



**HIT Policy Committee
Meaningful Use Workgroup
Listening Session
Transcript
May 20, 2014**

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Just a reminder to our workgroup members, especially as you are asking questions, if you could please state your name. And to our testifiers, when we open up to questions, please make sure you state your name. With that, I will now take roll. Paul Tang?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Paul. George Hripcsak?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, George. Amy Zimmerman? Art Davidson?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Art. Charlene Underwood?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Charlene. Christine Bechtel?

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

Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Christine. David Lansky? David Bates? Deven McGraw? Greg Pace? Mark Overhage? Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Leslie. Marty Rice? Marty Fattig?

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Marty. Matthew Greene? Mike Zaroukian?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Mike. Neil Calman? Patty Sengstack?

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Hi all, I'm here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Patty. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Paul. Rob Tagalicod? Stephanie Klepacki? Are there any ONC staff members on the line?

Elise Sweeney Anthony, Esq – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Hi Michelle, Elise Sweeney Anthony here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Elise. And with that, I am going to turn it over to Paul, but actually, I just want to make a few reminders before I turn it to Paul. To all of our testifiers, you will have five minutes for your testimony and I will give you a 30-second reminder. And to all of our workgroup members, when we open up for questions, we're going to be using that raise the hand feature. So if you want to look and see where that is now and make sure that you know how to put yourself in the queue. And with that, I'll turn it over to you, Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks a lot, Michelle. Welcome everyone and thanks to the panelists for participating in this one of two listening sessions on Meaningful Use Stage 3, really appreciate you're taking the time to talk to us. This is, as you know, an ongoing process of continuing to get input from the public. You probably also know that the rulemaking process has begun and so HHS won't be able to share anything in terms of their current thoughts, but everyone's always open to listening. And in particular, we the Meaningful Use Workgroup making recommendations to the HIT Policy Committee have an opportunity as we have in the past stages of making comments, to the NPRM, which is expected sometime later this year.

The process is they're making a proposed rule – they're writing a proposed rule now. They'll share that, we think, sometime later this year and then we will react to that and provide formal comments back via the Meaningful Use Workgroup making recommendations to HIT Policy Committee, who will make the final recommendations back to ONC and HHS, CMS in particular. This is ongoing development of the Stage 3 objectives, criteria and quality measures. Some of you know we had a hearing on certification, which also impacts the rulemaking as well.

So, in this first of two listening sessions we have two panelists, one eligible professionals and the other eligible hospitals. We're really taking it forward-looking stance; we're forward-looking towards Meaningful Use Stage 3 with the benefit of experience, particularly with Stage 1 and to the extent possible, early experience with Stage 2. We know not many people have attested to Stage 2 yet the deadline isn't quite here, but some of the folks who are on the panels have certainly worked toward Stage 2. So, we're looking for what benefits have you realized in your organization as a result of the participating in Meaningful Use Stages 1, and to the extent that you have, Stage 2 and what advice do have in terms of both in challenges but the things that would influence the recommendations we have back to HHS about Stage 3.

You know that we've already had our initial recommendations, but as I just explained, we're going to be feeding back, giving feedback on the NPRM as it comes out. And you know that we tend to focus more in Stage 3, now that we have EHRs really being installed in the majority of places in the United States, we're focused on the measurement and improvement of outcomes, concentrated on four areas. So we're looking forward to your feedback. George, do you want to add anything?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

No, very good, Paul. I look forward to the discussion.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay. So each panel – each person on the panel has five minutes and we've gotten a lot of benefit out of the discussion that happens afterwards. So, we can begin with panel 1 and Doug Ashinsky, from Warren Internal Medicine, are you prepared to go first?

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

Yes, I am.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Great, thank you. Go-ahead.

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

Good morning. Thank you members of the HIT Policy Committee for inviting me to participate, share my experiences with Meaningful Use, and probably improve it. My name is Dr. Douglas Ashinsky. You have my biography and you can see that I am at the forefront of technology in the medical field. As a solo practitioner, not only am I the physician provider but I am the front and back end user of the EMR of my office and I need to fully understand what the EMR can and cannot do. Meaningful Use was designed to eliminate paper charts and digitalize patient data into an electronic health record. This increases data transparency, the hypothesis being that if physicians met Meaningful Use, their quality of care would improve and the costs would be reduced. Instead, physicians call it meaningless use.

Reaching Meaningful Use guidelines has forced physicians to click, dictate or type on the computer to meet actuarial and bureaucratic endpoints. These endpoints are not based on any evidence-based medicine nor any type of medical research and are quite arbitrary. A recent article published in JAMA Internal Medicine examined these arbitrary endpoints. In fact, in the first of its kind, a well-controlled study at the clinics of the Brigham and Women's Hospital, it compared the quality score of physicians who achieved Meaningful Use versus those who did not. The study showed that Meaningful Use was associated with marginally better quality in two measures, worse for two measures and not associated with better or worse quality in the three measures.

My office has already attested to Meaningful Use Stage 1 and is attempting to attest to Meaningful Use Stage 2. However, many of you should know that the CMS released data on May first that said only four eligible hospitals and 50 eligible professionals have attested to it. These statistics are mind blowing in the United States. There's a prediction that 80% of hospitals will fail to successfully attest to Meaningful Use Stage 2 within the allotted time and these hospitals are the early adopters of Meaningful Use. So I asked this committee, was Meaningful Use implemented to improve the quality of care given, reduce the cost of medical care or is actually being used to penalize hospitals and physicians and balance the federal budget? I hope the answer is the former.

Primary care physicians are the backbone of medical care and they're being driven out of medicine by the rules and regulations that are being thrust upon us. It is alphabet soup out there for us, MU 1, MU 2, MU 3, PQRS, SNOMED-CT, ICD-9, IDC-10, ACOs. These have caused so much stress both the mental, physical, emotional and financial that burnout of the primary care physician is happening. The AMA wrote to the CMS last week with valid points and included an observation, unless significant changes are made to both the current program and future stages, many physicians will drop out of Meaningful Use. Patients will face disruptions and inefficiencies in their care. Thousands of physicians will incur financial penalties that will hinder further technology purchases. Outcome-based delivery models will be jeopardized.

They also made recommendations to remove the existing program's all or nothing approach to items. Allow physicians who meet the 50% of Meaningful Use to avoid the financial penalties. Add flexibility to the threshold required to earn incentives. Remove the concept of core versus menu items. Remove mandates that are out of the control of physicians, such as patient secure messaging, the arbitrary amounts of patients using view, download, transmit and the patient portal. These are beyond our control and are influenced by patients' preferences. Meaningful Use mandates should also be evidence-based. Costs needs to also be taken into account. The cost of obtaining Meaningful Use includes the cost of the multiple interfaces, the direct address, which unlike other e-mail addresses is not free, the cost to establish relationships with cancer or specialty registries.

Many of the problems with the EMR stem from the certification process, which is overly rigid and complex. It hinders the vendors from delivering us high-quality and high-performing products. I want this committee to listen to what a real physician has to say about Meaningful Use Stage 2 before implementing Meaningful Use Stage 3. This committee should look back at what Meaningful Use was designated for and supposed to accomplish, to improve the quality of care delivered in the United States. We need to keep the positives of Meaningful Use Stage 1 and 2 and stop the Meaningful Use calendar. Instead –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thirty seconds.

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

Instead, with input from real physicians, we can redesign Meaningful Use so physicians stop calling it meaningless use.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you, Dr. Ashinsky. Are you all set?

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

Yup.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Okay, thank you. Dr. Lee, are you ready?

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

I am.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Please go ahead.

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

Good morning, everyone. Thank you as well for inviting me to speak to the HIT Policy Committee and the Meaningful Use Workgroup. As you know, I introduced myself and Atrius Health in my written remarks, so I'm going to try to skip that for here. I have some agreement with the previous presenter, I may not be in 100% agreement, but I'm on that path. I too am a practicing pediatrician, as well as delivering our EHR. The big leaps that are established in Meaningful Use have been very valuable in terms of getting physicians on to EHRs, but are also really creating problems in the delivery of our systems and delivery of our technology.

And I think in my view, the best view for you looking at this is not only to look at Stage 3 but to say, what is really the future of this going to look like and think of Stage 3 in that regard. I think that if you do that, you'll see there isn't a real future for continuing to change technology from a central mechanism and through NPRMs and legislation. And therefore, it's really a great time to take a pause in this system and see really, what the effect is over time rather than continuing to force change before we really have a chance to analyze effect.

In terms of what we've seen, there are some areas of benefit to clinicians and patients. I am a huge supporter of the patient portals because I do believe that they enhance care and allow sharing of care. So I think allowing for that in the certification and requiring some use there has been beneficial. I think the focus on mark pieces of the chart as reviewed is perhaps skewed, but it has allowed us to work with some standardization in those areas of the chart. And to give people – give them the import that they need that if they're going to transmit information and have other people understand it, that they need to focus on core elements of the chart, like problem lists, allergies and medications. I think the ability to capture data, to monitor outcomes and monitor our care processes is a key portion of electronic records and probably the most valuable element overall. And so the adoption of CEHRT nationwide and the ability to monitor and capture data of course have been a value in Meaningful Use.

However, the focus on transitions of care is correct in terms of building a community of care providers and allowing information to move more seamlessly. But as you know, this piece of our environment is incredibly immature so forcing providers to use it, using whether it's the Direct transactions or other, forcing providers to use it when there isn't a clear business case or even a clear technology model that is functioning, has been an incredible challenge. For us, I have been unable to reach Stage 2 for a majority of our providers in the first half of this year, although we do feel we'll be able to get there in the second half of this year. The first group that will go through though are those that have exclusions in the transitions of care measures because the shared providers have access to our HER. Hopefully the remainder will come by Q4, but even that is a challenge with in Massachusetts the what we call Hlway, not fully functioning yet.

I think that inbound and outbound transactions, as I mentioned in my written testimony, are really a challenge in terms of the timing of when you expect them to occur and how much value they add to a clinical transition. And so while I think the ability to send the information is incredibly valuable, the creation of a HIway or an infrastructure that allows us to exchange information securely in a standardized way, incredibly valuable. But I think forcing the transactions when we're not really sure when they should be occurring or between whom they should be occurring, whether it's a department, an individual, a hospital, a network, is an incredible challenge. I do love the objective of having a shared plan of care eventually as a patient, so that everyone involved with the patient knows how to do that, but until we can figure out how to do that, I think that that's – we are too immature in our development to enable that as part of Meaningful Use.

So, as the environment is changing dramatically and we're seeing changes in the payment models and in the technology models and in practice structures, trying to adjust the technology by fiat is incredible challenge. And I would strongly advise the panel, as the previous presenter, that we really need to take some pause here really measure what we're trying to accomplish before we enforce more technology changes. So I think focusing on data and reporting, focusing on standards and transport that will probably be effective. Focusing on more work for clinicians to do and thresholds, I think, will not be as effective as you're moving forward. Thank you very much.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you Dr. Lee. Dr. Stutman, please go ahead.

Harris Stutman, MD - Chief Medical Informatics Officer – MemorialCare Health System

Thank you. I really do appreciate the opportunity to provide commentary to the committee. I know many of the committee members in our – on our day jobs. And I do not envy the committee its considerable challenges to walk a fine line between pushing healthcare information, technology and exchange toward more and better use of technology. As opposed to pushing us into areas that are over at the line and cause us, in my opinion, to spend precious time and resources on efforts that are less, in some cases much less, than value add. I represent an integrated healthcare delivery system so my remarks will, I think, probably cross the line and refer both to provider and to hospital-based examples of what I've just mentioned.

All of our hospitals and all of our eligible providers have successfully attested to Stage 1 through the Medicare or Medi-Cal, in terms of California, based programs as appropriate. And some of my comments are related directly to my own interest in informatics and the organizational priorities that we have here at MemorialCare through our medical groups and our hospitals. I've provided you with some high-level commentary in the brief PowerPoint that I shared and that has been posted and I hope you had a chance to look at that. As noted, Stage 1 has been a minor challenge to those of us who have been working on our EHR journey for some years, 8-10 years in our case. It required us to do pretty much what we were already doing, but to do it better, to do it more consistently. And I think in general, most of us here felt that this was really something that we strongly supported and were glad to see many of our sister institutions in Southern California and throughout the state get on board with what we had already been doing.

Stage 2, of course, expanded many of those objectives in ways that were, I think, sort of bureaucratic increasing some percentages and so forth and I'll return to that theme in just a minute. This was reasonably useful, but hardly pushed the envelope that is, changing percentages and adding a few additional tweaks on blood pressures or vital signs and so forth. But many of the other Stage 2 directions, as you've already heard from Dr. Ashinsky and Dr. Lee, have been defined in such a way that their inclusion is really quite challenging. There are a number of objectives that I have again found useful in pushing our organization forward on timelines that perhaps we would not have otherwise adopted, and I've listed them on the first slide of my prepared presentation. I believe that that really has moved the mark in provider and patient engagement, in some public health, especially our immunization registry interface and in patient safety.

However, the way that the Stage 2 measures are generally defined are causing us additional angst in many areas and lead me to wonder whether this is really contributing to our overall optimization of EHR technologies in the United States. Principal among these are the transition of care requirement that you've already heard about. On the provider side, secure messaging and patient reminders and on the hospital side bar code medication administration, especially as it's been defined. We have, just to give you an example, at least five different workgroups and committees who are working just on transitions of care. All of them meeting weekly, dealing with licensing numerous add-on technologies, purchasing new hardware and software, purchasing new consultant services to deal with interfaces that are required, engaging providers in our community that are not otherwise associated with our organization because otherwise they'd be excluded from the transition of care requirement.

And as you can well imagine, all of this costs money, resources and is distracting from other things that we would like to be doing in terms of areas of patient and provider engagement. What this will all look like and how I, as CMIO, am going to sell this –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thirty seconds.

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

– is very difficult in a world where incentives go away and it's only a matter of payment adjustments. So I believe in Stage 3 the focus should be on solid certification so everyone has an EHR that they can feel confident in. Focus on provider and patient engagement rather than more box clicking and percentages, making sure measures are not the sole criteria we use. If we can send a secure message or provide patient reminders that should be enough rather than picking arbitrary percentages that have no evidence. And finally, CQM synchronization among PQRS, Meaningful Use, IPQR and other programs is an absolute must, so we're not doing things redundantly. Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Dr. Heslin?

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

Good morning, I actually lost my voice so I apologize for the gravel and I thank you for allowing me to meet with the committee today. So, I'm a four-person group up in Northern New York State and I'll give you a rundown of my physicians, because it goes to this. Some think Meaningful Use is a conspiracy, some of them are overwhelmed, some of them are anxious and then there's me, kind of leading everybody along. And we are the best and worst of all possible worlds because we live in where we're not a single guy making decisions and we're not a large group with administration. So, we look at Meaningful Use, as it simply has to be good enough, because it's not perfect. And that it's sort of a game of sequential approximation where we are seeing that it kind of moves the ball forward, but at the same point in time, it doesn't quite get it to where we need it to get to. But we keep moving in the right direction.

As others have said, Meaningful Use Stage 1 was not such a big – challenge. We had already been doing medical home and a variety of other projects, so it seemed to be a nice fit and we moved rather well through that project, without any difficulty. I think that it became pretty apparent that as we looked at the different technologies that were out there, with the EHR's and different the stuff, that the companies that put these together certainly had proprietary agendas that were different than what we considered necessary to be able to move our project along. And did require us to start to think about how to change our stuff around. It gave us, as a small group, some guidelines by which we could improve what we were doing, we are both gather better data, do better measurement, we started to look at populations, this sort of gave us a process, but not only tools necessary to be able to get things where we needed them to be.

In Stage 2, as others have said, transitions of care are tougher if not impossible for smaller groups to meet, particularly when you're so much dependent upon your EHR, your vendor and also the ability to build the interfaces both with the hospital and with other groups. The highway simply isn't built well enough yet to be able to do some of those things. Yet the large part of the problem with it is not actually the electronic process, it's what has always existed which is the paper process and the poor communication that has existed for many years – we as physicians have become more siloed and more segmented in what we actually do. We didn't have good communications in paper, we don't necessarily are going to have better ones electronically unless we do a better job of establishing the practices.

So as we start to look at the environment out there, and this ecosystem of healthcare, we're looking at many different systems all doing things differently and there has to be some sort of convener. And I look at Meaningful Use as being part of that convening force to be able to get us to the place that we need to go. I actually think that you have more teeth rather than less teeth because I believe that if we don't get to a point where we can actually get a standardized way of doing things, we simply will never be able to transmit data to and fro. We won't be able to harmonize and get all of our information and our patients cared for adequately in our community. In my community alone we have about 12 different EHRs, the hospital uses two different ones, one in the ER one and one in the rest of the hospital. It's near impossible to get all of that communication, unless we're able to get the vendors on the backside to start following rule sets and – should help do that. And then us to be able to do it.

Do I think there are too many clicks? There are way too many clicks. Do I spend too much time doing that? I do. Have I hired more staff to be able to fill in all the little boxes? I've added probably 10% to 15% more staff just to be able to fill little boxes, yet at the end of the day what have we been able to accomplish? We've been able to get through MU1. We're able to work through our medical home project. We're able to sign up and become part of a comprehensive primary care initiative, which we probably wouldn't have been in a position to do, had we not started this process several years ago with Meaningful Use and our medical home project. Are we well set up for the state's – Project M4 District, which is in New York State? I think we're in the right position to be able to do some of those things.

So I think that as a convener and a focal point to get things started. I think it's the right message. I think that Stage 2 has made it much more difficult because frankly I don't think that the industry was ready to be able to handle this. Yet at the end of the day, if we continually go for perfect, we're never going to get anything done. We simply have to accept the fact that we are going to have good enough and that we're going to have people not be able to make the standards, but we as physicians are used to being A+ students and we have to continue to figure out how we're going to do that. We have to remember that at the end of the day that healthcare works out to be a huge chunk of our federal gross domestic product. We have to remember that turning this ship around over the last six or seven years going from an industry that was purely –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Ten seconds, I'm sorry.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

– is difficult and to do what we've done is good, we have to continue to focus hard on getting better measures that are achievable so that we keep people moving forward. Sorry for going over, bye.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you, Dr. Heslin. Dawn Sullivan?

Dawn Sullivan – Patient Portal User

Hi. I wrote up a little half page to answer some of the questions that Dr. Lee sent me, but basically Dr. Lee has been my pediatrician, my children's pediatrician for 17 years and since he's implemented electronic health records, it's been easier for me to manage their appointments, referrals and medicine refill requests. In the past, these tasks required frequent phone calls, time spent waiting for return calls and delays on my end in getting important care in a timely manner. My daughter has extraordinary medical needs and it takes time and effort to organize all the doctors she needs to see and when she needs to see them.

Having medical and surgery histories available in a centralized location is extremely helpful for keeping track of everything we need to do or have done. The MyHealth patient portal helps tremendously with my organization so I can make sure that I'm addressing all the recommended treatments and getting the best care for her. I can't tell you how daunting it is to have look through 17 years' worth of history in the file cabinet in my basement to locate one piece of paper that may be needed for an upcoming appointment. So manual management of her care is very time-consuming, inefficient, and probably not always accurate and now everything is at my fingertips, which helps me get the best possible outcome.

Some of the things that I love the best about the portal is the ability to e-mail the doctor for non-urgent things and keep the e-mail history. This really makes her care more accessible for me. This improved communication is much more efficient for me than phone use. I like being able to see lab results with the graphs, having the visual helps me see that effect the medication's had on test results over time. Seeing my upcoming appointments, because I'm never able to hang on to those little tiny cards that the doctor gives you for appointments six months from now. And then I would just say that the portal technology is very, very good, which is very important because I wouldn't use it otherwise. I wouldn't probably give it much of a chance if I ran into any kinds of issues at all. It's fast and intuitive and I've never gotten timed out when moving from page to page or other issues you sometimes have with websites.

So just one example of how logically it's laid out is, if you're in the preventive care page and you see a list of appointments that you're due for, you can click a button to request an appointment rather than having to navigate back to the appointments page. So, I just feel like it is really user-friendly and it facilitates better management and organization of my children's care.

Just lastly, I would just say I'm not sure why all my doctors don't use this, but if it's related to privacy concerns, my own personal feeling is that having records locked down in a database of electronic security and limits to who can see them is far more secure and safe than a paper file in a box somewhere.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you very much, Dawn.

Dawn Sullivan – Patient Portal User

You're welcome.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

And thank you to all of our panelists. We're now going to open it up for questions from the workgroup members. So, as a reminder, please use the raise the hand feature and we'll call on you as you put yourself in the queue. George –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So, thanks to –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

– sorry, Paul, go ahead.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks to all the panelists and appreciate especially the ones who gave us the real – the detailed reasons of what worked and sounds like for example Stage 1 worked quite well and there are a number of challenges you focused in on in Stage 2 that I'm sure we'll have some questions about. I'll turn first to George, who had his hand up?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Thank you. Hi, thank you so much for the presentations and we understand all the varying opinions. If you could just – if each of the panelists could just say the one – if you were designing Stage 3, what's your one top priority for what Stage 3 needs to accomplish in a positive fashion, what would that be? Some of you kind of stated it in different ways, but I would like to hear it sequentially, each panelist. What's the one top priority for Stage 3 next?

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

This is Mike Lee. If I had any particular measure that – and again I'm somewhat resistant only in that I'm not sure how far we should evolve this, but I think one of the most valuable features now that you have the fundamentals is really around population care. So even if someone didn't have an outcome improvement, the only thing that I would see that I think is the next logical step is to ask people to demonstrate use of the EHR to improve outcomes. So basically some sort of reporting around what they're doing to intervene to improve outcome. I think that's more important than adding more software tools.

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

This is Harris Stutman, I could not agree more with that. As I indicated in my initial remarks, I think one of the things that we are struggling with, is the fact that we have multiple reporting requirements, many of which go through the same federal agency, DHHS, CMS and so forth, for which the reporting on very similar subjects has different business logic. And that's incredibly wasteful from our perspective and we have again multiple, well several workgroups that just deal with the redundancy to, I think, little effect. I'm hopeful that we can choose a relatively well-defined number of quality measures both in the ambulatory and inpatient realm and then of course perhaps some that span the continuum of clinical care. And we can all agree on business logic for all of these different reporting requirements that is identical and would love to then be able to see how much we can push the meter into the high-quality range with the tools that we've already implemented it in Stage 1 and Stage 2.

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

This is Dr. Ashinsky –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

– okay, go ahead.

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

This is Dr. Ashinsky, what I would like would be some way to be able to get the interoperability between EMRs done. With patient portals, as described, if I've got a Medicare patient, they have a Blue Button from the CMS. If they go to the hospital, the hospital has its own patient portal and I have my own patient portal and if they go to a specialist, there's a fourth patient portal. If there was some way to be able to interface all of those so that there was only one patient portal, that would be wonderful.

I'm also in an ACO that's part of the Medicare Shared Savings and in order for us to meet the quality measures, each one of us has to fill out an Excel spreadsheet with our results, send it into the central area and then someone actually has to personally go through all of that Excel spreadsheets, put it onto one Excel spreadsheet to submit it to CMS. Now there was a way – again Apple and Microsoft initially were separate and you couldn't put Microsoft on one – you could put Microsoft on Windows, but you couldn't put it on Apple, now you can do it on both. We need to allow that to happen because once that happens, then we'll be able to meet quality measures. We'll be able to improve quality measures but not having to rewrite the same medication in four different portals, rewrite discharge in four different places. It's getting to be – it's impossible with the amount of times one has to enter one piece of data into things.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks. Dr. Heslin, do you have a comment?

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

Yeah, I was going to say I agree with all the others. I think that harmonization of the data so we can actually move it more efficiently is going to be important. I think that that's just key to us whether it's through the transition of care components of it or whether it's looking at the population management, my ability to get and track data from other people is just so limited at this point in time. The discrete data, even imaging, just doesn't exist and so we just have to drive it.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you. Dawn, It may not apply to you but I'd just give you a chance if there's anything you wanted to add? Okay, next is Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Great, thank you. Am I off mute?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Terrific. I want to thank all of the panelists for the interesting and thoughtful comments. I read the written material and I had to smile at your comments, Dr. Lee at Atrius Health, where you talked about being on the EPIC system for 20 years and pioneering a homegrown system before that. Actually I was the author of that homegrown system starting in 197. And so your organization at that point was called Harvard Community Health Plan, is actually one of the most experienced group practices in the country with electronic medical records. And I read your testimony carefully and listened to everybody's presentations, and I had participated in the certification discussions that we had earlier. And I understand that people are having great difficulty with Stage 2 and wondering what people would think of a variation of the AMA proposal where what they said was to qualify for Stage 2 you had to complete perhaps 50% of the measures. And then when you completed 100% of the measures in Stage 2 that would be defined as Stage 3, and then you'd be done. What would you think of an approach like that?

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

Yeah, I mean, interestingly, it's great to hear your comments and we have never met personally, my dad was actually involved in the early stages of the Harvard Community Health Plan, so I've known a lot about the history of the organization and the technology. I think that the real hurdle for almost everybody in Stage 2 is around the transition of care items. That's the one piece and I think that that might meet the need if you did something like that, or even just took that measure out of Stage 2 and said that's going to be a Stage 3 measure so we had time to really work on and get it right.

Again, in part of my comments I really worry about when you are forcing someone to send a very full packet of someone's medical information, but you're not sure of the intended recipient because of the time in transitions of care. I think hospital discharge is a very distinct time, ER discharge is a very distinct time, and patients are going from there exactly to another setting on that next day. But I think the other direction, going from ambulatory practices into a hospital system, unless they're going directly to the ER, they're going at very, very different times and I worry about forcing transitions of care summaries to go at times that aren't appropriate for the patient. That was one area of the Stage 2 measures.

But I do think some lightening of the load would be very much appreciated. I'm just not sure where you want to take Stage 3 and what the future of the program looks like. That's what I would – I guess I would be – I would love to get a sense of that philosophy before really commenting on what you think the future looks like for CMS in this area and then trying to figure out what the road is to that future.

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

This is Harris Stutman again. I think the idea that you could meet Stage 2 by meeting a percentage of the requirements is intriguing and I hadn't heard that before. I guess I'll have to think about that a little. My preference, however, would be to say that most of the Stage 2 requirements, I think are, in terms of their intent are reasonable. There are things we ought to be doing in terms of patient reminders and secure messaging and even transitions of care. The problem really lies in these arbitrary percentages. If the certification criteria are so designed and configured that we know that if you have certified software it's capable of doing these things and we can demonstrate that we have sent a secure message, we have sent a patient – received a secure message, sent a patient reminder or even sent a C-CDA. It seems to me that that ought to be the requirement.

How much of that we do, whether it makes any business sense for our prac – for the practice or the group or the healthcare system, really is something that ought to be defined by the practice or the system and not again by I sort of an arbitrary percentage of 10% of this or 50% of that. As long as we have a system that's capable of doing that and we can demonstrate that we've done it once, I think that ought to be the focus of Stage 2 and then in Stage 3, that we can move onto fleshing that out.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

So, this is Gene Heslin here. I think that the transition of care piece is just incredibly difficult to do something with. I think that the technology, though certified, some of them are just becoming certified at this point in time to be able to actually put a workflow in place and actually make that work. Just because it's certified doesn't actually mean it actually works between different vendors. And so the timing to be able to meet that on a quarterly basis by the end of the year is going to be a challenge for particularly smaller groups, but even larger groups because the – it just was a big push to get that in place.

And so I think that having the program is important, but to actually use the program is more important. And I think the sense – what you guys try to do with the program I guess partially defines how you want to make this particular measure be used. In terms of the rest of the MU 2 requirements, they seem to be all things that are least within our control at this point in time and how we actually actuate that in our practices is something that I may decide we want to do or not, business case or not. But that one particular part of transitions of care, it just – I'm not sure the industry is ready to actually have us do that, and I think that's where a large part of the problem lies.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Doug, do you have something? Might be on mute.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, so – go ahead.

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

So with the getting 50% is at least a thought process, but again, the transition of care is and extremely difficult thing to meet. Again I'm in a suburb of New York and there are no specialists who have a Direct address in this area. So I can't send transitions of care via Direct to any of my specialists that I use. The only ones I can send it to are either hospitals or to nursing homes and I don't have enough people going there to meet the requirements. So, it should be like what it was with sending a message to the immunization registry. You do it once, prove that you can do it so that next year or the year afterwards when the technology exists, you can then get 10%.

The same with secure messaging. I just got an e-mail from my EMR on Friday that they are still are unable to give me a numerator on my secure messages coming from the patient's as well as the VDT requirements. So as long as the happens once, we know that it can be done and down the road when the technology exists, when they interfaces exists, when the interoperability exists, when I can actually send something it will be good.

The other thing is, if anyone actually looks at the transition of care, it's 14 pages of nonsense. So the other thing we have to do is we have to eliminate the excess amount of paper that's being sent with these CCDs that when a physician looks at it, basically they look at the last page, which is the impression and figure out what's going on. The 14 pages prior to that are a waste of a physician's time.

Paul Egerman – Businessman/Software Entrepreneur

Well, this is Paul Egerman. So I'm listening to these comments and the idea I'm getting is one of the things we can do to improve things would be to somehow take transitions of care and carve that out of Stage 2. And perhaps make that be what Stage 3 is, to try to get that right because it's something that's very hard, but if we sort of have that as our focus for Stage 3 for like two or three years from now, that that could be a useful focus and also make Stage 2 doable. Am I hearing that right?

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

Yes, Gene Heslin here. I think one of the things is, is that if you were to use this as a driver to start to harmonize the vendor industry in such a way that not only do they have to build a CCD, but actually integrate into their EHR's the ability for this transition of care document to be able to come in. It's not going to be good enough to necessarily have it as a secure e-mail or an STMP, but actually build it into the true workflow of the EHR, it then becomes a useful tool for us as physicians, as opposed to the 14 pages of gobbledygook that you get. And so what we're – in that way, you're going to use the rule to drive vendors in a way that becomes productive and actually gets us to a point where we get a positive out of this. It's still incumbent upon us to work with our communities to be able to develop those communication pathways between our referring physician, specialist, hospitals etcetera, which isn't always best in the world to start with. But at least it gives us the technology backbone to be able to actually accomplish it.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So this is Paul Tang, I'll pick up on this comment. And once again, I want to thank everybody for very constructive discussion. Clearly, everyone's focused in on the transfer of care – transition of care in Stage 3, so let me swap paths with you here. So one of the problems – I think everyone agreed that it would be wonderful to have this information in your EHR and someone pointed out that, well gosh, we didn't have it on paper and it's not as if the electronics are necessarily going to make that better. When we had testimony at a hearing with ACOs, as you recognize they all need to have better care coordination and need to have this exchange going on. And at the top of their list is the observation that neither the vendors nor the providers were necessarily willing to do that exchange.

What policy lever would you pick to try to encourage this exchange to go on? Do you think it's been limited by technology? And I gave an example of where, I think it was Gene that pointed out, well, it's not all the technology, somehow we've got to work with these social barriers that prevent either vendors or the providers from wanting to do the actual exchange. What ideas do you have in terms of moving things along? Sometimes it's better to have somebody else be the scapegoat, like a regulation say, well, you know we've got to do this because of such and such, when both of you, both parties actually want to have information exchange and feel that it would benefit patients here?

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

I think that's really an excellent point, Paul – this is Harris Stutman, again. And I think most of the comments that we've heard have been supportive of the concept of transitions of care and the capability to send this information when patient's move from provider to provider or organization to organization. I think what we're struggling with, and from what I infer, what others are struggling with is the actual business of figuring out, well, who do I send these things to? And how many of them are there? And how many of them don't have access to my EHR or are using different technologies? And so it really isn't so much a technology issue as it is an organizational logistic issue. And again, I don't understand how a small practice would even begin to bring together enough people and resources to figure this all out. We're a large medical group with hundreds of providers and we can barely do that.

It seems to me that in the current stage that the requirement for transitions of care ought to be that the certified software is capable of producing a C-CDA. And that there might be some sort of a test environment where we could demonstrate we can indeed generate a C-CDA once, and send it to this test environment that CMS or someone sets up. So, we've got the software, it can be done. And then let the – again, let the information superhighway, Massachusetts or otherwise, work itself out. So that as folks begin to see the clinical advantages and business advantages of being able to send such information from place to place works out that we all know that we have the technology that's been, I don't know, enabled to do that. Again, rather than picking arbitrary percentages and whether it's same EHR technology or foreign EHR technologies, I think those seem like such really arbitrary requirements that don't really move the ball forward.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

So this is Gene here.

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

This is Mike –

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

I'm sorry.

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

No, go ahead.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

I was just going to say, I actually think that it is somewhat of a technology issue and as part of an outcome of trying to have this measure in 2 people are doing alternate things. Like they're setting up webmail and things like that as alternate ways to try to meet the requirement, since some of the vendors can't actually meet it, so they're doing it portal-to-portal. They're trying all different things that are not necessarily moving it forward, but are actually counterproductive to the process of trying to do the transition. I do think it is a technology issue at this point in time because although people are certified in doing it, just because they're certified doesn't mean they can actually interact with each other.

And as you look at the, I don't know what it is, EHNAC or whatever it is at the site, lots of vendors can't communicate, even though they're certified with each other by Direct at this point in time. I do also think it is a social issue, because certainly the large groups in my area that are multidisciplinary are not particularly interested in having me send my patients to them. They'd rather have me send my patient and then keep that patient and they certainly don't want that patient to use me as their provider because they are in an environment that's controlling all the patients. Some say we have 95% of our patients in-house in all ways, we have no desire to share data. So, that's an economic social issue.

But clearly, as we start to look at the overall future of what we're trying to do, particularly in primary care, we're going to need to have this out. So you spoke about levers, I think that you have to explore the vendor community lever of not only certification, but the interoperability with the – with other vendors at the same level. It's sort of like okay, where do you want the level of order to be, do you want it to be at the backend, so all share data with each other? It's very difficult to accomplish that though because these things started off as EPMs and they became glorified secretarial systems, then they became population management tools and now we're trying to share things. So, we're building an environment that is built sort of backwards, we're starting with stuff that's this technology and we're now looking at it and okay, what can we do with stuff that really was never designed to do what we're trying to accomplish.

So, you have to maybe get a couple of steps ahead, say this is our most desired zone and then build some levers in place that will make the industry move to those levers. Have the vendors compete, not on the data, but have them compete on some other aspect of what they can charge us more money for.

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

I think – this is Michael Lee, I have a couple comments and those are great comments. I think that some of the big concerns around this were around charging, first of all, from the vendor community. That because this is difficult work from their end, that this ended up being a potential revenue opportunity for charging for transactions going between vendors. So if you take a scenario where as a clinician, I can fax something for free, essentially or call somebody on the phone or send a letter for free. And now all of a sudden I'm going to be charged to send a C-CDA, required by the government to do so, that puts us in a very bad business and operational scenario to be in.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

Um hmm.

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

I don't know how you can win that lever on the vendor side, but I think that that's an important area that hasn't been addressed here. I think the best levers that I always feel that you guys can use are around the foundations and the standards, which I think have been fantastic work over the last five years. I think the ability to say, this is a med list and maps to RxNorm and it's going to look the same in this record as another that has tremendous value.

If you look at it from a patient perspective, if I leave Atrius Health and I go to a practice on a different vendor, our printouts are legendary. I have friends in other practices who say, I don't know what to do with that 840-page printout you just sent with that patient. The printouts are just legendary and for the ability for a patient to quickly move their information, if they choose to go to a provider outside, that's helpful from a standard perspective. We've put in a number of portals to allow our medical partners to look at our EHR and us to look at their EHR. That has enabled a lot of patient movement with excellent access to information, which I've used for Miss Sullivan's children as well, so that you can very quickly see another clinician's impression without needing to move the information back and forth. I think the business case around moving the information is very specific to certain circumstances. I think ER is one, the SNF – skilled nursing facility discharge to a skilled nursing facility is one – is really valuable

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you. I have three people in the queue, Marty, then Mike Zaroukian and then Charlene. So Marty?

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Yes, this is Marty Fattig, a critical access hospital CEO in Nebraska. I'm wondering if any of the panelists would like to comment on the JASON report and do they believe that the designing interoperability around this type of framework would be of value?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle. I'm wondering if the silence means that none of the panelists know what the JASON report is.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

I peripherally know – Gene Heslin, I peripherally know what it is, but don't know enough to make a reasonable comment.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

All righty, thank you very much.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

All right, next is Mike Zaroukian.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

Yeah, so hi. Again, my thanks to the panelists as well. I wanted to turn the focus a little bit, if I can, to the comment made earlier about the resonant – resonance that some physicians have about certain parts of Meaningful Use seeming meaningful to them, and others seeming meaningless. So particularly looking forward to Stage 3, I'm interested in knowing what the panelists are seeing as perhaps the most meaningful of the proposed measures, which might be the least meaningful to them. And perhaps the related questions, since I heard some resonance around improving outcomes as a greater focus than meeting functional measures of preferred goals for Stage 3, to what extent do you feel that some of those measures should have greater weight with regard to Meaningful Use. Is there adequate role for clinical quality measures or too big a gap? Are there certain proposed Stage 3 functional measures such as CDS that would more directly resonate with physicians?

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

Whoa, that's a lot to bite off Mike.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System

So maybe the first part is just which one of Stage 3 measure's do you find is most or least meaningful as we go from what we proposed to –

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

I'll be glad to take a crack at both of them and if I swing and miss this twice then somebody else will have to pick up strike three. In terms of looking at what's on the current list for Stage 3, I was struck by two things. The first is that some of the items that we were working really hard on for Stage 2, including on our hospital side, the barcode piece and on the provider side, the reminder piece, get dropped, which sort of seems odd, given how hard we're working on those sorts of things. And I'm not sure that that quite makes a lot of sense, other than the fact that okay, you can do it once and then you don't have to do it again.

As others have said I think we have to be really careful about requirements or objectives with associated measures that are often outside our control, or actually, are outside our control. And I do note that there are a number of those on the proposed Stage 3 list like that, the results of consults being in a closed loop, electronic notifications that may go – that would be required to go again, outside our EHR and even the patient generated data requirement, which I am philosophically much in support of. I'd really need to understand more about how that's going to be defined, because again, that might well be outside the control of any of us to be able to actually deliver. Again, unless it's something that we could demonstrate that are EHR is capable of doing and there's some sort of the test protocol that we could comply with. So those are the things that kind of keep me up in terms of what might appear in Stage 3 that I'll be worried about in 2016.

On the quality side, the only thing I would say is I'd really like to see the focus be on outcomes and not on process measures. I think we have enough to know that with CDS and how many – whether or not we are required to have 5 rules in place or 10 rules in place, really seems like a really trivial and not incredibly forward thinking approach, and even within those rules, how many of those are process-based. And again, I'm just not sure exactly how that moves the needle very much. I'd like to see most of the things really be focused on outcomes, I know those are harder to measure, but if we don't start to get at that, again how many of our patients get, I don't know, A1cs or flu shots, etcetera, ultimately isn't what we're all about, it's how healthy are we keeping our population. That's it.

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

This is Michael Lee. I would generally agree. I think the challenges are when you look at different practice styles, so if you're an independent orthopedic practice and you're focusing primarily on sports related injury, family history, probably not a huge impact in the work that you're doing. Yet it ends up being a highlighted component in some of the other – in some of the views that I've seen for suggested measures. I think CPOE and ePrescribing, once you find the workflow that actually makes that work, nobody does 80% or 50% they tried to do 100%, so I think finding threshold measures, and those are challenging.

I agree with the comment on CDS, we have clinicians who have literally hundreds of CDS items and some who have very few. So it's very hard to pick a number 5, 10, 11, whatever the number is and say, that should really be the right number for people. What should be important is that vendor be capable of providing that and allowing the practices to decide where it is. I think that the submission to public health agencies, the ability to create registries, I think that's actually a real population importance to us and so I would encourage you to continue along that line of making sure that the EHRs can report information correctly to public databases, especially around specific disease entities. I think that is a worthwhile pursuit, immunization registry, very worthwhile – a very worthwhile pursuit over time, public health-wise.

I think the patient messaging is a challenge, I think if you have it but don't require people to use it in some way, and then patients aren't benefiting. And what I always try to figure out is what is from the patient perspective. It's one of the reasons I actually like the low threshold in Stage 2, I know it's difficult for people to measure, but I actually liked the low threshold because it really enforced the fact that you need to use these tools with patients. And I think you heard from my patient that if the clinician and the patient find value, there is a real general both perceived and actual value in having access to this information from the patient side.

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

This is Dr. Ashinsky. A couple of things, the stuff where patients have to make the decisions, having an arbitrary number that really has to get – that really can't be. I can't force patients to do certain things, patients have their own preferences and if they would prefer to call me to get a result rather than go on an email for it, I can't force them to do it. Now, someone had just talked about registries, they're nice, but in New Jersey, a primary care physician cannot report to cancer registry, so I lose that menu item completely. And in New Jersey, there are no specific disease registries also that I can refer to, so I actually have to pay a company to set up a specialized registry in order to do that for Meaningful Use Stage 2.

So now if you're going to make this even more difficult in Meaningful Use Stage 3, little independent physician offices as myself are going to opt out, and that's not what we want to do. We don't want to make this so onerous that in addition to doing this, in addition to doing PQRS, in addition to doing this, you can't do this, you're going to force small businesses to go out of business and that's not the purpose of Meaningful Use. I'm having a difficult enough time as a solo practitioner to meet the guidelines. I'm actually – it's very, very difficult and it's very costly. And every time you add a cost to a small business, especially a medical business, where you – we're lucky to be – we don't even know come next year what's happening with our Medicare reimbursement, if it's going up, if it's going down, we don't know any of that. If you keep on adding these costs to it, every small business is going to end up dropping out and saying it's just not worth it anymore.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

So, this is Gene Heslin. Mike, this is Gene Heslin. I think that a lot of this resonates with me in terms of – and most of what's been said. But I think that getting to an outcomes-based measure and moving them forward is actually pretty important. And there are projects out, the ACO world is working on its CPCI certainly is pushing some outcomes-based type of measures. And I think that we can look to some of the projects that are going on in CMMI, to be able to get reasonable thresholds of what the most advanced groups certainly in primary care are working on out there in terms of some of this stuff, and then be able to retro that maybe into some of Stage 3 type work.

Clearly improved population management in my world, and I'm a small practice without any functional administration if you will, because my wife's my administrator, never mind, I better not say that. Anyway, the issue is that we're doing better population management and our patients are doing better for it, so in terms of our internal registry functions and what we do with it, it's made a difference. In terms of getting things to the outside world, as we're looking at immunizations, going through the EHR we're just pushing that through at this point in time, even though New York State has had a registry for a long time, our vendor has just started to figure out how to connect up to that. It's a frustration that we're not – along with it, but at the same point in time, it's starting to get there. Again it goes back to, is it perfect? No, but it's getting to be good enough for us to be able to actually use it.

There are frustrations around discrete data with imaging, to be able to have that and available would be a great thing to be able to make us more useful. It's things like that that improve the functionality of how we think. We have to also remember that as we are moving forward over the next eight or 10 years, the rule sets of how we practice medicine is going to become very different. Because as the population ages and as we get into different categories of people, we've already seen the rule sets change and yet we read it in a book, we do it by up-to-date. We do it by all sorts of different methods, but we're going to have to get that CDS to us from the population in the modeling systems down to a digestible form to our patients. So, it's a multistep process if you will and we need the vendors to be able to do that in a way that we can all access and can understand it. So I think that's actually really important.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, Charlene, please.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Yes, I had two questions. This – one was to kind of build on the concept that Paul Egerman – this is Charlene Underwood from Siemens, had suggested which was, was there a way to solve some of those challenges with Stage 2 by breaking down the program and potentially deferring transitions of care. And I know we got some different comments on that. So my question on that was, we have three years of Stage 2, so would you see it possible that there is an uplift with – even in the context of Stage 2 is a possibility, as you look at all the myriad of requirements that you have to face? Or would you still say, just say wait until Stage 3? So that's kind of a yes or no, but just thoughts on that.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

Gene Heslin here, I suggest to wait to Stage 3, your early adopters, the people who supported you early on in the process that got done in 2011 are stuck at this point in time, either getting it done by the end of this year or they are going to be kind of in a stuck position. So I think that people who were early supporters are really in some quandaries at this point in time on getting through the process and trying to decide if it's worthwhile continuing. So jumping it to Stage 3 gives everybody a clear shot at what they need to do at the right time.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Okay. Any other comments?

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

This is Michael Lee from Atrius, I mean, I would agree. I just think the transition of care to me is in both directions, right, it's the summary of care going out at the transition of care, it also is med reconciliation when they're coming back in, and med rec is so important. But trying to actually tag when the transition of care occurred, so that you need to do med rec, is actually not that easy. And that one also is a challenge. So med reconciliation is so important, but trying to tag the actual denominator there is getting to be an incredible challenge. But I just don't see the industry rallying in a way that we can get the volume going to understand where the value is in transition of care quickly enough to make it a useful Meaningful Use measure.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Doug, you had a comment.

Douglas S. Ashinsky, MD, FACP – Warren Internal Medicine

Yes again, I would also await Stage 3 before doing that. Again, the transition of care would be great to have and hopefully there's a Google or something out there that will do what they did with regular computer technology. It's like what it used to be, we used to all have Blackberry's and we were happy with it. Apple came out with an iPhone, which was better technology. You didn't have to actually force people to buy Apple, it was a better piece of technology, everyone switched over to it and now everyone liked the Apple. They're not as happy now with the iPhone, so Android comes out with a better device.

The same thing is going to eventually happen with EHR, but we have to give it time. And before we even give it time, we have to say to people, listen, we understand that Stage 2 is very difficult. We're not going to penalize you for not even attempting Stage 2. Let's get rid of the penalty in December of this year, let's extend Stage 2 instead of having it end the 90 days in December 2014, and make it December 2015. At the end of 2015, probably the technology will be there, the Direct addresses will be there, and then we can then go from afterwards to Stage 3 or etcetera. But let's stop the penalty at the end of this year and allow those of us who are early adopters, again, I did it in 2011 and I'm looking that if I don't finish it this year, even though I was an early adopter, I'm going to be penalized. We've got to get rid of that.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

So, Gene here, I respectfully disagree. I don't think we stop Stage 2, I think we just remove the one problem area or we let the 2011 early adopters roll six months or a year to be able to have the technology catch up.

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

I think – this is Harris Stutman, again. I think Charlene's suggestion is not unreasonable, except for the fact that the incentives, at least for all of our Medicare-based providers are sequential. And so by saying we're going to get this in the second or third year that we have a Stage 2 opportunity means that we'll forfeit the incentives. And for those intermediate years take the payment adjustments, which would be a) difficult to swallow and I think create a mindset where you get off the train, it's a lot harder to get back on the train than just to stay on the train, if that metaphor resonates at all concerning the Meaningful Use train.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Anyone else?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Yeah – I just have one more question on – this is Charlene again. As we look at, and all of you kind of spoke to this, we're really trying to get toward outcomes-based payment systems to support health reform, managing populations and all that. And there's been a lot of work in the industry and investment by CMS to try and look at harmonizing and bringing together your clinical quality measures. Over time could you see the ability to be able to interoperate and share data evolving into some sort of a framework like a clinical quality measure? I know this is a jump in concept, but so much of it is, did you get the da – and I know these are process measures, but is that something that would be something you'd be willing to report against or think about?

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

So how do you put a numerator and denominator to that?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Right, right, in terms of your clinical quality measure, right, right. So we'll still have a denominator problem in any case, so –

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

But, I think it's not necessarily such a bad idea, but at the same point in time, I don't know how to build a denominator to that.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Yeah, okay, it's a dominator problem.

Harris Stutman, MD – Chief Medical Informatics Officer – MemorialCare Health System

I mean, I think if the thought is that we're looking at, and this is not the right word, but some sort of a federated data set, database where we could all share quality data. So that again, we're looking at true patient outcomes and not just patient outcomes as they relate to the care that I deliver within my practice or my organization. But we look at the patient as its – as his or her own entity, I think that would be really an exciting direction to go, but it's really a leap from where we are right now, a big leap.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Okay. Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, any other questions or comments from the group? I want to thank this panel, I think the discussion has been very rich, lots of good ideas and turns out to be very focused, a lot on the transition of care. I think the message has been heard and appreciate your suggestions as well. Any other final comments from the panel? All right –

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

I'd like to say – Mike Lee, I just want to thank you guys for listening so much. I actually think that as one of the major benefits of this program is actually showing one of the good things about government is the ability to listen to the people who are the constituents of that. And your program has been a great example of that, it's not perfect and it has its warts, but you should really be commended for the amount of effort you put in and for your ability to listen to the user community.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

I was going to say that it's not just the users, but it's the vendors and it's the insurance plans and everybody has a different agenda. And to be the convener focuser of all of that and get all of our welcomed comments from all of the different environments you have thick skin and you are very appreciated in how you then take our thoughtful or thoughtless comments and then divine them into the next set of thoughts. So thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Well, thank you for the comments. We have –

Paul Egerman – Businessman/Software Entrepreneur

And Paul –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

– a lot of work – at least.

Paul Egerman – Businessman/Software Entrepreneur

Paul, this is Paul Egerman. I also wanted to thank the patient representative for her comments about the portal, which was very helpful. So, I appreciate having that as part of the presentation.

Dawn Sullivan – Patient Portal User

You're welcome.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Well thanks everyone and we will transition to our second panel. We'll let people get a little bit organized, but thanks so much to Panel 1, appreciate your help.

Michael A. Lee MD, MBA – Director of Clinical Informatics – Atrius Health

Thank you.

Eugene P. Heslin, MS, MD – Bridge Street Family Medicine

Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, are the second panelists on the line?

Pamela Arora - Senior Vice President and Chief Information Officer - Children's Medical Center

Yeah, you have Children's.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer - Somerset Medical Center

Yup, Somerset Medical Center's here.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

Daniel Griess, FACHE – Chief Executive Officer – Box Butte General Hospital

Yup, Box Butte General Hospital's here.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

Thomas Johnson, MBA, CPA – Chief Information Officer – Penn Highlands Healthcare
Penn Highlands Dubois.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Super. Why don't we start with, according to the agenda, Dan, is it Griess?

Daniel Griess, FACHE – Chief Executive Officer – Box Butte General Hospital

Yes, Griess.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yes, go ahead, Dan.

Daniel Griess, FACHE - Chief Executive Officer - Box Butte General Hospital

Okay, thank you. I want to thank the members of HIT Policy Committee and the Meaningful Use Workgroup for holding this hearing and inviting me to testify. This is a critical time in healthcare not only with respect to the adoption of electronic health records, but also as we pursue the improvement of care coordination, patient engagement and quality improvement while at the same time, finding new ways to control healthcare costs. In 1994 we partnered with Healthland to replace a homegrown financial and general ledger software platform and then in 2005 we went live with our electronic medical record on the hospital side, followed by in 2012 going live with the EMR in our physician's clinic. We've been a client with Healthland for 20 years and thus have cultivated a strong relationship.

In late August of 2013, our hospital attested and successfully met all the hospital requirements for Stage 1.

We signed a contract with Healthland in January of 2013 to migrate to Centriq, Healthland's planned 2014 edition certified solution with a go live date in the fourth quarter of 2013. In the spring of 2013, Healthland notified us that due to the sheer number of migrations, they needed to rethink their organizational strategy and we were placed on hold. Eventually Healthland made a decision to certify their Classic version, due to the fact they could not meet the aggressive timeline for Meaningful Use attestation with Centriq alone. We were notified by Healthland of a new timeline, to begin the foundation build for Centriq in January of 2014 with a go live date in June of 2014.

After further discussion Healthland then recommended to us to attest to the requirements for Stage 2 on our current – on the 2014 edition of Classic version instead of migrating to their new platform Centriq. We disagreed with this plan due to the fact that the emergency department, surgery, central scheduling, barcode med administration all – and other modules were not available on the Classic platform. Following another delay, our team did arrive in Minnesota the week of March 10 of this year to begin our foundation build with Centriq with a go live date of September 9, 2014, more than nine months after our originally contracted go live date.

Healthland currently has 400 clients nationwide of which 130 are operating on Centriq, 30 clients are currently in the migration phase leaving 240 or 60% still operating on the 2011 certified edition of Classic. The 2014 certified Classic solution was scheduled to be released the first quarter of this year and then delayed until April, and then again delayed until sometime in May and as of this date, we still have not received the version. Also, this version includes only hospital functions, it does not include the physician practice. Therefore, we do not have a 2014 certified solution from Healthland to use to attest to the 2014 Stage 1 criteria.

The complexity of this experience from a rural health perspective is incredibly difficult and poses great risk to our organization. Moving at this pace will cause our organization to transition from the 2011 certified Classic platform to the 2014 certified Classic platform and then to the 2014 certified Centriq platform over a 3 to 4 month period of time. We employ nearly 300 staff including physicians and providers, as well as partners with two private practices and nearly 30 specialists who will need to be trained on all three systems. There are times when I believe it would be a better strategy to slow down our pace and to potentially pay a penalty than to put our patients at risk of a failure due to the complexity and moving at the assigned pace. However, we understand the importance of the finish line and have committed to lean towards the tape.

Our experience also shows that the two-year cycle for Meaningful Use is not realistic and I believe CMS should extend the length of each stage of Meaningful Use to be three years for all providers. The current 2-year cycle is simply too short for vendors to develop safe, usable products that providers can then deploy in safe, efficient ways that really help them better coordinate care, engage patients and to control healthcare costs. The cultural changes that are needed to fully realize the promise of EHRs requires more time than the current year over year changes that Meaningful Use allow.

Our facility and others like it would have a better chance of meeting Meaningful Use and bringing its benefits to our patients if CMS extended the 2014 fiscal year reporting requirements into fiscal year 2015. We are very uncomfortable waiting until the very last reporting period to attest on what would be a brand-new system with no room for further delays by our vendors or unanticipated issues in the implementation and use of the upgraded systems. Building on 20 years of investments in EHRs, my hospital is proud to be successful in the first year of Meaningful Use. We will strive –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thirty seconds.

Daniel Griess, FACHE – Chief Executive Officer – Box Butte General Hospital

– mightily to overcome all of the many challenges to be successful in our second and future years. I ask, however, that as you make recommendations to CMS about the future that you really learn from Stage 1 and from Stage 3 experiences through studies and site visits before locking down new requirements for Stage 3. An analytic approach that does not factor operational realities into account from the beginning, may appear to be the solution, but face nearly insurmountable challenges on the ground. I appreciate the opportunity to share my story and stand ready to help you and HHS to better understand how this program is working in rural settings. Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you very much. Stephen Stewart.

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer - Henry County Health Center

Yes, my name is Steve Stewart, I'm the CIO at Henry County Health Center in Mt. Pleasant, Iowa. Meaningful Use Stage 2 has required some very heavy lifting to get where we are today. At this moment, and I put this together on May 15, we are on target to meet all requirements for MU2. Our biggest challenges can be put into four categories, the state reportables, transition of care, the state of readiness of other people to whom we transfer patients to receive Direct secure messaging in a rural area just not there.

We have, anecdotally, our largest practice – independent practice, has had an HL7 interface that gives them far more than a CCD document ever could in place for over 10 years, yet we have to send these transitions of care to them via an antiquated or a backwards technology using Direct secure messaging. As one of our physicians put it, we are doing meaningless work for meaningful use. The third category of problem is accountability for things the beyond our control, specifically portal usage and referrals are the prime examples. And finally, time to operationalize the workflows of the required changes.

I will review each of these each of these four categories a little bit more detail. At the time we installed our MU2 certified code in September of 2013, the State of Iowa was not prepared to accept labs, immunizations or syndromic surveillance. That has changed, immunizations are live now, labs are due to be live by July 1 and we are in the testing phase of that. The State of Iowa has no syndromic reporting at this time. The State HIE called IHIN, Iowa Health Information Network, this requires exchanging CCD documents to the state that can be queried by others. It's turned out to be more difficult that first blush would have one believe. Apparently there are different interpretations of the requirement for a valid CCD and its – packaging, depending on the EHR vendor.

Further issues exist concerning scanned documents, images, etcetera. This required some intervention on the IHIN governance structure to define what IHIN would utilize. All in, our cost to our EHR vendor for these interfaces totaled \$50,000, plus all of our time. Syndromic reporting will add a cost of \$5-10,000 dollars, that total when Iowa implements. While incentive dollars assist with this cost, it is of significance, especially to a facility our size.

Referral sites for transitions of care measures are admirable in their intent and offer a great opportunity to improve care and enhance outcomes. My organization embraces this concept warmly. Our system produces a CCD document on every patient visit immediately, so the 50% requirement should have been and actually was a nonissue. However, the requirement to send 10% via Direct secure messaging was an enormous challenge and we are ready and able to send the documents via DSM, but had no one who was able to receive them. We are a small critical access hospital, 25 acute beds and 49 long-term care beds. The LTC beds are on our EHR, so they do not qualify as a referral site nor would transition document be required as it is all one EHR. Larger hospitals in our area, in our referral pattern, are not ready to accept these. Patients transition to home or referred for follow-up care to their primary care physician presented our only opportunity and our main PCP group, who I mentioned above, who represent 75% of our admissions, we could only exchange data with them by setting up a medical mailbox, a step backwards for them.

Measures beyond our control, beyond the transitions of care are the view, download and transmit or the patient portal. I have very mixed emotions about this. We are able to meet the first measure of creating a CCD documents within 36 hours quite easily. Where I have the mixed emotions is the standard of 5% of patients who actually use it. This we have absolutely no direct control over, yet are subject to reimbursement penalties if we fail to meet it. However, as we have learned, we do have significant influence over this measure. We have gone to a process of walking the patient through portal set up and initial access at discharge. This is more easily done for inpatients, as your more time. Outpatients present a challenge, but we are working on those as well.

The mix of emotions is this, I believe that we are being held in accountable and possibly punished for something that we cannot control. We cannot force a patient to use the portal. Yet on the other side of the coin, would we expend the same effort to influence the usage absent the possibility of penalty. Right now –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thirty seconds.

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

– right now we believe the efforts we are expending, though they are significant, are well worth it and we intend to continue. My final point is workflow optimization. We are at a point where we have implemented many things over the last five years. My hospital had the great advantage on Meaningful Use 1 in that we had started in 2004 to implement an electronic health record. But we have, I think every vendor in the health IT space would admit that things have been done and implemented in ways to check things off the list to meet certification requirements without due consideration being given to the impact they have on workflows, particularly physicians. We – I fear that if –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you Stephen, I'm sorry, your time is up.

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Aaron and Pam?

Pamela Arora – Senior Vice President and Chief Information Officer – Children's Medical Center, Dallas

Yes, this is Pamela Arora, I'm the CIO at Children's Medical Center, Dallas and joining me for Q&A is Aaron Miri, who's our CTO.

Aaron Miri, CHCIO – Chief Technology Officer – Children's Medical Center, Dallas

Hello.

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

Thank you for allowing us to comment. With Children’s similar to a number of the speakers today, we are really trying to encourage the sharing of data across the continuum of care. When you work in pediatrics, making life better for kids is just such a compelling mission. We’ve been on that road though and that journey for some time and we were deploying our EMR, EPIC, back in 2007 and ended up collecting – one of the first of two organizations to collect Meaningful Use Stage Use check in May 2011, which was north of \$2 million, very important to our organization.

As far as the challenges when we take a look at the Stage 2 piece, though, using the highway themes that a number of speakers have mentioned, we really need to build highways that a number of organizations can ride on. And we’re having similar challenges to other folks around transition of care because there haven’t been – there are relatively few providers prepared to accept C-CDAs and the flow of information is really not robust. As far as the patient – pace of adoption, we have to shift the culture in the marketplace and that takes time. During the first year of using our health information exchange, and at this time it was using the federated model provided by our EHR, we were able in a years’ time to exchange roughly 10 patients. It takes time to get the roadways there and to get the organizations to adopt.

I will stay in that early timeframe there was general unease about really what was going to happen when you exchanged this data and what some of the fallbacks were going to be. I think the legislation helped to encourage organizations to do that exchange, so I think that that’s one of the things that are really positive about Stage I.

Patient engagement has been a challenge. I will offer that with our patient engagement, again it’s shifting culture, but it’s on a number of different dimensions. It’s shifting culture with the physicians to encourage it, as well as the folks that are registering the patients. It’s shifting the patient families to recognize that this data can be made available to them via a portal. I really appreciate the patient family comments that occurred earlier. As far as the number of messaging that we’ve had since we’ve deployed that, we have about 31,000 patient families that are signed up right now. And if you look at Children’s, we see about 200,000 children each year with 760,000 encounters. So when you look at the 31,000, I’d say that there’s room for growth there, but of those 31,000 about 10% are doing messaging ongoing and we’re seeing an increase in patient adoption when we’re encouraging that. We’ve had students come in and help show people how to sign up. So that’s really made a big difference as far as getting adoption.

One of the big points I want to hone in on though is cost, and as far as the financial consequences, if we build unique interfaces from point-to-point, you’re paying for a private dirt road. What we need to do is pave the highway through these HIEs, linked to the states so that when those linkages are made, as other organizations become ready, they’re able to ride those same highways. And from the vantage point of the data, we talk about the encounter at the point of care, but we also need to aggregate the information. That federated model that was the early part of how we were exchanging information, it doesn’t aggregate data so that we can figure out how to improve the care of populations, such as asthma. If we can aggregate that data, we can figure out where we can drive down costs and increase quality because what – with that data, you know where you need to expand the highway so the services along the roadway can deliver that point of care.

One other point I'd like to make is around the audits. Children's has noticed a lack of consistency in the audit requirements and it further complicates requiring multiple audits by different bodies. I will offer that if you are riding – driving your car down the highway and any police officer that pulls you over had different requirements of what you should do when you're driving on your speed limit, that just wouldn't be something that you could be confident about driving down that road when you are talking about exchanging the data. So we really –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thirty seconds.

Pamela Arora – Senior Vice President and Chief Information Officer – Children's Medical Center, Dallas

We encourage the committee to expand incentives around using HIEs to transport population and public health data, as well as just like you encourage docs to use the electronic health record, let's encourage providers to use the HIEs, because I can write the point-to-point interfaces, but that isn't going to help everyone else. And we're only going to have the data follow the patient if everyone is using the information and transferring the information and that leads to better care and lower cost care. Thank you.

Aaron Miri, CHCIO – Chief Technology Officer – Children's Medical Center, Dallas

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you Pam. David Dyer and Barbara Boelter.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

Yeah hi, this is Dave Dyer.

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

And Barbara Bolter from Somerset Medical Center.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

And we're located in central New Jersey and we were able to attest to Stage 1 in 2011 and we just met the threshold of Stage 2 attestation in April of 2014. We were kind of added on to the panel quickly, at the last minute, so with the short notice, we were unable to provide written testimony. And we'd like to go forward and kind of verbally discuss what we've been through.

Success factors for us is we were early adopter of EMR technology, we came live with our EMR in 2002 and brought up CPOE in 2004. And just a note, we have mostly independent medical staff and it took us six years to get to 75% CPOE. So we felt that meeting Stage 1 was relatively not as difficult as others, since we had been an early adopter. We're also a founding member of the ONC Grant Funded HIE Jersey Health Connect, so we've been live and contributing CCD, C-CDA data since 2010 to that. One of the other success factors we had is back in 2009, we take the original Stage 1, 2 and 3 matrix and then negotiated a contract with our vendor to comply with all of those stages. And we looked at Stage 2, tried to bring up the majority of those things for Stage 2 in the 2012 timeframe.

One of the key – key challenges are really four or five main key challenges is cost. This exercise in getting through these three stages cost us, in terms of operating and capital expense for 2009 to 2014, \$10 million. Obviously the transition of care was one of the critical components of Stage 2, which we barely met the threshold on, but we did meet it and it's very difficult. View, download and transmit was the other one. And for Stage 1, probably our biggest key challenge was the clinical quality measures for Stage 1 and then obviously the functional, or what we call dysfunctional reports that we were getting from the vendors to make them work properly.

Regarding transitions of care, it was quite a lift for us to move from a CCD to a C-CDA. And then also, in the state of New Jersey, we're sending a CCD to an HIE, we're printing a transition of care for the patient and handing it to them as they're discharged and then were sending a transfer of care record via Direct. And then within our state, the state law requires us to send a universal transfer form, which is paper to long term care facilities. So we're doing the same thing four different ways right now and that's very inefficient for us as well.

The other piece is that the technology suppliers out there are not ready for Direct. They're just now understanding what a sending and receiving HISP are and are – it's a very difficult process for them as well as us to get those. And it takes – the process itself is onerous, getting the address itself is onerous, the amount of time it takes to get these organizations like long-term care and home health to sign those documents is at least six weeks to get that done.

On the view, download and transmit side, 5% is really tough for us. We were able to do it, but our patients are reticent to give us email addresses, our patients are reticent to sign up for this service as well. And we put out quite a big effort to get this 5% done, even though for us it was around 180 patients that we had to do, it was very difficult.

In terms of what advice I would give, interoperability for Stage 3, being able to send out a C-CDA to an HIE or to another provider, but also the ability for that HIE to consume at C-CDA or the EMR vendor to consume at C-CDA would be a nice to have. But interoperability should be the focus because once you get the C-CDA information, you have the results in an HIE, then you can start supporting ACOs and population health, and being able to follow and extract data from that HIE to provide to the ACOs for GPRO reporting and to other providers for reporting.

Benefits that we've seen to date so far, really it's around the patient safety in terms of the EMR implementation. The whole medication process for med reconciliation, computerized physician order entry, barcode medication administration and ePrescribing and med reconciliation at discharge, I think have been the biggest benefits to our patients. And then with the HIE, data sharing is definitely – that's definitely a benefit for other providers in the continuum of care. So, with – kind of in summary, again really the med process and then the HIE piece of it has been our biggest benefits and successes.

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

And the only other two cents I want to add is about view, download and transmit for patients because as Dave pointed out about our Jersey Health Connect, they're – and we have, in New Jersey, a fair amount of physicians that have adopted numerous types of EMRs, you have patients, as Dr. Ashinsky so eloquently put, have four patient portals. And then we as a hospital are sitting there trying to get the patient to join our portal when their engagement really should not be with the hospital. Their engagement should be with their primary care physician and as Dr. Ashinsky pointed out, a way for the patient to have all four portals. Because what we're doing is we're siloing the information for the patient. So if we want the patient to be involved in their healthcare and the patient to own their healthcare, we have to be able to provide an interoperability methodology for them to be able to have all that data in one site. I really appreciate –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you Barbara.

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

Okay.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Sorry your time is up. I'm going to turn it over to Kelly and Tom, who are even more last minute additions. They – we just got final confirmation this morning, so thank you both for being able to join us.

Thomas Johnson, MBA, CPA – Chief Information Officer - Penn Highlands Healthcare

Thank you, this is Tom Johnson.

Kelly Grube MSN, RN-BC - Director, Information Systems - Penn Highlands DuBois

Hello, this is Kelly Grube from Penn Highlands DuBois in DuBois Pennsylvania.

Thomas Johnson, MBA, CPA – Chief Information Officer – Penn Highlands Healthcare

Yeah, I'll go ahead and start. We're a four hospitals health system in rural Pennsylvania. One of our hospitals is a critical access hospital, we have 130 physician practices as well. So for us, we were an early attester in 2011, so we were one of the first groups to attest for Stage 1. We attested the very minute the site was open for Stage 2, so we believe we were the first hospital to attest for Stage 2 as well. The HITECH Act and Meaningful Use has been a real blessing for our organization, prior to that we may very small investments in IT, we were mostly paper-based and highly siloed. We were arguably a HIMSS 3 hospital now we're very closely approaching HIMSS 7, so Meaningful Use has been extremely transformative to our organization.

We've used a very integrated approach that brought our entire hospital together. It's greatly increased transparency throughout our organization, we're able to see where the gaps are in care and address them very quickly. It positioned us as a leader in our region as far as patient safety, as far as quality and outcomes. So Meaningful Use has been a huge focus for us and it's not isolated to IT. We've tried very hard to integrate it into all the projects and initiatives we're working on. We didn't simply try to meet the measures, we tried to max the measures, so every measure we tried to hit the maximum in Stage 1, which positioned us very well for Stage 2, which we're trying to do that as well, tried to hit the max on every measure, which will then position us better for Stage 3. And I'm not just talking core measures, I'm talking doing every menu item as well and doing it at the maximum.

Yes patient safety and engaging patients and their family in care is difficult, but worth it. HIE difficult, but also worth it. Prior to doing HIE we tried to connect our communities. During Stage 1 we gave remote access to all the nursing homes, physician practices, everyone involved in that continuity of care has access to the information. So, it really didn't benefit us much to do the HIE, because they already had all the information, but we certainly did it to meet the requirement. Further, we added no additional staff to IT or anywhere else in the process. We use Cerner as our EMR and we have a very, very tight relationship with them, which we think is key to being able to be successful.

My biggest concern going forward is as the financial incentives go away, which we just got our last incentive, I'm afraid that we'll start to see some backsliding because the focus will start to go away, since we got all of our money. So for me going forward, I think the bar continues to need to rise to be able to incentivize the organizations to achieve, otherwise they'll just go back to paper, is my fear. So, those are my comments, I'll let Kelly make a few comments. And I do think it's worth looking at the Jason report as well, as was talked about in the earlier group, I think there are some good ideas there. Kelly, I'll give you the balance of my time.

Kelly Grube MSN, RN-BC – Director, Information Systems – Penn Highlands DuBois

Hi. my name is Kelly Grube and I'm the Director of Information Systems. I come from a clinical background and I've been working in health IT since 1996. I feel Tom has said, we really took on Meaningful Use and said we are going to do this to the extreme. We're always constantly looking forward. I don't think that you can achieve Meaningful Use if you are just trying to do the bare minimum, it's too difficult to do that. It does require a tremendous amount of focus and effort from all of our staff and I agree with Barbara Boelter, who spoke earlier about the patient portal strategy. We also struggle here because we have four different facilities, not all of them are currently using Cerner. We have some work ahead of us because right now a patient could potentially have to use four separate portals to get their information and that is very complex.

I think really going forward, I think there's great value in Meaningful Use. But we have to drive more value to the consumer. We have to make it more meaningful for them. And certainly I think the way to do that is through more standardization. And I know that might be criticized by some people, but if we can't do these exchanges in an easier way that's more effective, sure we met Meaningful Use, but it was quite a stretch and I'm not saying we should lower the bar, but the bar has to be reasonable. Other than that, we really did have sort of short notice on this but I appreciate the ability to participate in the hearing. Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Just a reminder, we'll now open it up to the workgroup for questions. The panel participants do not need to use the raise your hand feature, just please state your name before speaking, as we don't know all the voices. And with that, we'll open up to workgroup members for questions.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

This is Paul Tang, I want to thank the panelists. Just like the first panel, I think this was heartfelt feedback, we certainly received that as such and really appreciate your time in developing these comments and talking to us about it. First hand up is with Paul Egerman.

Paul Egerman – Businessman/Software Entrepreneur

Thank you Paul, it took me a minute to take myself off mute. I want to also thank all of the panelists, this was a very helpful and insightful presentation. I have a question that I want to first direct to the people from Somerset, I think that was David and Barbara, I hope I got your names correct. You say that you have made it to Stage 2 and I want to first congratulate you on doing that, you are among the very first to accomplish that so that is significant and congratulations.

One of the suggestions that I made in the previous panel, however, was to sort of suggest that ONC admit that the transitions of care and the Direct protocol perhaps wasn't ready for prime time and we should pull that back from Stage 2 and make that a focus of Stage 3 instead. And there was some interest in that in the first panel. But I'm curious for – to a group that's already gone through all the work and has implemented transitions to care and the Direct protocol successfully, would you consider that unfair if ONC were to do that, to pull that back after you've done all that work?

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

This is Dave, I don't think it would be unfair at all. Again, Dr. Ashinsky rightly pointed out that probably 80% of hospitals are going to really struggle with this. I would think it would be nice to have an option if you're part of an HIE, like we are in our state and you are contributing and sending that. We're...we already provide access to the long-term care facilities to the HIE, so really the Direct piece is redundant for us. And if we didn't have to do it, that would be – because we're already accomplishing the same goal really, I think giving an option either/or for transition to care for hospitals would not be a bad thing. Because the long-term care and the home health really do like the transition to care documents and it is helpful to them and it's helpful to the patient. But maybe making it more optional or having various options of how to do this, or even making it that first phase is testing of being able to do one or the other or both might work.

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

Yeah, we know of some of the facilities local to us that are very close to Meaningful Use Stage 2 as well, and this is their biggest issue is getting the long-term care and other next level of care signed up and the amount of paperwork it takes to get it. And for instance, the one hospital we know is not going to be able to attest because they can't meet the 10% and it's just got to do with the red tape around getting addresses and things like that set up. So, we appreciate the difficulty of it and we wouldn't think it's unfair because it's really a very daunting task. It's worthwhile, it's got some great things I think that long-term care really enjoys having this information, but it I think it's very difficult to do.

Paul Egerman – Businessman/Software Entrepreneur

And so, I just want to make sure – this is Paul Egerman again, I heard David’s comment correctly about the options. So are you saying that you’d like to have the option to make a transitions of care but just not use the Direct protocol, to use some other transmission approach? Is that the option that you mean?

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

Yes. I mean, again, we’re participating in a regional health information exchange and sending C-CDAs into that exchange now and the long-term care facilities have access to that now. And then in addition to that, we are sending via Direct to a separate portal for them to log into yet another portal to access the Direct messages, the C-CDA and transition of care document that we’re sending through that other portal, so they have actually two places to go to get the information. And if we just had the one and via the one methodology, I think that would meet the intent of what you’re trying to accomplish.

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

And not only that, but in my opinion, it’s better for the coordination of care because if that long-term care facility sent that patient to us and then two months later sent it to a different facility. When they log on to the HIE, they have one site in looking at the trending of the patient data versus getting a Direct message from me in one web portal and then maybe a Direct message from them. It just makes more sense to have one place to look for the data.

Paul Egerman – Businessman/Software Entrepreneur

That’s helpful. I’m curious if the other panelists have any reaction to dropping the Direct protocol and/or dropping transitions of care out of Stage 2?

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

This is Pamela Arora. We will be working through Stage 2 over the next couple of months. We actually have an organization that we can meaningful exchange the information with now, but I do want to allow our CTO to comment here.

Aaron Miri, CHCIO – Chief Technology Officer – Children’s Medical Center, Dallas

Sure, hey guys, this is Aaron Miri, Children’s Medical Center. Paul, I appreciate your question. Regarding the Direct protocol, we are moving down the path of using Direct to achieve Stage 2 Meaningful Use. However, I think to your question to, should ONC consider dropping or pushing it out some, I think that is a fair concept. One of the noteworthy things about Direct though, that I do want to give credit to was, using certificates, using that – looking at security and the privacy in data integrity is one of the key components for transmitting using Direct. So to whatever degree or protocol perhaps is considered in the future, if you do decide to go a different direction than using Direct, make sure that security is a key and fundamental component to it. As the way we exchange data here at Children’s, we make sure that all the criteria for any type of secure transmission is top and foremost of mind. So, I just wanted to reiterate that fact, that that is something key and foundational to the issue.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you.

Paul Egerman – Businessman/Software Entrepreneur

Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Next is Amy Zimmerman.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Hi, thank you so much. This is been very helpful. My question is whether – I know there's been a lot of discussion about the use of HIEs, there was some discussion about patient engagement and in the former panel there was some discussion about the fact that patients have to go to multiple different portals. I didn't know if any of you were thinking or were able or were considering or had HIEs in your community where you could use them as a certified component for the patient portal component, because they have that integrated view and minimize the patient from having to go to multiple portals. And along those lines, it sounds like there is some of that with transitions of care, you had state requirements and other things make you sort of make that redundant. So I just wanted to address if any of you are able to use your HIEs as components. And if so, is that a viable option to go forward with in those communities that have them and how are you able to then track the numbers? I think that's been one of the bigger issues in the discussions.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

Yeah, this is Dave Dyer, Somerset. Jersey Health Connect does have a personal health record offering and we – we're trying to push that as kind of the super portal, so to speak, for all patients to use and we're modularly certified for the view, download and transmit. And the numerator calculation comes out of the HIE and the denominator comes out of the EMR. So we are able to utilize that personal health record for the view, download, transmit measure here at Somerset.

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

But in order to get the patients to use that as their one, for instance, Dr. Ashinsky is in our area, he would have to abandon his portal and get his patients use Jersey Health Connect. So you would need the cooperation of all the physicians then to give up their individual portals and go on to Jersey Health Connect. So that's the issue we face.

W

This is –

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Do you think that that's easier for providers or no because they've already invested too much in setting them up and trying to get to where they are now for Stage 2? I'm just again looking from a simplicity point of view from recommendations and thinking through some of the issues raised.

M

Yeah...go ahead.

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

This is Pamela Arora, I’ll comment around the HIEs here in North Dallas area. As far as Children’s, we could use the portal that’s part of our regional HIE or use our own portal. We have found that because our regional HIE hasn’t gained the amount of participation with the patient body that we’re talking about here, which is our pediatric population, from that vantage point we’re finding that it’s not as compelling to use that regional HIE. I will comment though, the value is completely where the most traffic is, where the biggest highways are.

And from that vantage point, you want to have the options where patient families can leverage whichever solution has the most information that’s of value to them. As far as getting a single HIE is for exchanging information with that HIE, our intent is to also house that in our environment to the degree that we are sharing encounter data. Additionally, we’re also hosting pediatric practices using the Stark exception, and we’re expanding and trying to make it attractive to pediatric offices so that we can make the portal more compelling where the data flows among the pediatric organizations for those pediatric patient families.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Thank you.

Daniel Griess, FACHE – Chief Executive Officer – Box Butte General Hospital

This is Dan Griess from Box Butte General Hospital in Alliance, Nebraska. We’re located in the western part of the state, nearly 400 miles to the east is our state capital. We have a health information exchange, a state-recognized health information exchange called NeHII. The difficulty for us is that we do not send our patients, just because of the distances to the east, to Nebraska facilities. Our referral patterns are to South Dakota, we’re about 150 miles south of Rapid City and also to Colorado. And we’re about probably 200 miles northeast of Denver, Colorado. So having an information exchange for us isn’t really helpful because it’s difficult to share information – patient information outside of Nebraska to South Dakota and Colorado. I think we’re going to get there eventually, but at this point in time, it’s not realistic.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

It looks like Marty has a question.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Thank you, Michelle. Yes, Marty Fattig, Nemaha County Hospital, Auburn, Nebraska, a critical access hospital, what – looking at operationalizing Stage 2 and looking forward to Stage 3. What would the panelists say are the things that they would recommend that the workgroup do to first of all operationalize everything, make it so we can get things accomplished, and yet make this more meaningful for our patients?

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

This is Pamela Arora at Children's Medical Center. I'll just underscore that I really believe that it's going to increase quality, because people will share data more and it'll drive down cost if we can really encourage being able to use the HIEs as a mechanism for interfaces and for driving the information. And that can help with incentives in that regard. We were one of the third to join the Healthway Initiative, the VA was first in Oregon, but what we were using it for was eligibility/disability determination. And prior to that, we had snail mail as far as how we were working it and the time – the cycle time was weeks versus days.

Well we wrote an interface and that was about – it's about \$20,000 a year to maintain that and we're just talking one interface here. From the standpoint of that private highway, we've been encouraging the state and the state is connected with the Social Security Administration now and they're getting in the process of connecting with our regional HIEs. We're a state that has 12 regional HIEs, but when you take a look at it, there are six – over 600 different hospitals across Texas, so connecting, while it's not one HIE, connecting to 12 is a much lower cost for the providers as well as for the state agencies, when you're just connecting to the 12. So that's really key. Very important to encourage the use of the HIEs so others can use it.

And again maybe the portal becomes more relevant out of that HIE if you have more participants and the data is flowing there. We also recommend the committee consider implementing a 72-hour turnaround requirement relative to receiving the results or orders. What's happening is, when you say 24-hour timeframe, what ends up happening is, there's not enough time for our providers to turn around the information where multiple diagnostic tests are required to establish a patient's care plan. So we, with all due respect, we think that allowing enough time so a thoughtful review can take place is incredibly important.

Aaron Miri, CHCIO – Chief Technology Officer – Children’s Medical Center, Dallas

And Marty I want to add real quick, this is Aaron Miri from Children's, to your point, what more can the committee do? I'm going to underscore what Pamela noted, which was standards. We need those standards to be put in place to allow us to be able to exchange data, to say Texas to you, being in Auburn, Nebraska, we can be able to exchange data securely – and through a means of least cost with maximum bang from our buck. So that a point of the road, it stands up to the transmission of the data, it's secure, we know that the data can get from point A to point B and that you can receive a CCD or whatever data set that we're sending you, that's what the committee needs to consider and look at. To be able to put those types of metrics in place, so that way we can lower cost, do this fast, seamlessly and efficient and enable that the delivery of care at a rapid pace.

Daniel Griess, FACHE – Chief Executive Officer – Box Butte General Hospital

Marty, this is Dan and I've really enjoyed the conversations today and have learned of all the exciting things that are going on in hospitals across this country. However, in rural medicine, and especially in the remote areas geographically of Western Nebraska, limited financial resources and in-house technical expertise make it really difficult for us to achieve Meaningful Use with the time frames that CMS has set. I know that two-thirds of critical access hospitals in the United States either have negative or breakeven margins.

In my written testimony, I shared a story about a hospital just 75 miles from us out here in Western Nebraska that is having to make decisions to financially support heating and air-conditioning for their patients, let alone pursuing electronic medical records and Meaningful Use and trying to share information on the HIE superhighway. I think that it needs to be recognized by this group that there is a digital divide between urban and rural. You know, as I shared in my story earlier with my vendor today I still don't have access to a 2014 certified solution to even pursue Stage 1 2014 criteria, let alone even embark upon Stage 2. So, I think just that understanding that there are many hospitals like myself out here and to be appreciative of our story and our experience. Thank you.

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

Yeah, this is Steve Stewart from Henry County in Mt. Pleasant, Iowa and I would echo what Dan said. I think that one of the – it was mentioned earlier, I think in the first panel, that perhaps a three-year cycle on Meaningful Use stages was appropriate. But what we've found in the last five years is that from the time the final rule gets written to our vendor partners have to go back and rewrite their applications and then we run – we have to implement those on the timeframe. There just isn't enough time and we have done some things, I know in my organization, we have implemented some things and process workflows that are dissatisfiers to our physicians. And my fear is, that if we don't do something about smoothing those out, eventually they will get fed up and say, look, we're just not going to do it. Most of our physicians are not employed, they're independent, so they could, quite possibly say that. So I think we need to look at the timeframe.

We need some time right now to look at the things that we have implemented with our vendor partners and say, are there better ways to do these things to increase the clinician satisfaction with using the application? And I guess the last thing I would say is, we need to make sure, as Dan intimated, when you're rural and small, human capital and financial capital and access to those are really quite critical. And while the incentive program has been tremendous and enabling some investments to be made that might not otherwise have been made, those days will come to an end in the not too distant future, as well they probably should. But being mindful of what we've got to do going forward and the cost of those.

And I guess my very last point is on the security front. If there's anything that keeps CIOs awake at night, it's probably security considerations. And developing a security framework that is scalable and affordable and yet effective and safe is a critical thing going forward. And I don't have an easy answer for that one, but it's something that is critical. And standards are the thing that is going to make interoperability possible. Just last week I was on a conference call with the VA and ONC about the VA Blue Button project and the VA has added a requirement to Direct secure messaging that is not part of the Direct secure messaging standard. It probably is going to turn out to be not that big of a deal, but once you've already implemented your VSM solution, to have to go back and reestablish the certificates to do it a different way. So here we have two different entities of the government requiring two different things and causing us to rework the process that we originally created. So thank you very much.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you. Any other workgroup member questions, comments?

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

This is Pamela again at Children's Medical Center. I do want to sympathize with the rural hospitals and the rural organization’s physician offices because we do appreciate that it takes a lot of time for adoption. I will say that we have focused on really getting the physicians engaged. The Wilson factor of what’s in it for them is incredibly important as far as helping them shape it. I use a realtor analogy, you don’t have the realtor pick out the house you’re going to buy, but they may have a good sense of the market. It’s the people who are going to live in that house that are going to know which ones they’re willing to pay for and live in. The same is true with physicians with the EMR and how we configure it and how the alerts work, etcetera.

In the case of the rural hospitals, we’re finding that that’s been a huge opportunity around telemedicine and getting leverage across the community. What we’ve also been trying to do to be able to help kind of bring things along across the full continuum of care is hosting primary care offices where it may not be affordable. But we can figure out ways with that Stark exception to host and be able to expand the use of the EMRs and be able to allow them to get to Meaningful Use and we’ve been aiding them in being able to submit for that, really kind of shortening the cycle time for them to get to goal. But I do think that it really takes the whole community and if we focus on the patient as far as patient-centered care, we are wanting the data to flow with that patient wherever they happen to be getting care and from that vantage point, we can get very creative about how we go about doing that.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you. Marty Fattig?

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Yeah, this is Marty again. I guess I’ll ask my Jason question again. Have any of you panelists read the Jason report the does that framework seem like something that would be a good method for us to move forward with.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Well, I think I have the same response.

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

Yeah, I will say we’re familiar with the report, but really don’t feel in a position to comment on it. I do think anything that helps the flow of data though, in different models to do so, really need to be thoughtfully reviewed.

Aaron Miri, CHCIO – Chief Technology Officer – Children’s Medical Center, Dallas

And this is Aaron, I would agree with what Pamela said. And I, again, we’re familiar with the Jason report in sort of a topical level of standards and interoperability, and I kind of agree with that data set. But to the degree of specificity, I think really it’s more about the standards again that the committee can come up with for Meaningful Use and making sure that criteria and that highway is built appropriately to lay out the groundwork so that we’re not all running on dirt roads.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks and Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Great, thank you, Paul. Interesting discussion, people have talked a little about physician satisfaction levels and my question is – relates to the usability of the EHR system. And the question is, to what extent has Stage 1 and Stage 2 improved or not improved usability?

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

Things get – this is Pamela at Children’s Medical Center. Thing – any solution gets better with use and with our physicians, again we engage them and they are very vocal. I will say a month into our CPOE implementation, we were at 93-94% adoption, but that was because they had a lot of say into how it was configured and they were very engaged in the process. I will offer that that has to be an ongoing event though, because from the standpoint of alerts and making sure that it’s meaningful, so they’re not getting spammed with alerts and just not taking them in. There’s a constant dialogue and our CMIO here, Chris Menzies, does a very good job as far as acting as a hump to get that feedback.

We actually think that the Meaningful Use Stage 1 and Stage 2 has been very positive. We see it moving the needle within our organization, but at the same time, you have to get into the details to figure out why certain areas aren’t moving the way you would like them to and you work it through with the people who are using the system.

Paul Egerman – Businessman/Software Entrepreneur

That’s interesting. You’re almost suggesting that maybe, if I’m hearing you right, that some of the concerns about usability are actually more a reflection of lack of participation in the process. As long as the physicians are collaborating and involved in the process, there’s less of a concern about usability? Is that what you said?

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

That is what I’m suggesting – this is Pamela, again. What ends up happening is if the right people are making the decisions, the people who are going to live in that house, using my analogy, they’re more likely to live in that house and figure out how they want to decorate it and use it even better than if they feel like something’s being pushed upon them. And that engagement is incredibly important to success.

I do think that the outside incentives that are here though are getting people very intrigued where physicians want to adopt and I think that there’s a lot of interest across the entire community. It’s not a matter of like a provider healthcare system saying, physician you need to adopt the system. Now we’re looking across the community with private physician offices and they’re saying, you know I’m interested in an EMR, maybe can help us. We are interested in these Meaningful Use opportunities please help us. So beyond the walls of our own organization at Children’s Medical Center, we’re looking across the community and I believe that the incentives are helping to get the interest. But then you need to engage the physicians across the community as well, so that they feel that they are adopting what they truly want to adopt.

Aaron Miri, CHCIO – Chief Technology Officer – Children’s Medical Center, Dallas

I would also quickly add – this is Aaron, to that point, the other part of your question about usability and Meaningful Use, you have to have the EHR vendors participate, and you have several good ones on your committee now, you’ve had ones in the past as well. And our EHR vendor, EPIC who we work with, we actually speak with Judy Faulkner routinely. She interacts with her audience, we speak on a monthly basis. She speaks with other customers, so there is engagement to hear back from the folks actually utilizing the product, literally eating the food per se, to understand, hey did this – this metric, this quality criteria, did this denominator suddenly cause some sort of variable reporting that threw everything out of whack and now it’s unusable to you? So it’s that constant feedback loop that’s important.

So one of the important things to note, as we roll through the stages of Meaningful Use, is that it’s a two-way road, again we’re going back to the whole road analogy. It’s a two-way street. You have to be listening to what’s going on in the community, just as we’re listening to the physicians and taking back their feedback into what we’re going forward with, the EHR vendors have to be listening to the community at large, that’s where the bread-and-butter happen.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

Yes, this is Dave Dyer at Somerset and from a community hospital perspective, it’s been – there have been a lot of workflow changes for the physicians and really Stage 2 hits them hard. One of the things is our vendor has been very good about coming up with these complete like what they call playbooks for physicians. Unfortunately at Somerset, we haven’t been able to take full advantage of implementing all of those recommendations, because our resources have been really dedicated to transitions of care and view, download, transmit and doing the other pieces of Meaningful Use. And to a certain degree, we’ve kind of neglected some of the physician requests just from a lack of resource that we’re now trying to catch up to.

But med reconciliation at first was a real downer for our independent physician practices and then that got better over time as the software vendor developed it further. And then with the 2014 code, they seemed to like that a lot better. But again, it’s you have limited resources and have to pick and choose your battles. But we’ve been working on CPOE, again it took us six years to get, with an independent medical staff, to get to 75% CPOE or 80% now, but that’s kind of where we stand with being able to engage docs.

Paul Egerman – Businessman/Software Entrepreneur

And so as a community hospital, the way I understand an independent medical staff is, if they’re unhappy, they like can vote with their feet, in other words, they’ll just practice someplace else, is that –

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

Absolutely.

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

Physicians have patients, hospitals don’t.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

That’s correct.

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

I would add to the preceding – this is Steve Stewart again, I would add to the preceding comment that at least in the case of our EHR things have improved. Med rec was kind of a train wreck when it first came out, but it did what it needed to do to get certified. It has improved over the iterations since then,. There are things about the portal that was just released in the fourth quarter of last year that have been revised, but that’s where I came from on the thing, we need some time for the vendor community to go back and really take a look at these.

And the opening speaker who talked about the experience with Healthland and the delays that they’ve faced, not all of us are EPIC or Cerner. And for those of us who are not, there are some challenges that perhaps, and I agree with the comment that that open dialogue with your vendor – your EHR vendor is huge. But some of the vendors have a much more difficult time responding. It doesn’t mean that they’re bad partners, it just means that it’s more difficult for them to respond, they don’t have the resource pool, they don’t have the user base and we need a little bit of time to smooth some of these things out. And I have the utmost respect for both EPIC and Cerner and the quality of that application, but not every application out there is an EPIC or a Cerner.

Paul Egerman – Businessman/Software Entrepreneur

So when you say –

Aaron Miri, CHCIO – Chief Technology Officer – Children’s Medical Center, Dallas

This is Aaron – I’m sorry, this is Aaron at Children’s. I just want to make a quick analogy to what you’re saying. I kind of equate this to the standards that are placed on car manufacturers. So by the EPA mileage has to go up 20 miles, 25 miles, 30 miles as a standard, and the cars become more efficient, more green, using less fuel and those sorts of things and you have ultimately a better product at the end of the day. The standards that are being put in place, while I completely understand with you that in the case of an EPIC or Cerner, that maybe you can liken it to a Ford or Chevy versus some other manufacturer. That you’re not going to always get the same type of mileage, but the standards still apply because that is what the standards are in this country. So to the degree of what they’re doing with putting the standards in place, I to think all EHR vendors – certified EHR vendors, are going to have to strive to meet a certain criteria in the long run, what you’re going to see is the standard of care go up just like we’ve seen miles per gallon go up.

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

I like Aaron’s analogy – this is Pamela. But I will say that we do recognize at Children’s too, depending on which vendor you’re working with, it varies. And I have worked in an organization, an academic medical center that had a different flavor than an EPIC or a Cerner, and I have to say, as far as turnaround with some of the recommendations that were made, it did take more time. And some of the case that’s being made to extend certain phases to be able to allow everyone to adopt is incredibly important because when you are talking about sharing data, it’s lonely sharing it by yourself. The whole point –

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

Absolutely.

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

– is having it follow the patient. Annette calls with the patient.

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

Absolutely, and this is Steve again. And I wholeheartedly agree that standards are the standards and they apply to everybody. All I am imploring here is that some time be allowed to focus on not doing new things, but optimizing the things that we have already done so that we increase – because I agree with Pamela completely on the engaging your physician. But when you’ve got issues that are representative of dissatisfaction from the providers, and on the first panel when they talk about cliques and that sort of stuff, having some time to deal with some of those things actually would be of great benefit, in my opinion, to increasing their satisfaction and keeping them on board.

Because to the small rural facility like ours who has independent medical staff, it was well said, they can vote with their feet, they can go somewhere else. And there are four other hospitals within 25-30 miles of where we’re located. They can refer patients there instead of to us. And we’ve got to try to – we need just a little bit of time to try to make them a little more satisfied with the applications we have.

Paul Egerman – Businessman/Software Entrepreneur

So this is Paul Egerman, again. So, I just want to make sure I heard it right, because I think you said something very important. You said, Stage – I’m hearing two things. One is that Stage 3 should – there should be a pause, we should have more time before Stage 3 and secondly, Stage 3 should focus on incremental improvements to what’s already there as opposed to introducing new concepts. Is that what I’m hearing?

Stephen Stewart, MBA, CHCIO, FCHIME, FHIMSS, FACHE - Chief Information Officer, Compliance Officer, Security Officer – Henry County Health Center

Speaking again in terms of dealing with our EHR vendor, I would agree with that. I mean, our EHR vendor I think has done very, very well to rewrite their application twice the last five years to accommodate the things that didn’t exist on February 17, 2009. But to keep that pace up, I think is becoming more and more difficult and the smaller the EHR vendor, the smaller their user base, the less resources they have over which to spread the development cost of all of these things we’re asking them to do and the more potentially challenged some of them become. I think, I’m all for what’s in MU2 and we’re going to – we’re in our attestation period right now. We believe, as this morning things look great, we’re going to be there on June 30 and things are looking good for us.

