

**Information Exchange Workgroup
Subgroup #2
Draft Transcript
July 24, 2012**

Presentation

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committees Information Exchange Workgroup Subgroup Two on Care Coordination and Patient and Family Engagement. This is a public call and there will be time for public comment at the end and the call is also being transcribed. So please make sure you identify yourself when speaking. I'll now take roll.

Larry Garber?

Lawrence Garber – Reliant Medical Group

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Larry. Jeff Donnell?

Jeff Donnell – No More Clipboard – President

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jeff. Peter DeVault?

Peter DeVault – Epic Systems – Project Manager

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Peter. Jonah Frohlich? Arien Malec?

Arien Malec – RelayHealth

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Arien. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Micky. Are there any other workgroup members on the line? Is there any staff on the line?

Kory Mertz – Office of the National Coordinator

Kory Mertz with ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Kory.

Emma Potter – Office of the National Coordinator

Emma Potter, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Emma.

Tari Owi – Office of the National Coordinator

Tari Owi, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Tari. Okay, Larry, I will turn it back over to you.

Lawrence Garber – Reliant Medical Group

Thank you. So can we first bring up the Word discussion document? And while that's coming up—so the first thing I realized as I was reviewing Peter's work, um, about how the work flow could go for process of basically requesting an authorization form and then sending that to the releasing organization so that they can release information, it dawned on me that one piece we were missing is if an authorization already exists.

So I think at the point that there's a query going out looking for the authorization form, if there already is one that may apply to that provider organization that's doing the request, that should be sent back saying, "Hey look, you've already—you've already gotten authorization," you know, "go for it." Um, so you don't have to have that patient sign again. Um, I think that that would be a useful feature. Does that make sense?

Peter DeVault – Epic Systems – Project Manager

It does. Although the way we do it and kind of envisioned it is that if there's already an authorization on file so that the patient didn't need to sign again, then the, record-holding organization would not have in the first place, um, said that there was an authorization requirement.

Lawrence Garber – Reliant Medical Group

Perfect. That works.

Peter DeVault – Epic Systems – Project Manager

Okay.

Lawrence Garber – Reliant Medical Group

So, all right, so having talked about that let's scroll further down so that the care coordination is at the top there. All right, so once—this is a piece, the last piece that we really haven't discussed at all and that is the issues of-of care coordination. You know, the fact is, you know, this involves a master plan.

A lot of it has to do with the fact that a lot of care takes place without transitions, that there's simultaneous care going on among the care team members, that there are changes that are taking place, um, with the- the plan of care without the movement of the patient and that there needs to be some form of communication among the care team outside of transitions. And there's a whole slew of problems, you know, such as, well, there are no definitions for any of this stuff.

Um, and one of the other things that, you know, that we've also talked about tied to this is that it's unclear of the status of orders. You know, when an order is placed, you know, where there is no closed-loop process going on to ensure that they're done. Um, and so getting into the solutions—

Arien Malec – RelayHealth

Larry, just one additional problem, um, that we talked about last time, is that there's, there are no good standards for versioning the court health information.

Lawrence Garber – Reliant Medical Group

That's right. And also tied to the, um, the closed loop ordering is in the care plan, you know, there are certain things, like, let's say there's a-a problem. I have a pulmonary nodule. You know, someone's responsible for that and responsible for making sure that, you know, follow-up CT scans are done.

And there's this game that goes between the primary care doc and the pulmonologist is, "Is this your nodule or my nodule?" And so there needs to be ways—it's not necessarily an order of referral, but it's really an assignment of responsibility and acknowledgement, "Yes, I take responsibility for this nodule," or, "I'm handing off follow-up visits of this nodules back to you, the primary care physician." And so that's also tied into this care coordination that needs to be figured out ... versioning.

All right, so, other problems that you guys see out there in general with the care coordination before I get into solutions?

Okay, so what I'm thinking about—so there are two pieces to the solution. One is that we really need some standards. You know, and some of those are being developed already in the SNI framework, longitude and coordination of care group, um, but-but clearly there needs to be standards of, you know, what is a master plan of care. Um, there needs to be, you know, versioning. There-there needs to be providence. There-there's a lot, there's a lot of, you know, a lot of pieces that need to be defined.

Um, and then the other thing is that there needs to be a notion that there's got to be messaging outside of the standard transition of care. Um, there-there have got to be other points in time, you know, that—which, which I'm calling clinical activity points where there's some clinical activity that's taking place that says, "Some message needs to be sent." You know, "We're changing the goals. The rest of the care team needs to know about that," or, or, "Certain members of the care team need to know about that. We are changing interventions. We've got some assessment that shows that, you know, things are not going according to plan."

All of these points need to, should-should require some kind of messaging even though there's really no transition of the patient during most of these. Um, and, and so what I'm thinking is that we should define—and that's what I've done here—is define these clinical activity points where messaging should take place. There needs to be some definition process to define what exactly should be sent at that moment in time, um, and who it needs to be sent to.

So let me go through the list and-and see if-if this is making sense to you guys. Um, so can you, can you scroll down further please so I get to the numbering. Yes, one through whatever number it is. And actually, so, this is the old list. So I'm gonna, I'll, I have, have a newer version that, um, I sent around, but I'll go through it.

, so first is, you know, when an order is being placed. So there's messaging, actual, you know, transmission of that order to the person who's going to be performing it and also if there's an authorizing entity like the health plan, um, that, you know, that messaging should take place.

Um, there's the point where the approval of the order takes place. So the health plan, when they approve this procedure to be done, um, or this consult, um, then-then that messaging needs to take place. Um, when it actually gets scheduled, you know, I've asked for a PET scan when it's actually scheduled or a consult when it's actually scheduled.

I, as the person who placed the order, want to know that it's—I want positive confirmation that it's been scheduled. When the patient shows up somewhere, I want to know that as the primary care physician. So that may be that they've shown up for a procedure or maybe they've shown up for the emergency room, but that's basically arrival at a place.

When a completion, when something is completed I want to know about it. So that can be the completion of a, of a procedure or a completion of a course of treatment or a completion of a hospital stay. So that would be a discharge. I want to know what the disposition at that moment in time.

Um, when there's an actual result, which may not be at the moment that's something completed, you know, there's, , the discharge summary may come, you know, may be a few days later, , or the, , the-the result of a, , the reading of-of some study may not be right away. Um, I need to, I want to, you know, obviously be notified of those results or consult notes or whatever.

Um, when there's a handoff of responsibility or, as I said, where I'm as a primary care—when-when the pulmonary-pulmonologist who's following a lung nodule wants to hand off following that lung nodule back to me, , there should be a pass off saying, you know, "Take this back." And then there has to be an acknowledgement, an acceptance of that responsibility saying, "Yes, pulmonologist, I agree that I'll follow this. Thank you for your advice and-and the care plan."

Um, there should also be, you know, , for that matter when there's any change in the plan of care, um, that, you know, such as if there are changes in-in the goals or the patient's family preferences or their wishes or if there are changes in instructions for how the patient's going to be, you know, what the patient's home-sliding scale is going to be for their insulin, um, or there are other interventions that maybe aren't order specific, that are non-ordered interventions, use different heel pads or whatever for your heel spurs, um, those kinds of things need to potentially be communicated to the relevant members of the care team.

If there's a change in the primary care physician, , that's something that needs to—there's nothing else down there—and if there's a change to the primary care physician, that's something that ought to be communicated and perhaps that's coming from the health plan, um, but it may be whoever-whomever knows that-that's taking place.

If the health care proxy's been activated, you know, that's where the patient is no longer competent to—you know, it's not whether they have a health care proxy, but now they're no longer competent and officially all decision making is being done by the health care proxy, that person. It's important that everyone on the care team knows that-that-that has taken place.

And then finally, a death notification, you know, when this is a huge problem that, you know, when someone dies the care team needs to know about that and the hospital often is the one that knows it and the rest of the team needs to know. So that'll be another clinical activity point.

So what do you guys think?

Arien Malec – RelayHealth

Um, a-at the risk of, um, I-I have a couple of things to add and then, and then, um, and then also a concern that we're too complicated.

Um, but there are pharmacist inventions, for example. There are medication fills. There are, sorry, from the simplest to the more complex in the pharmacy there are-there are simple things like medication fill and dispense activities. There are more complex, cognizant services the pharmacist provides. There are cognizant services that a nurse care manager or care navigator might provide. Um, there are services that a diabetes nurse educator might provide.

Um, an-and I think, um, if you think about an ontology of these there are, um, there are services that are, , that are implicitly part of the plan of care and some need to update the status of that-those plan of care items. Um, and then there are—and-and I think a lot of the things that you just mentioned fit into the, "I have ownership for this item in the plan of care and I'm updating the care team relative to what's going on with this aspect of the plan of care."

Um, and then there's some specialized, , needs to track the life cycle of workflow related to, , referrals, but I'm wondering whether before we think about the workflow tracking relative to referrals, , we might just want to think about the send/receive, , portions. That is that, , if I-if I send an order, there's a lot of workflow states that happen with the order and I think you captured a lot of them, um, but that gets really complicated really fast.

And I'm wondering whether we want, might just want to think about the, the refer consult note or admin discharge or order results correlation, that kind of in-out process as being the simplest thing that at least we're considering tackling, and whether there's a need to get to the full level of workflow tracking complexity that I think you, you've really well outlined.

So—

Lawrence Garber – Reliant Medical Group

Well, just on that, I mean, just on that one point, we actually do have those pieces, those data sets in one of the other, in the transition piece, where we talk about those-those pairs. And so this really sort of takes it as a separate measure to a separate level. And then ... the point is good as to what is the timing of this? You know, is this, is this a phase one, is this a 2016 or a 2017 type of deliverable or beyond?

Arien Malec – RelayHealth

That's right. And-and I guess what I suggest as the, as the, since we're already tackling the in-out notion of a closed loop, um, that we tackle the plan of care and updating segments of a plan of care as the, as the higher need for at least some, the highest need in, in this list.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

So, this is Micky. Who, as we're thinking about this as a meaningful use requirement, who is responsible for the plan of care, the master plan of care?

Arien Malec – RelayHealth

That's a great question.

Lawrence Garber – Reliant Medical Group

The whole care team.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

So what does that, what does that, what that mean?

Arien Malec – RelayHealth

It's a really great question because, from a meaningful use perspective, it needs to apply to all providers. Ideally, the plan of care is either owned by the ACO or it's owned by the medical home.

Lawrence Garber – Reliant Medical Group

The tricky part here is that, you know, I tried to approach this as the Information Exchange Workgroup and not the Meaningful Use Workgroup. So, I'm taking this from an information exchange perspective as to how we can facilitate what I believe the Meaningful Use Workgroup is focusing on, which is more the details of building a, building a plan of care.

Arien Malec – RelayHealth

I think that's, I think that's right, and I also think that is the policy, because this is the Information Exchange Workgroup as part of the Policy Committee, the Policy Committee mandate is not confined to meaningful use, and I think we should clearly articulate these needs, as needs relative to care transformation, ACO, medical home, but maybe not appropriate for meaningful use.

Lawrence Garber – Reliant Medical Group

Before we get to the details of what's in and out, I guess I just want to ask does anyone else have any thoughts about, um, you know, about this kind of approach, because then we can jump to the spreadsheet and we can talk about the details of suggestions-suggested objectives and measures and timing?

Peter DeVault – Epic Systems – Project Manager

This is Peter. I think I'm kind of with Arien in thinking that this is an enormous set of small problems to try to tackle and that by focusing our energies on, um, making sure that we know how to close a loop, that the loops will, you know, devolve naturally as people discover workflows.

Lawrence Garber – Reliant Medical Group

Okay. All right, well let's jump over to the spreadsheet. I don't know how well this is going to display. I hope you guys have, are all on full screen or-or have the, um, the-the spreadsheet up on your own computer.

And so let's go to 17. Oh, you need to know the number, number 213. This isn't going to display well. Can you, you-you're there, oh, you can scroll, good. Yeah, keep going so that it just shows that one. