**Discourse – 9 October 2016**

1)  Shaping our response:  What should we plan to deliver?  What should we plan to ballot?  When?

2)  Promotion, soliciting input:  What should we announce?  Who should announce (e.g., HL7, ONC)?  Who is the target audience (AMA, ANA, ACP, AMIA, AMDIS, HIMSS…)?

3)  Establishing a process:  in and out of cycle meetings, teleconferences, leads, delivery targets

4)  Capturing content:  What are the issues (problem statement)?  What are solutions (standards, guidance, policies/regulations, optimization of work and data entry flow…)?  What are ready sources/references to consider?

Already:

•  Developed a Straw Man “Minimum and Beyond” proposal

•  Responded to Wayne Kubick (HL7 CTO), Pat Van Dyke (HL7 Chair) and Ken McCaslin (HL7 TSC Chair) and shared our single slide.  What level of support and promotion might be expected from HL7 and ONC?

•  Made a specific request to our EHR Usability WG regarding work they have to contribute on this topic  (Leads:  John Ritter and Mitra Rocca (FDA))

•  Started environmental scan (Diana Warner…)

Now/Next:

•  Get together - likely via GoToMeeting (Gary to host)

•  Gather comments, sources/references

•  Begin to reach out for interest and input

Begin message:

**From:** Gary Dickinson <gary.dickinson@ehr-standards.com>

**Subject: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU"**

**Date:** 26 September 2016 at 13:27:42 PDT

**To:** David Markwell MD <dma@ihtsdo.org>, Sam Heard MD <sam.heard@oceaninformatics.com>, Ed Hammond <william.hammond@duke.edu>, Linda Fischetti RN MS <lfischetti@mitre.org>, peter@epic.com, Corey Spears <sagacity@gmail.com>, Donald Mon <donmon@rti.org>, John Ritter <JohnRitter1@verizon.net>, Patricia Van Dyke <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, Helen Stevens <helen.stevens@shaw.ca>, "Mark G. Janczewski" <mark.janczewski@verizon.net>, "Reed D. Gelzer" <rgelzer@provider-resources.com>, Diana Warner <Diana.Warner@ahima.org>, Brody DPM Michael L <mbrody@tldsystems.com>

**Cc:** Gary Dickinson <gary.dickinson@ehr-standards.com>

EHR WG Co-Chairs Past and Present,

I’m addressing this email to each of you as a current or former EHR WG Co-Chair.  A request has been conveyed to us via Wayne Kubick, HL7’s New CTO, from key leadership at the US Office of National Coordinator (ONC).  This is the first semi-formal request from ONC to the EHR WG in well over 8 years.  It focuses on a key pain point in widespread adoption of EHR systems.  Physician participation in MU Stage 1 was ~55%.  Stage 2 is still south of 25%.

“[Steve Posnack] was, however, very interested in the topic I raised about how the FMs/FPs might be able to help with the problem of Physician complaints about excessive data entry requirements of EHRs under MU.  Anything your WG can offer in this area would likely be enthusiastically welcomed.”

Now the question is how best to respond to this request.  I put together the attached slide as a straw man proposal (minimum or more?).  What do you think?

Thanks for taking time to respond.

Regards,

Gary



Begin message:

**From:** "Michael L. Brody, DPM" <mbrody@tldsystems.com>

**Subject: Re: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU"**

**Date:** 26 September 2016 at 15:10:31 PDT

**To:** Gary Dickinson <gary.dickinson@ehr-standards.com>, David Markwell MD <dma@ihtsdo.org>, Sam Heard MD <sam.heard@oceaninformatics.com>, Ed Hammond <william.hammond@duke.edu>, Linda Fischetti RN MS <lfischetti@mitre.org>, peter@epic.com, Corey Spears <sagacity@gmail.com>, Donald Mon <donmon@rti.org>, John Ritter <JohnRitter1@verizon.net>, Patricia Van Dyke <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, Helen Stevens <helen.stevens@shaw.ca>, "Mark G. Janczewski" <mark.janczewski@verizon.net>, "Reed D. Gelzer" <rgelzer@provider-resources.com>, Diana Warner <Diana.Warner@ahima.org>

Hello Gary and all other current and former co-chairs.

In reference to this issue I sit at a very interesting intersection.  In addition to my HL7 activities, I happen to be an EP as defined by Meaningful Use and have been a successful participant in the program since 2012.   I also provide consulting services to a vendor who produces certified software and I regularly travel around the country providing CEU lectures to doctors.  Through these venues I have had the opportunity to obtain feedback from many providers who

* never participated in Meaningful Use
* Participated in Stage 1 but not Stage 2
* Participated in both Stage 1 and Stage 2

Pain point 1 - The audit process

There have been numerous instances where for a variety of reasons the entity that received the Meaningful Use Incentive check did not receive the audit notification and as a result lost the audit and had to return the incentive check.  These individuals were very vocal and dissuaded other providers from participating or continuing to participate in the program.

There have been numerous instances where a provider failed an audit and then appealed the decision.  Their general experience has been that the appeals contractor has been difficult to communicate with, the appeals process has been less than transparent and follow up appeals, which is standard for medical claims , was not available to providers.  Once again these individuals were very vocal and dissuaded other providers from participating or continuing to participate in the program.

Pain point 2 - The decreasing incentives

The first year of Meaningful Use had incentive payments of 15 - 18 thousand dollars per provider.  This provided a significant financial incentive to spend the time and money to implement certified technology.   Stage 2 of Meaningful Use was delayed 1 year so EP's who began the process in 2011 were able to spend the first 3 years of Meaningful Use as Stage 1.  These providers would be required to spend a significant amount of money to upgrade to Stage 2 (2014) certified software.   The incentives monies that remained available to these providers was much less significant ($4,000 less 2% sequestration)  and there was no financial pressure to upgrade to 2014 certified software.

Pain Point 3 - Disappearing Vendors

Between Stage 1 and Stage 2 many vendors who certified dropped significantly.  In fact many vendors simply went out of business, including cloud providers who disappeared with patient data.  This lack of stability in the industry moving from Stage 1 to Stage 2 further disenfranchised many providers further depleting the numbers who would continue to participate in future stages of Meaningful Use.

Pain Point 4 - The perception that many of the Meaningful Use measures are too difficult to meet.

* For example the requirement that over 50% of patients be provided with electronic access to their health information for each visit.  This is very problematic with providers who treat populations who are either in socio-economic areas where many do not have internet access or who treat geriatric populations that do not access the internet.  Many EHR systems required that a patient have an email address in order to enable the patient portal.  When a provider had more than 50% of their patients who could not provide an email address they could not meet this measure.
* Providing access to information was at times very problematic  in that there were some vendors that produced a printed instruction sheet to provide to the patient.  Unfortunately patients had to activate the portal within 30 days or the portal expired.   Providers did not realize that the portal activation expired, and even though the patient did have 'access' for visit 1 of the year, the patient did not have access for visit 2 of the year and as a result found that they failed Meaningful Use.
* Another measure of Meaningful Use requires that over 10% of Transition of Care documents be sent electronically.   With about 75% of providers not opting for Meaningful Use it does make it difficult for those who wish to participate to find providers to send these documents electronically.   In my own practice community I have had to work VERY HARD to get provides whom I work with to get direct addresses to the point where I have produced instruction sheets based upon their EHR systems sent those instruction sheets to providers in my area and I still have had very limited success.
* For specialists, many of the CQM measures to not apply to their scope of practice resulting in scores of 0.   This provides the impression for these specialty providers that they can not meet Meaningful Use and embodies a feeling of frustration.

Pain Point 5 - Vendors

Vendors were very fast to sell their certified software but did very little to educate and support providers in their process of meeting Meaningful Use.  The Regional Extension Centers were funded with a mandate to support primary care providers,  there was not a support program for specialists, and many of the individuals found, at the time of attestation that they did not meet Meaningful Use further depleting the cohort of EP's that were able to attest successfully.

How can the FM / FP's help with the problem?  It goes beyond the data entry requirement.

Develop FP's that relate to data portability and data retention.

