and seeing whether the public agrees with that and then showing how it might show up in the specific objective.

George Hripcsak – Columbia University

I see, so we're asking the public as part of the RFC.

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

Yeah.

George Hripcsak – Columbia University

For advice on whether we should in fact be specific in clinical decision support about having to do say hypertension diagnosis?

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

Correct.

George Hripcsak – Columbia University

Okay.

Arthur Davidson – Denver Public Health Department

So, I like the way that this is evolving, Paul, I think that the example of smoking is a little bit different though, because it's one thing to say capture the smoking status of patients, the next thing after that is that you're asking them, you're capturing that, then the next step after that is to advise them that that's not healthy, and then you can't just refer them you have to engage them in a conversation to get them to decide to accept the referral.

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

Yeah.

Arthur Davidson – Denver Public Health Department

So that's part of that advice which is different I think then I have a, you know, 160/110 and I'm going to give you some drugs.

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

Yeah, no I agree with you.

Arthur Davidson – Denver Public Health Department

Yeah.

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

And there is also some evidence about what is and is not effective.

Arthur Davidson – Denver Public Health Department

Right.

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

So, maybe we take it a step at a time. I agree with that, that one is different. So, at first get the public's reaction to focusing in, sort of lasering in on a specific health issue through the Meaningful Use Program and once we deal with that then if they like that idea then we can hash out, well how do we do that in the least burdensome, the most effective way the most effective and efficient way. Okay, does that make sense? I think we're responding very well to the suggestion there.

The next comment is on immunizations and really we just talked about the close the loop. We did talk about it as a future. I couldn't find the 401A and B when I quickly looked at it this morning. Is that one where we postponed for a future stage where we have sort of automatically know what's good for this patient?

Arthur Davidson – Denver Public Health Department

No, I think in 401B to receive, generate or access appropriate age, gender and immunization history based on recommendations. So, I think it's in there in Stage 3. George did you think that there was something here in Tom's message that we weren't doing?

George Hripcsak – Columbia University

I thought he was saying we support this.

Arthur Davidson – Denver Public Health Department

Okay.

George Hripcsak – Columbia University

401A and B.

Arthur Davidson – Denver Public Health Department

See, I think, we're okay with this part.

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

Okay, okay, basically this is not, it's not patient specific, right? It's what are the current recommendations; it's keeping up with the recommendations.

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

Yes.

Arthur Davidson – Denver Public Health Department

Yeah.

George Hripcsak – Columbia University

Wait, what is that Paul?

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

It's keeping up with the recommendations; it's not giving a recommendation about a patient.

George Hripcsak – Columbia University

We're saying we should keep, it's patient specific.

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

Its age, gender and history specific recommendations. Okay and we already satisfied ourselves that is possible or will be possible.

Arthur Davidson – Denver Public Health Department

Yes, it is possible.

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

Okay, okay. So, I think, this is just an endorsement.

Arthur Davidson – Denver Public Health Department

Yes, that's the way I read this paragraph, it was an endorsement of what we wrote.

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

Good. Okay.

Michelle Nelson – Office of the National Coordinator

Paul, this is Michelle, can I just loop back real quick?

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

Yes.

Michelle Nelson – Office of the National Coordinator

Do we still, even if we have the approach for this is done separately, do we still want to bring any of this to the Quality Measurement Workgroup?

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

Yeah, which one for the hypertension?

Michelle Nelson – Office of the National Coordinator

Yeah.

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

Yeah, I think we do. So, let's make sure that David gets a copy of this.

Michelle Nelson – Office of the National Coordinator

Okay.

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

And some notes about our approach.

Michelle Nelson – Office of the National Coordinator

Okay, thank you.

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

Yes. Okay, so let's go to, thank you.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Can I just, this is Amy, I'm re-reading the CDC memo here under immunizations and I'm not – the way I read it I interpret it to mean getting back with individual recommendations per patient.

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

It is.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay.

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

No and I misspoke about the recommendations we have is patient specific.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, okay, okay.

George Hripcsak – Columbia University

But they both are patient specific.

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

At least age, gender.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, yeah, okay, I mean there is no reason why we shouldn't try to do that. Okay, thank you.