But in terms of Stage 3, and I – we need some more time. I think one of the things that was suggested early – I believe it was in the first panel, was that the penalty that kick in – if they were delayed for a year, would make a huge difference in people continuing the adoption. I know of colleagues who are in critical access hospitals throughout Iowa and Nebraska and the Dakotas that are doing the calculations of what is the penalty going to cost me and can I survive absorbing that penalty, because I’m not sure I can keep this pace up.

Pamela Arora – Senior Vice President and Chief Information Officer – Children’s Medical Center, Dallas

This is Pamela at Children’s. I agree with that comment as far as it having different ramifications for each organization. I will offer that early adopters do help bring the community along. So what I would

suggest is while we're looking at these phases, Stage 2 and Stage 3, it's not so much pushing back the start date, but pushing out the end date. And I agree relative to the penalties, we should really look at relaxing the penalties because from that standpoint, it really is about adoption. That's exactly what we're trying to all get to and having that data follow that patient so they don't have repeat test and the quality keeps going up and the cost goes down. So, I think that everybody is aligned around that, it's just making sure that we bring everybody along, it's so critical.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

Yeah, this is Dave, I would agree with those statements. The other thing I would put under consideration is having maybe two 90-day data collection periods, one for 2014 and then another 90-day for 2015, because doing this for an entire year for transitions of care and view, download, transmit it's almost impossible to accomplish for an entire year.

Daniel Griess, FACHE – Chief Executive Officer – Box Butte General Hospital

This is Dan –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

All right, so I'm going to move along with our final two questions. One is from Marty Fattig.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Yeah, this is Marty and I – by the way things are written right now, everybody must be using a certified 2014 edition by July 1 of this year and be using it in a meaningful way. Can I kind of get the sense from you people on that panel from around the nation, how you feel – well, you obviously are all early adopters. How do you feel about your colleagues? Are your colleagues going to be able to meet those timelines?

Daniel Griess, FACHE – Chief Executive Officer – Box Butte General Hospital

Well Marty, this is Dan Griess and as I stated, we have yet to receive from Healthland a 2014 certified product in preparation to be up and running by July 1. I appreciate everyone's comments to date as we've dialogued about this topic. My concern is we're running to Stage 2 and then ultimately Stage 3, which is a premise of this phone call and hearing today is that there are just so few people who have attested to Stage 2 this late in the fiscal year. Of nearly 5000 hospitals, just a handful have actually struggled to get to Stage 2 attestation and I think before moving to Stage 3, we really need to take the time and allow more hospitals to transform to Stage 2 criteria before making judgments about what Stage 3 is going to look like.

For me Stage 1 has really made an impact in our organization and as one of the earlier presenters stated, we also have maximized our percentages in preparation to be successful in Stage 2. But having a medical staff that is a mix of both employed physicians as well as private physicians, my experience has been that there are generational issues. Physicians and providers that are younger seem to be engaging and understanding the bigger picture as we painted it here locally as opposed to physicians and providers who are nearing retirement that are not wanting to embrace the Meaningful Use criteria or even an electronic medical record. And that's one of the struggles that we have faced in our organization is that divide between generations of medical staff on who's going to be on board and who's not going to be on board.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay Charlene, do you have a question?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Yes. Looking forward, one of the main enhancements in Stage 2 was the ability to be able to use the EHR to start to calculate clinical performance measures. And I was just going to – you didn't touch on that, we spent a lot of time on the transition of care, but could you share any of your experiences there and give the committee any advice moving forward in that area?

Barbara Boelter BSN, RN, MHA – Assistant Vice President, IT Operations – Somerset Medical Center

This is Barbara Boelter from Somerset. That's a very daunting task as well because you take a look at your clinical quality measures, even skip, you have to make sure that anesthesia's online and documenting when antibiotics are given and things like that. So, it's a very difficult thing also to reach because if you make sure all your processes are automated.

David P. Dyer, CHCIO – Vice President, Information Technology Services and Planning and Chief Information Officer – Somerset Medical Center

Yes and at least on the Stage 1 piece of it we basically duplicated resources, so we were doing the CQMs for Stage 1 within the EHR but then the same folks that were abstracting and doing that process we're still doing that, so the synchronization of CQM can't come fast enough and if we could have that in Stage 3 where it becomes one and one reporting methodology and mechanism, that would be wonderful.

But I don't think that the vendors are ready and the technology suppliers are ready to be able to do a 100% of CQMs and then be able to send that out accurately. Unless you have a full, complete electronic health record across your entire organization, you're still going to have a lot of manual data abstraction that's going to go into it. And right now most of the submissions are samplings, not a hundred percent of populations.

Pamela Arora – Senior Vice President and Chief Information Officer – Children's Medical Center, Dallas

This is Pamela at Children's. We have measurable results and if people have an opportunity, reading the Davies case studies would be beneficial, but I'll just give one example. We have seen a reduction in the number of x-rays and that is a healthy thing. More is not a good thing when you look at these small kids and having extra x-rays that are unnecessary. I will also comment that there have been some impacts in a number of areas, but I'll give the example of pharmacy medical waste reduction. We realized in the time that we've gone live, we've reduced by approaching 13 million dollars in medication waste, and a lot of that has to do with the visibility that we get with the electronic medical record. And because for the small kids, you have to do special dosing, just being able to keep track of where they are relative to whether they're close to discharge or not, that isn't taking anything away from the patient, it's just reducing the waste that we have in our system and it's a sizable amount.

Aaron Miri, CHCIO – Chief Technology Officer – Children’s Medical Center, Dallas

And this is Aaron from Children’s and let me add on to what Pamela just stated. Charlene with your question about the clinical performance measurements, especially as we move to a DRG model here in Texas for state reimbursement, we have to be able to measure at a granular level everything from looking at reduction of length of stay, to looking at any types of readmit, all of those sorts of the items that the adult hospitals have had to deal with for years. So from our perspective, we’ve been very focused on all of our care plans and what exactly we are giving to a patient, when, at what time, looking at everything down to the step level for nursing and making sure that on the outcomes basis, we are monitoring and measuring proactively on an ongoing basis. So beyond what Meaningful Use gave us, it instantiated a culture shift and one had to take place because of reimbursement, but two was needed in a pediatric market space, because it hadn’t been traditionally there.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Well, I think we’ve exhausted our questions on the workgroup side. I want to express our sincere appreciation for this panel, like the one before. Everyone really brought their case forward in their feedback, I will use that adjective, it was really heartfelt in terms of what you were thinking about and both the successes and the challenges you’ve had. I think across both panels we’ve had a uniform praise or benefit from Stage 1, because I think we’ve brought a lot of people online. Similarly I think we’ve heard uniform challenges from Stage 2 and probably the most uniform every speaker has talked about is the transition of care.

I think everybody’s in support of the concept, I think Pamela used this metaphor of people – providers getting out of the office and seeing some of the light of day and seeing what could be done. But she also talked about in some places, rural more than others, that there are dirt roads rather than certainly rather than a superhighway that we’d all like to have there. And I guess part of the challenge is how do we get the highway built? Just what levers do we have to build this highway and for people to get out in their cars? That will be improved over time but get out in the cars so we start seeing what it’s like to have modern transportation in this case of data.

I think the common element has been both timing and time. So timing, people have said it’s a bit early, and that’s the whole dirt road. The time required is not just the technical and not just the standard, but the time – the social organizational time it takes to build relationships where there weren’t any around the actual communication and understanding and getting the data transmitted in a way that they can be consumed on the other side. So everybody’s sort of almost has to be somewhat in sync for it to start flowing, go back to the facts. You almost had – the first person with the facts, and I think actually Pamela brought it up, too, that in some cases you actually need to have some deadlines so that somebody gets the ball rolling. But then there has to be this tipping point where a lot of folks, or enough people get on the highway so that you actually have places to go. There are exits to some place.

But anyway, so those messages have been both well-articulated and I think as you can tell from the questions, well-received and appreciated. And I know that the folks who write the rules are also listening, so hopefully we can find this right balance of levers both the push and the time, the pausing to allow the whole market to develop in a way that's constructive for patients and patient care. And I know that was underlying all of the comments we've heard today. I really, really appreciate everyone's time invested in preparing their testimony and responding to all the questions, so thank you so much.

At this point we will, unless there are any other comments – George any other comments? We'll open up to public comment.

Public Comment

Caitlin Collins – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-6006 and press *1 to be placed in the comment queue. We do have public comment, Chantal please proceed.

Chantal Worzala – Director of Policy – American Hospital Association

Good afternoon. Chantal Worzala at the American Hospital Association. I want to thank everybody for a really, really interesting set of perspectives and insights. I think it was just kind of conversation that needs to be had. I just want to share the true sense of urgency that's developing around Meaningful Use in the hospital community. Fiscal 2014 does end in September, any hospital that hopes to attest to Meaningful Use this year only really has the July to September quarter left. And we know that only a handful of hospitals have attested so far.

And I appreciate the conversation, I hope that this workgroup will understand the urgency and work to encourage HHS to make some changes now, so that the 2014 year is not the year where we find the Meaningful Use progress has been halted and providers conclude that the program is unworkable. So the things that we really need in the 2014 program year include more time and flexibility for providers to meet Meaningful Use this year. We need to modify the requirements that make provider success contingent on factors outside of their control, such as VDT and transitions of care, and we really need to recognize that 2015 will also be a transition year. So what I want to add to the conversation, which I think was very rich, is that sense of urgency because July 1 is only about six weeks away. So thank you very much.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you Chantal. Just a reminder to all of our public commenters, public comment is limited to 3 minutes. And it looks like Mari Savickis has a comment.

Mari Savickis – Assistant Director, Medical Affairs – American Medical Association

Hi thanks very much, Mari Savickis with the American Medical Association. I just – I appreciate too the conversation that happened today and the panels who were testifying, I listened with a lot of interest. And one thing I would caution is that sometimes what – one thing is hard for one doctor to meet in Meaningful Use is not necessarily the same thing that another physician is having a challenge with. Arguably some of the transitions of care, that's, I think, going to be a challenge for the vast majority, but there are some that are just – they're just not going to be able to meet that and for one reason or the other, and you've see one physician, you've seen one physician and their patient populations may be different.

So what we've been asking for, and we think this is a great way to address some of the challenges of the one-size-fits-all. Not having to do – like and the all or nothing approach where if you miss a fraction of a measure you lose our is to just say, hey, if you meet 75% of the Meaningful Use requirements that you're deemed to be accepted and you have – you will obtain an incentive. And if you meet 50% of the requirements, then you are deemed to have avoided a penalty. So those are our very high-reaching recommendations and for anyone who's interested in what our Comment Letters say, I know there are a lot of doctors on the phone our website is www.AMA-ASSN.org/go/HIT. So, we encourage your input. Thank you.

Caitlin Collins – Altarum Institute

Our next comment comes from Jeff Smith.

Jeffrey Smith - Director of Public Policy – College of Healthcare Information Management Executives

My name is Jeff Smith, I'm with the College for Healthcare Information Management Executives and I'll go ahead and echo the thanks that Chantal and Mari gave to the group. On a personal note, I'm very happy and excited that this conversation is happening, especially since the Health IT Policy Committee gave its final recommendations for Meaningful Use Stage 3 just over two months ago. And I feel like this, along with other hearings that have been held in the recent past, indicate a willingness to have a clear understanding of what's going on in the field. And I think that the panelists did a tremendous job in trying to convey the degrees to which their challenging and the degrees to which Meaningful Use has been a boon for their efforts in deploying Health IT.

With nearly four years of experience with Meaningful Use, we've got some high-level observations and it seems that many objectives are being met well above prescribed thresholds. Most providers who begin the Meaningful Use journey have successfully continued thus far. And finally, 2014 may well be an end to those high levels of success unless changes are made to Meaningful Use timing and flexibility, both of which Chantal and Mari covered, so I won't go into that.

As far as Stage 3 is concerned, I think this group needs to keep two very important factors in mind. The first is that positive incentive of stimulus funds will no longer be in play for most providers in 2017 and every additional requirements, every increased threshold amounts to more cost with highly, highly variable degrees of benefit. Because of this, we believe Stage 3 should be characterized by deliberate and impactful objectives, appropriate measures and less prescriptive than previous stages. Specifically, based on the recommendations made by the Health IT Policy Committee, we do think that there are a handful of measures that would meet this calculation of having more benefit than others. Specifically technology and workflow innovations focused on clinical decision support, measures and objectives around lab tests, order tracking, view, download, transmit, summary of care for transitions of care and notifications would seem to be a more appropriate focus.

Again, we would urge this committee in deliberations ongoing with CMS and ONC you keep the measures to an absolute minimum and you design some kind of test to understand the relative value, and complexity and demand for such kind of data. Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you Jeff. You went over time, but I let you have some of Mari's time. Is there anyone else Caitlin?

Caitlin Collins – Altarum Institute

We have no more comment at this time.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you very much. I think all the comments, all the panelists, the public comment are all very, very helpful. And as people pointed out, we've turned in our recommendations. There's rulemaking going on, I think this is a deliberate intent both by the Policy Committee as well as HHS to continue the listening going on and I appreciate the commenters talking about that as well. And we will have our formal feedback when the NPRM comes out.

So thank you so much to everyone for this session. We have another listening session coming up on May 27, and we'll be talking to vendors and ACO folks and a number of other stakeholders in this, to continue to get feedback. Thank you everyone.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you very much.