1) Develop Conformance Criteria that requires certified software, whether in the cloud or locally installed to produce backup files that the EP can store locally.  This way, should the vendor disappear, the EP is not left without data and will have the ability to provide the back to a new EHR vendor who can attempt to import the data into the new system.  This means if the backup is encrypted, the EP must be provided with a method of decryption.

2) Develop Conformance Criteria that requires certified software to create 'bulk exports' of CDA and other data portability documents once again easing the pain for providers who wish to switch EHR systems.

3)  Develop Conformance Criteria that requires certified software to proactively provide updates on how an EP is doing on each of he Meaningful Use Measures and build in help files to assist providers in using the EHR systems properly to meet the requirements for Meaningful Use.  (Context Sensitive Help)  The feedback should be specific to enable EP's to perform at a high level in Meaningful Use MIPS or what ever the current program happens to be.

4) Develop Conformance Criteria that allows for the creation of patient portals that do not require a patient to have an email address, along with conformance criteria regarding patient portals that do not have potential issues such as the access expiring.

5) Encourage the development of specialty specific functional profiles, and certify programs to these profiles.  Allow specialists to use software that has been built specific to their specialty to successfully participate in programs.  Specifically exempt specialists from measures that are primary care centric (Sending out referral's) and replace that criteria with something more appropriate such as sending referral reports back to referring physician.  Look at the 10 MU objectives and determine if / how the objective helps a specialist improve quality of care among the various domains identified and determine if the current criteria is appropriate to the specialist or if there is a better criteria that better engages physicians in the process.

6) Engage payors in the process so that quality reporting can be provided to payors allowing EP's to participate in many of the pay for performance programs that are being developed outside of CMS.

7) Engage malpractice carriers in the process so that Conformance Criteria can be developed to manage the risk of malpractice - they have vast databases on adverse outcomes and can provide valuable input to the process.

I believe that better protecting providers from issues such as vendors going out of business, or vendors holding data hostage will eliminate much of the perceived risk associated with EHR systems, and that by creating certification that recognizes the differences between specialists and primary care providers would allow a greater amount of physician engagement in the process, especially in the ambulatory space.

Other pain points I have identified are beyond the scope of the FM / FP's

Just my 2 (or maybe 3) cents, I will think on this and see what else comes to mind.

Michael

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Begin message:

**From:** Reed Gelzer <rgelzer@provider-resources.com>

**Subject: RE: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU"**

**Date:** 28 September 2016 at 04:07:04 PDT

**To:** Gary Dickinson <gary.dickinson@ehr-standards.com>, David Markwell MD <dma@ihtsdo.org>, Sam Heard MD <sam.heard@oceaninformatics.com>, Ed Hammond <william.hammond@duke.edu>, Linda Fischetti RN MS <lfischetti@mitre.org>, "peter@epic.com" <peter@epic.com>, Corey Spears <sagacity@gmail.com>, "Donald Mon" <donmon@rti.org>, John Ritter <JohnRitter1@verizon.net>, "Patricia Van Dyke" <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, Helen Stevens <helen.stevens@shaw.ca>, "Mark G. Janczewski" <mark.janczewski@verizon.net>, Diana Warner <Diana.Warner@ahima.org>, "Brody DPM Michael L" <mbrody@tldsystems.com>

Thanks Gary,

Thank you to Dr. Brody for his notes as well.

No doubt we’re all fascinated and intrigued by how we can facilitate an effective response to this request.  We each and all have our POVs and “windows” on this.   For example, my employer, PRI, has been a contractor on the MU feedback mechanisms since its origins and, most recently, on managing the processes for waiver/hardship/opt out, as well as providing SME on EHRs for CMS, FBI, AHRQ, HRSA, ONC, USPO, and private payers.   With a nod to Dr. Brody’s accurate observations about auditing/oversight, it has been an “interesting” exercise to work with the periodically mixed motivations of agencies…

From the information in Gary’s note, the element that Mr. Posnack apparently highlighted was “excessive data entry requirements of EHRs under MU”.   No doubt others have a wealth of experience with clinicians reporting that the main attribute of “excessive” is “of no apparent value to me in patient care”.    My experience with clinicians has been that if the value is apparent and trusted, then complaints taper off rapidly as utility value is achieved.

On individual and small-group bases we on this string have been discussing these matters for years.   Some of you are already familiar with my perspectives.  For those who are not, here it is again in brief.

My recommendation is that any path we might construct by majority or by consensus, must have three necessary components:

1. A positive focus, based on areas of already demonstrated success in patient care transformation.

2. A scenario or, better yet, a Use Case

3. A representative stakeholder with specifications for content and for minimum “trust” requirements.

Some additional particulars to consider:

a) Emphasis on reaching out to orgs that can show evidence of having achieved trust in some particular setting, end-use, or other situation that demonstrates accessibility of the two components noted above: Scenario/Use Case and an actual stakeholder with specifications/trust requirements.   No doubt others have examples as well.  Those of some familiarity to me are the successful CLABSI initiative, Strong Start (reducing elective early delivery of newborns), the experience of Anesthesiology Information Management Systems, and an HIV clinic in Birmingham, AL.  We might also reach out to healthcare sector winners of the prestigious Malcolm Baldrige Awards, such as Denver Health.   In other words, entities who have achieved measurable success in real-world patient care settings and have buy-in with supporting data.

b) Currently MU (along with oversight/enforcement) does not require compliance with CMS’s long-standing Documentation Requirements for Evaluation and Management Services.    The “front matter” regarding records requirements in both the 1995 and 1997 versions are identical particularly in those components which, at best, are fuzzy with regard to interpretation into digital records environments such as “author is evident”.   An “update” that clarifies a host of documentation attributes that some clinicians perceive as “excessive” until they are oriented to documentation fundamentals such as State and Federal requirements for business records.   (Rare is the individual who argues in favor of “cloning” <as a defined EHR function> once they understand “attribution” from a business records, evidentiary, and especially medmal defense POV.)

c) Recent summary report from Mathmatica/Lantana noting that EHRs are not reliable for reporting eCQMs, which are a primary component for healthcare transformation and payment reform.

In sum, the recommendation would be to initiate with a Scenario that represented even a very basic outpatient encounter that also maps to at least one eCQM would therefore capture substantial current and forward-looking fundamentals, especially based on one already in part or in-total in use in a clinically successful setting.

Combining that with one or more of the report/rendering requirements Dr. Brody outlined might be a good set of starting points for a Scenario/Use Case.

It may also be of value to note that the last Certification Requirements under CCHIT had criteria (and testing regimes) referencing the EHR FM R1 that were rendered moot by MU but nonetheless would offer a starting point for functions that have some additional attributes of interest:  They went thru two rounds of public comment and some vendors had already previously certified against them.

No doubt there are other ways one could constrain this initiative to render it more focused, more likely to accomplish initial progress in relatively short order.

In the meantime, the “good” (?) news is that the U.S. legal domain is rapidly grasping the ready impeachability of EHR-sourced records since, among other influences, trust attributes have been out of scope for MU and for the EHR marketplace as a whole.  Thus feedback from that domain, and the increasing numbers of clinicians and clinical enterprises being caught in that riptide, “trust” is achieving increasing visibility, along with Security, as necessary “must haves”.

Again, “excessive” diminishes when utility is readily apparent and proven in use as testified by clinicians, where oversight also is trusted to assure fairness.

By focusing on measurable and documented success in patient care, we will focus on positive voices, positive messages, evidence-based success, perhaps partially satisfying and partially bypassing the  cacophony of (justified) upset at the current state of HIT.

Regards,

RDGelzer

*Reed D. Gelzer*

**Reed D. Gelzer, MD, MPH**

**HIT Policy and EHR Specialist**

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Begin message:

**From:** "Fischetti, Linda F" <lfischetti@mitre.org>

**Subject: RE: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU"**

**Date:** 28 September 2016 at 05:38:18 PDT

**To:** Reed Gelzer <rgelzer@provider-resources.com>, Gary Dickinson <gary.dickinson@ehr-standards.com>, David Markwell MD <dma@ihtsdo.org>, "Sam Heard MD" <sam.heard@oceaninformatics.com>, Ed Hammond <william.hammond@duke.edu>, "peter@epic.com" <peter@epic.com>, Corey Spears <sagacity@gmail.com>, Donald Mon <donmon@rti.org>, John Ritter <JohnRitter1@verizon.net>, Patricia Van Dyke <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, Helen Stevens <helen.stevens@shaw.ca>, "Mark G. Janczewski" <mark.janczewski@verizon.net>, Diana Warner <Diana.Warner@ahima.org>, Brody DPM Michael L <mbrody@tldsystems.com>

Gary, thank you for including all of us on this email.  It is an honor to be remembered and included!

Reed and Michael, excellent comments from critical industry vantage points.

When I look at the question posed to this group, it prompts the question, what we can bring that is a unique and new perspective.

The obvious advantages of assembling this group includes:

#1 We have FM/FP’s.

#2 We have International experience (standard adopted in 18 countries??  Isn’t that right? And broad international representation on the ‘to’ line).

#3 We are positioned in all industry segments.

#4 What else?

How can we leverage our uniqueness to deliver insight that only the HL7 EHR WG can provide?

Should we establish a Skype meeting one evening this week to discuss?  Could the HL7 CTO come to delivery more context to what it is that Steve needs?

Linda

**Linda Fischetti MS RN**

**Department Head Clinical Quality and Informatics**

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*MITRE is a not-for-profit organization that operates federally funded research and development centers for the government.*

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Begin message:

**From:** "Mon, Donald" <donmon@rti.org>

**Subject: RE: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU" + Doodle Poll**

**Date:** 28 September 2016 at 13:10:53 PDT

**To:** Gary Dickinson <gary.dickinson@ehr-standards.com>, Linda Fischetti RN MS <lfischetti@mitre.org>, "Reed D. Gelzer" <rgelzer@provider-resources.com>, Brody DPM Michael L <mbrody@tldsystems.com>

**Cc:** David Markwell MD <dma@ihtsdo.org>, Sam Heard MD <sam.heard@oceaninformatics.com>, Ed Hammond <william.hammond@duke.edu>, "peter@epic.com" <peter@epic.com>, Corey Spears <sagacity@gmail.com>, "John Ritter" <JohnRitter1@verizon.net>, Patricia Van Dyke <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, "Helen Stevens" <helen.stevens@shaw.ca>, "Mark G. Janczewski" <mark.janczewski@verizon.net>, Diana Warner <Diana.Warner@ahima.org>

All,

Sorry for jumping into the conversation late.  Thanks for Reed and Michael for their extensive treatment of the topic.  I also like your original slide, Gary, as it points to the “better yet” activities that should be done, as well as Linda’s process to organize the effort.  One thing that we, the healthcare industry, have always avoided in the discussion of the data entry burden on clinicians is how we never capitalize on the collect once, use many times concept, or how to organize data captured upstream by a clinician in the work flow so that it present for the clinician downstream in the work flow, ALL THE WAY TO SECONDARY DATA USE.  The complaint that clinicians are asked to collect things to satisfy payment and reimbursement ring true.  But we haven’t sufficiently studied how to harmonize the data needed fro secondary data use into the collection of data during patient care.  We just keep adding it on, instead of harmonizing.  So, my primary recommendation is a study of this nature.  If Michael Brody’s input was 2 cents, then mine must be half a cent. (Wow, Michael!)

Don

(708) 250-4374

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Begin message:

From: Mark Janczewski <mark.janczewski@verizon.net>

Subject: Re: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU"

Date: 28 September 2016 at 16:34:14 PDT

To: Reed Gelzer <rgelzer@provider-resources.com>, Gary Dickinson <gary.dickinson@ehr-standards.com>, David Markwell MD <dma@ihtsdo.org>, Sam Heard MD <sam.heard@oceaninformatics.com>, Ed Hammond <william.hammond@duke.edu>, Linda Fischetti RN MS <lfischetti@mitre.org>, "peter@epic.com" <peter@epic.com>, Corey Spears <sagacity@gmail.com>, Donald Mon <donmon@rti.org>, John Ritter <JohnRitter1@verizon.net>, Patricia Van Dyke <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, Helen Stevens <helen.stevens@shaw.ca>, Diana Warner <Diana.Warner@ahima.org>, Brody DPM Michael L <mbrody@tldsystems.com>

Just a short note: It’s not just the “excessive data entry requirements”, it’s also HOW the data has to be entered. Most docs would prefer free text; but structured formatting does provide better opportunities for data mining.

Mark G. Janczewski, MD, MPH

Diplomate, ABPM Clinical Informatics

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Begin message:

From: "Michael L. Brody, DPM" <mbrody@tldsystems.com>

Subject: Re: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU"

Date: 28 September 2016 at 20:04:31 PDT

To: Mark Janczewski <mark.janczewski@verizon.net>, Reed Gelzer <rgelzer@provider-resources.com>, Gary Dickinson <gary.dickinson@ehr-standards.com>, David Markwell MD <dma@ihtsdo.org>, Sam Heard MD <sam.heard@oceaninformatics.com>, Ed Hammond <william.hammond@duke.edu>, Linda Fischetti RN MS <lfischetti@mitre.org>, "peter@epic.com" <peter@epic.com>, Corey Spears <sagacity@gmail.com>, Donald Mon <donmon@rti.org>, John Ritter <JohnRitter1@verizon.net>, Patricia Van Dyke <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, Helen Stevens <helen.stevens@shaw.ca>, Diana Warner <Diana.Warner@ahima.org>

I have been thinking about the current opportunity and have been thinking (yes that is a very dangerous thing) I will start with the constraints that I assume along with my rationale for these constraints

· In the past CMS has been very willing to do pilot and demonstration programs to determine if a paradigm will be successful. ACO’s began as pilot programs, there are many and a visit to https://innovation.cms.gov/ will provide you with some more background information on these programs

· ONC is looking for a new paradigm for adoption of Health Information Technology in that the Meaningful Use Program which looked much more promising in terms of adoption 2 years ago has lost momentum.

· Providers are not satisfied with the current state of Health Information Technology in that they do not feel it meets their needs and it interferes with quality patient care

· Podiatry as a profession has embraced Health Information Technology and as a group were an aggressive early adopter of Meaningful Use, and a greater percentage of practicing podiatrists are current of former Meaningful User than most other medical specialties

· Podiatry as a profession is relatively small with less than 15,000 practicing podiatrists nationwide.

As the current EHR Co Chairs are aware I have been working to build a team to develop a Podiatry Profile of the EHR-S FM. I personally believe that one of the problems with the current system is that the certification criteria for vendors and the requirements for providers was not sensitive to the needs of the provider at the point of care especially the needs of specialists. I believed that a profile needs to be developed that addresses the needs of the providers, the payors, and even the malpractice carriers. To accomplish this task I have been working to engage a team that had representatives from these stake holders. I am pleased to say that I have engaged stakeholders that represent the following groups:

· Payors – Lenel has committed to bring Blue Cross to the table and has committed to engage Optum Health as well as United Healthcare

· Certified EHR Vendors – Epic has expressed interest in this project and the largest niche vendors in the Podiatry space that represents over 30% of practicing podiatrists has committed to engagement in the project and I am in talks with a second vendor that represents another 20% of practicing podiatrists

· Registries – A Registry that represents three specialized registries and a PQRS registry has committed to engagement in the project

· Malpractice Insurance Carriers – The largest malpractice carrier in the podiatry space has committed to engagement in the project

· Providers – the American Podiatric Medical Association has committed to engagement in the project

· Representatives from workgroups including CIMI, Mobile Health, Devices and Pharmacy have expressed an interest in the project

My goal is to develop a profile with conformance criteria that enables the following events:

· Built in Risk Management (based upon data from the malpractice carrier) building in criteria that reduces the incidence of malpractice claims clearly has the impact of reducing medical errors, and adverse events. It should be clear that this will have a significant impact upon the quality of care that is provided. If these tools are successful, the malpractice carrier will have reason to provide rate discounts to providers who use software that meets the criteria of the profile. This would be a financial incentive for providers that has no impact on the federal budget in terms of incentives but could reduce costs associated with care related to these adverse outcomes that generate malpractice claims

· Built in quality reporting to payors. This would allow the payors to have input on the data that should be collected and reported and would enable providers to participate in pay for performance programs by the payors. The data collected would be relevant to the profession and collecting and reporting the data would result in financial incentives for the providers. The implications of secondary use of this data for development of additional quality measures fits in with many of the goals of the Health Information Technology EcoSystem

· Built in standards compliance for communication with PQRS and Specialized Registries as well as other clinical quality reporting. With the inclusion of the specialized registry this is a very achievable goal and this is a gap that has been identified by a recent report.

· Improved audit tools and data provenance. This would improve the trustworthiness of the data in the EHR systems and would enable malpractice carriers to better defend their insured providers, would carriers to better adjudicate claims, and would improve the quality of information shared among providers

· Focus on data entry that is relevant to the profession, and obtain other data points from other primary care providers and specialists rather than require all providers enter the same data reducing redundancy in the system and reducing the work load for all providers who are engaged in health information technology

I personally believe that I have assembled the necessary set of stakeholders and these stakeholders represent a large enough cohort of the podiatry providers. I believe that this program could be stood up as a pilot and the results of it would be statistically significant. If it works this could be the model for future functional profiles that ONC could use as certification criteria to better engage provides in Health Information Technology and increase adoption of this technology to the benefit of all in this environment.

With the support of HL7 and ONC this Functional Profile could be fast tracked and we could have a significant incremental advancement in the state of Health Information Technology in this country.

I request that this concept be put on the table and discussed when we do have our teleconference.

Sincerely

Michael L. Brody, DPM

EHR Co Chair

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Begin message:

From: Reed Gelzer <rgelzer@provider-resources.com>

Subject: RE: ONC Request for EHR WG Input on "Excessive Data Entry Requirements under MU" - Tuesday, 11 October - 5PM ET (2PM PT)

Date: 2 October 2016 at 22:19:04 PDT

To: Gary Dickinson <gary.dickinson@ehr-standards.com>

Cc: Wayne Kubick <wkubick@HL7.org>, John Ritter <JohnRitter1@verizon.net>, Patricia Van Dyke <patricia.vandyke2@gmail.com>, Lenel James <Lenel.James@bcbsa.com>, Helen Stevens <helen.stevens@shaw.ca>, "Mark G. Janczewski" <mark.janczewski@verizon.net>, Diana Warner <Diana.Warner@ahima.org>, Brody DPM Michael L <mbrody@tldsystems.com>

Gary,

Thank you for setting this up.

I’ve copied the main HL7 group here, please extend the list to whomever else should be included.

For preparation for October 11, perhaps a Wiki or similar might be set up for sharing resources compiled to date. In particular:

· Communications from ONC, especially those received from Steve Posnack providing ONC’s voice on their needs and expectations.

· The “Already” list below from earlier in this string.

“Already:

• Developed a Straw Man “Minimum and Beyond” proposal

• Responded to Wayne Kubick (HL7 CTO), Pat Van Dyke (HL7 Chair) and Ken McCaslin (HL7 TSC Chair) and shared our single slide. What level of support and promotion might be expected from HL7 and ONC?

• Made a specific request to our EHR Usability WG regarding work they have to contribute on this topic (Leads: John Ritter and Mitra Rocca (FDA))

• Started environmental scan (Diana Warner…)

Lastly, from the previous communications, it is important to have entities at the table who have the experience of success in creating trust. “Excessive” documentation is, as previously noted, a function of what clinicians know to be important. A substantial fraction of “excessive” can be eliminated by systems that embed end-use specifications, thus also the pivotal importance of normalizing “Verify” as a Lifecycle event that references end-use specifications.

If others on this distribution have clinical and non-clinical orgs who have demonstrated measured success in actual patient and population health, no matter how “niche” focused, let’s compile those as well. I’ve reached out to several of the orgs noted in the list in my earlier notes for their input.

More when back from vacation on the 10th.

Thanks again,

RDGelzer