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

Okay, can we go back to the public comment area and there is a couple, okay, so one we can talk about the care plan. Here's my recollection of the discussion and those of you on the subgroup probably are more deeply involved, but I think we went through a process where we came up with things that we'd like to propose, meaning the principles that we talked about, then we passed it off to standards and got their advice on what exists now and the reason that's important is because if we promote something ahead of its time you end up with a whole lot of things that can't be exchanged, one or have to be redone when standards do appear. So, those are counter balances to doing something without standards.

George Hripcsak – Columbia University

Paul, before you even get to there I'd like to give a – first remember that we already put care plan in, our first proposal from the Subcommittee was to have care plan be part of the care summary for referrals message, ah, objective, that's who we first conceptualized it because we're trying to reduce the number of objectives because we know that CMS is just going to compress them anyway.

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

Yes.

George Hripcsak – Columbia University

Then we said, well care plans are important maybe we should separate it out, so we did separate it out. Then what got pushed forward into Stage 4 because of the process you just talked about, getting input from the Standards Committee, was the separated out care plan, but the care plan is still there as part of the summary of care record, as far as I'm concerned Stage 2 and 3, so characterizing this as delay in the care plan is not accurate.

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

I see.

George Hripcsak – Columbia University

It's just delaying the separation of the care plan from the care summary.

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

No, that's helpful. In other words there are placeholders for the fields?

George Hripcsak – Columbia University

In Stage 2, it's the plan, you know, it's the team; the ... I'm blanking right now, sorry.

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

There are 4 elements.

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

...instructions.

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

There are four elements of it.

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

Right.

George Hripcsak – Columbia University

So, in Stage 2 was the 3 things and then I can pull it up, anyway, yeah, yeah. Oh, here is it, oh, goals and instructions, right? It was goals, instructions.

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

Right goals and instructions.

George Hripcsak – Columbia University

Is what is in Stage 2 and then in Stage 3 we have the 4 things.

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

Okay.

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

And this is Charlene, and then as we look toward...and I think this linked into this kind of the little vision that we were talking about was starting to emerge to this, if you will, patient facing interactive platform which people could interoperate with and we all said, okay we're venue specific but what will help us advance that platform that we don't know how it will exist yet, we've had that conversation. So, we thought Stage 3 is kind of the pivot point to start to get the infrastructure in place. So, I read the comment about, well can we move to that more interactive platform sooner and Paul it's exactly as you said, there are some obstacles in terms of getting those standards in place to be able to do that.

So, for instance we don't have...the good news is there are standards out there, there are a lot of them. I would even hesitate to name them because I'd probably miss one, you know, that starts to encode practice things like patient goals, the interventions which are a superset of orders. So, some work needs to be advanced to really put some nomenclature, some taxonomy behind those to really advance the ability to interoperate. So, that was kind of, you know, so we'll get some more of that I think for Stage 3, but it's certainly not as comprehensive as I think, you know, the full view of this care plan is emerging in terms of managing it across venues.

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

And the other component of that, not only, I mean, most of the, what Charlene mentions are the technical aspects, unfortunately professionally we don't have a clear view, I don't think.

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

Yeah.

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

Certainly amongst the physicians of what quote "it" is, so that's something ... I mean, that work should proceed anyway and I think hopefully it will under the models of accountable care, etcetera, but we really would love to have the professional agreement on definitions of what a shared care plan is and what are the important elements of that and then move that into something that can be transmitted unambiguously amongst systems. So, with that in mind I think of the questions that you shared with us the first two sort of hit home in terms of what are some of the scenarios we should be looking at as use cases and then number two is what are the data elements that are essential in trying to facilitate the coordination amongst the sites that are elicited in the use case in number one. Is that a fair summary of the main message that you're trying to get across Charlene?

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

Yes and the only other question that we ask and this is relevant to that first question and I don't know maybe question 3 which kind of asks the question about, well then who governs it, right? Who governs this shared care plan? And so maybe that is somehow thought through in terms of question 1 and we can just encompass it in there, right? Like, but I agree with you, really the two key ones are ... you know, we kind of envision this but we really didn't operationalize it, so how might this really work, is there a longitudinal care plan with persistent data or, but how do you make sure that the venue specific data that's important gets carried across blah, blah, blah, you know, all those kinds of things.

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

Right.

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

So, those were the cases and we chose high priority use cases and again, you know, based on some guidance from the Care Coordination Group and then clearly then about what are those essential data elements and then what's the current status of the standardization, to start to call to question, if you will, there's, you know, multiple vocabularies out there and our job here is to select through the process, not us, a national standard, right, for these different venues.

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

Yeah.

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

So, the only other one, do we want to add the governance comment in the first question?

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

So, isn't governance a...I mean, that's again one of these the profession doesn't even understand how to collect ... who governs the problem, how do we ... that's not an EHR problem to solve is it?

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

No, it's a how does the process work in the real world.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

Well, but Paul, I'm not sure I totally agree, if by what you mean by governance is sort of who updates the care plan and how do those updates get shared across the team and what is the patient's role, I mean, the care plan, I would imagine as the care summary I think did in Stage 2, would include some goals that the patients are going to want to say or providers, okay, this goal has been achieved now we're onto the next one.

So, that is, I think, an EHR function. I mean, not the question of who owns it, there I think like we get into trouble. But the question of technically speaking how do you facilitate updates and then the sharing of those updates and the revisions, and then the incorporation of that back into the EHR, I think that is more of a technical question and, you know, we may or may not be able to get there in Stage 3 but we need to get there by Stage 4.

So, getting information on and we have some similar language in patient and family engagement section, but getting information on how do you update and how do you then incorporate updates into the EHR is I think important.

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

So, I think the question is how would you tell the EHR vendor what to do if we don't know who actually is responsible and accountable for such and such.

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

And it wasn't the word accountable that was used, Paul, so I don't, yeah.

Christine Bechtel – National Partnership for Women & Families

Well, but, right and I don't, I mean I think that's, you know, this reminds me of the argument about, you know, who owns your record which is just a complete morass to get into.

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

And what we, the approach that we've taken writ large to who owns the record is, you know, more about updating information and sharing it rather than trying to figure out who owns it. So, you know, there are – all I'm saying is that there are updates that can come from multiple places and when you have a patient identified care team in the care summary and you have that summary being shared how the care...you know, should we just incorporate the care plan as a piece of that and how do you build the technical capacity to update and, you know, more dynamically and share it, it's those pieces rather than getting in for the ownership issue.

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

Yeah, I don't think I was talking about ownership, I was talking about the who – so let's say you have two providers working on heart value, who decides what the treatment plan is, is it provider A, provider B or the patient and what the patient wants to – so, I'm not trying ask for an answer, it's just that how would you tell the vendor what to do?

Christine Bechtel – National Partnership for Women & Families

Well, I assume it's like who decides, you know, if the patient is going to, you know, go on a drug, it's like, well you're here, I'm treating you, we agree that this is the next indicated step whether that's a plan or, you know, some other kind of intervention like a prescription or a referral, you know, there is something organic to the care delivery process, so if the physician says, okay, do you have a care plan? No, I want to create one, should that, you know, okay, great, just like sort of a care summary then okay, how do I share that with others across the team and update it if I created it, you know, it goes from there. Do you know what I mean?

It's more organic than trying to say, if you have a care plan in your EHR you own it, it's more like, well if you have a care plan reflected in your EHR how is it possible for you to receive updates and to update it yourself regardless of whether you initiated the update or someone else did, how do we make sure your system is capable of receiving those updates.

George Hripcsak – Columbia University

So, for the time being...so clearly this is complex and so the question is how can we most efficiently exploit the public's comment? I think Charlene's questions are generic but as good as we can get without, you know, really having a mapped out plan. I'm supportive of that.

Christine Bechtel – National Partnership for Women & Families

Yeah, so ... it's very difficult to read them on screen, is that notion of update in there?

George Hripcsak – Columbia University

No, it's more general I think.

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

Right.

Eva Powell – National Partnership for Women & Families

Yeah and maybe it's good to put, this is Eva, maybe it's good to put something about issues of provenance in here, because that gets at the updating issue and I'm pretty sure there is work going on about that somewhere, but I'm not familiar with exactly what that is.

Christine Bechtel – National Partnership for Women & Families

Yeah, and all I'm suggesting is not that we try to solve the issue but that we get public input on the process and what are the technical capabilities that need to be facilitated for updates and things like that.

Eva Powell – National Partnership for Women & Families

Definitely and I think in here, in whatever we put out both for the RFC as well as everywhere else I think what will be critical is to make sure that people understand that this is intended to be a tool but it's not intended to be something that replaces provider to provider communication when that's necessary and I think it's really easy to start viewing this as replacing any sort of phone call or other interpersonal kind of the organic stuff that Christine was talking about that's so critical to care, this is a tool that would prompt some of that hopefully, but I don't think you can use this and never expect to talk to ... have one provider talk to another if there was ever a question, which is kind of part of what I was gathering, Paul, from what you were saying even if that wasn't what you were intending.

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

See and question 3 did kind of touch on that, maybe it's not clear enough, how is the use of such a tool, this includes both viewing and contributing kind of updating information governed, but maybe you want to make it...and I kind of wove that into this whole governing concept but maybe we want to add the provenance question into that one, you know, and we kind of said, is this useful for a rural-based access, is it technical, so maybe question 3 is really, okay how do you use such a tool in terms of the rule.

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

Okay, why don't we include the first three questions then as part of the RFC so that we can start getting more information about this?

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

That's fine.

Christine Bechtel – National Partnership for Women & Families

I think that would be great, I just think, Charlene, you might want to clarify like what do we mean by governance and governance decisions, I'm just not sure that folks are going to understand what is meant there, it might just be...

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

Yes, I'm going to try, Paul, and keep out of like who owns control.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

Correct.

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

Make it more an updating kind of thing, right?

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

Yeah.

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

A little bit more technical as opposed to ...

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

Okay.

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

The first one should touch on the process issue and then the last one will get a little bit more explicit.

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

Okay, the other thing I think we need to talk about is, is a new concept that was introduced by the AMA and that is the – as we all know it's an all or nothing, you have to fulfill 100%, there are menus in the criteria, but you have to comply with all of the objectives, meet all the objectives at the threshold in order to get payment in Meaningful Use. The AMA asked in the public comment, is there room for partial credit. Now, they didn't say this, so I guess there is one question is, if you get 90% of it should you...is there any kind of forgiveness and you still get 100 or if you get 90% should you get 90% of the payment, they didn't say it exactly that way, but I mean, those are amongst the questions of is there anything less than all or nothing? This is probably not...we obviously are not going to decide here, but is this something we want to ask as part of the RFC?

Christine Bechtel – National Partnership for Women & Families

Paul, its Christine, I think it's a good idea. I mean, we, you know, that, you know, that rationale is used for pushback on a lot of the, you know, criteria that we proposed that are sort of more progressive and probably changed the culture of medicine and so if, you know, we can remove that as a crutch I think that's good, but I think we have to, you know, we have to carefully frame some options because...and talk more about the intent, which is, you know, we don't want to facilitate gaming of the system and we want people to do, you know, to really focus on the more advanced uses by Stage 3 so that if we did go to some kind of an approach like that, you know, we don't want to set up a scenario where you're basically able to do almost everything you did in Stage 2 to meet, you know, on one thing, you know, kind of new and you get 85% and you're good go, because that's not really meaningful.

So, I think we have to frame it carefully, but I do think it's a good idea to just say, all right what are the other options out there and maybe we list some criteria, you know, that would meet these criteria, how would you propose, you know, thinking that through.

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

Okay. Other people's thoughts?

Arthur Davidson – Denver Public Health Department

I think I agree with that, Paul, I think that it seems like we should allow them some leeway but not too low, so I wouldn't say you get 50% if you do 50% so that's one area and then the second thing is maybe this is going along with what Christine was saying, as you progress in Stage 2 and Stage 3 you should have achieved that first, the Stage 1, item that was not achieved, so, I don't think we want to make if forever that you don't have to get to complete performance.

Amy Zimmerman – Rhode Island Department of Health & Human Services

You know, this is Amy, there is one other way to look at this and this is to look at percent of improvement or sometimes in quality improvement, you know, it's okay maybe you didn't hit the benchmark but you...because you started so low, but you were able to improve by 90%. So, I don't know if that concept...I'm trying to think, I haven't thought this through how that concept would apply here, but, I mean I understand you should have already done certain things by Stage 2 and you don't want to discourage people if they miss the mark by a teeny bit because you want to encourage them to keep going, on the other hand, if there is some way to think about this, the framing it in terms of you've actually demonstrated really good effort and I don't know how you would measure that or some level of improvement that shows that you're working towards it and you're not trying to game the system, maybe there's something in that line of thinking that we could use.

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

I think it would be useful, if we're going to cross this line to take baby steps. So, it sounds like, at least from some people that have spoken would like to open up a question about other options to the current all or nothing approach in terms of earning MU incentive, is that correct?

Marty Fattig – Nemaha County Hospital

Paul, this is Marty, I'm agreeing with the discussion but this is something that is going to take a lot of thought. The other thing I think we need to find out is, is there funding available if we open this up to people who aren't meeting 100% of the requirements.

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

That's another good question. So, I think we can...I think as homework we'll ask whether this is one an allowable scope change, you know, whether there's anything that would ... in HITECH that would prohibit this change and the other is – some of the other considerations like what Marty just raised, that of course is ... all we do is provide some advice but we also want to be as informed as we can in terms of recommendations.

So, I think I hear the group is saying, let's get some ideas from the public, there is obviously no commitment either to, you know, on behalf on ourselves or ONC and CMS, but maybe open to some ideas on other strategies and we can leave it open in terms of letting people propose.

Christine Bechtel – National Partnership for Women & Families

Paul, its Christine, I think that's right, I think though that we probably want to ask, we want to be fairly clear to the degree that we can about – so for example are we only talking about Stage 3 or would it apply to Stages 1 and 2 or should the approaches, you know, be different, right, since people can still attest to Stage 1 and 2 for a number of years, you know, it reminds me a lot of the alternative that the Quality Measures Workgroup proposed where they said that, you know, if you want to ... given the dearth of really great IT enabled Meaningful Use measures, if you want to work with the specialty society and create a measure that reflects the following, there were, I don't know 5 or 6 sort of criteria, then you can do that and get credit for quality reporting as long as you agree to A meet the criteria and B report back and say like why you succeeded or why you failed. So, that kind of approach that is more geared toward innovation and things that are truly different than what we have today I think is like fundamentally different for Stage 3 than it would have been for Stage 1. Do you know what I mean?

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

Yeah.

Christine Bechtel – National Partnership for Women & Families

So, maybe we could, you know, articulate some questions around this and I agree we have to be very careful how we do it that get to, you know, sort of conceptually here's what we're trying to achieve, you know, meaningful advancements in the way that EHRs are used and etcetera, etcetera.

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

Right.

Christine Bechtel – National Partnership for Women & Families

But also, you know, clarify should this be like – should the mechanism be different for Stages 1, 2, 3 etcetera.

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

So, we need to get to public comment, so let me propose that we draft some language for us to cover on the next call. I think it's wise for us to be careful not to signal that all of a sudden everything, you know, all the whole program is being changed in terms of requirements, I don't think that's helpful and ...

Christine Bechtel – National Partnership for Women & Families

Yeah, I agree.

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

Try to see how can we in a measured way look for other ideas to help deal with let's say the 98 or 95% compliance with the objectives and thresholds.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, and Paul, this is Amy, I would agree that before we open any door with the public we need to make sure legally we could even go there.

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

Correct. So, a couple of things, we'll try to make sure that we can do the homework, Michelle, to figure out what's the latitude that ONC and CMS even has related to this question and then put together some draft language about how we would ask the question in ways that are not alarming or disruptive but start ... but ask what kind of flexibility people think could be built into the system.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Paul, this is Amy and I have one other question, I'm conscious of the time and I know you need public comment, but I have one question for the group, because this came up recently in my own state. So, under the patient engagement part was there ... I know there is some discussion about patient reported data and generated data, has there been any discussion about standardized screening tools like ages and stages for developmental screenings where, you know, we'd be looking for capability for those to be incorporated both from a scored and a potentially, you know, comment and/or the full tool being incorporated into an EHR.

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

So, Amy, that's a really long question and so maybe we could ...

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yes, we can have it next time.

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

We can move that into or even the Patient Engagement Subgroup, because we have discussed this.

Christine Bechtel – National Partnership for Women & Families

Paul, I can answer the question in a very short way, which is yes we considered exactly that approach not necessarily with that tool, but with a set of other tools and we're told by the Standards Committee that it was not possible to do by Stage 3.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay, thank you.

George Hripcsak – Columbia University

Paul, this is George, I don't think it's necessarily decided that the question of how to make it more flexible goes in the RFC. I think we should talk about it, because it could open up a free for all and not matter what we do someone is going to just miss whatever the new algorithm is.

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

Right.

George Hripcsak – Columbia University

Then we need to add flexibility to include the next group and the next group.

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

Right.

George Hripcsak – Columbia University

And if the thresholds are too high then we should lower them. So, anyway, so it's a discussion of whether to put it in not how to phrase it.

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

Correct. So, George you might actually, you know, participate in sort of the drafting of what to do with the question. Okay, so we have some behind the scenes, you know, homework to do and understanding the legalities and what's progressive even what we're capable of doing and we need to talk about it as George mentioned as far as the wisdom of opening that up. Okay, lets open up to public comment and then we do have another call, which is when, Michelle?

Michelle Nelson – Office of the National Coordinator

I think October 30th I'm just checking. Yes, October 30th.

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

Okay, oh, actually I don't have it on my schedule.

George Hripcsak – Columbia University

Let me check.

Christine Bechtel – National Partnership for Women & Families

Hey, Paul, I actually have one quick question before we go to public comment, its Christine again, so in the RFC language there are some elements that are missing for the Patient and Family Engagement Subgroup and there are just some things that I think need to be clarified, what is the process for adding or revising language?

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

Michelle?

Michelle Nelson – Office of the National Coordinator

We haven't really talked through that yet and maybe we can do it at the subgroup level, you know, Christine, if you think there is something – so maybe each of the subgroup leads can review their section and if there is something that needs to be changed we can go through them.

Christine Bechtel – National Partnership for Women & Families

Okay and is the format going to stay the same with the tables and the questions embedded in the tables? Because we had a number of much more lengthy questions that I think need some context etcetera and Charlene's document is a good example in a way, so I'm wondering, you know, how you ... maybe when you reach out to the subgroup leads you guys could give some thought to the format of the RFC and let us know what we need to give back to you.

Michelle Nelson – Office of the National Coordinator

... attached, thank you for bringing it up Christine, because I wanted to at least have people to look at, tell me how they want it to look and what makes the most sense, so ...

Christine Bechtel – National Partnership for Women & Families

Great and we needed a deadline too, if that's hopefully not unreasonable.

Michelle Nelson – Office of the National Coordinator

Yeah, I'll reach out to all the Subgroup leads, thank you.

Christine Bechtel – National Partnership for Women & Families

Thank you.

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

And also, I think I see it on October 22nd as a possible call.

George Hripcsak – Columbia University

Oh, no it's the 30th at 10:00 a.m.

Michelle Nelson – Office of the National Coordinator

It's on the 30th. I forwarded it to you, Paul.

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

So 10:00 until when?

George Hripcsak – Columbia University

Noon Eastern Time.

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

Gosh, I don't have that on my calendar and I've got a commitment. Okay, so I'll have to work with Michelle. Okay, why don't we open to public comment then please?

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Operator can you please open the lines for 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 your telephone you may press *1 at this time to be entered into the queue. We have no comment at this time.

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

Okay, well thank you everyone, sorry for going a few minutes over, we'll have to work on this call for the next time and we do have a number of things we wanted to talk about before the final release of the RFC. So, thank you everyone.

George Hripcsak – Columbia University

Paul, Paul, we're not presenting to the Policy Committee again are we? This is just before the RFC, right?

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

Correct, correct.

George Hripcsak – Columbia University

Thank you.

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

Thank you. Michelle, can I call you?

Michelle Nelson – Office of the National Coordinator

I actually have a call right now.

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

Okay.

Michelle Nelson – Office of the National Coordinator

But yeah, we do need to talk.

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

Okay, thanks.

Michelle Nelson – Office of the National Coordinator

Thanks, Paul.

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

Bye-bye.

Michelle Nelson – Office of the National Coordinator

Bye-bye.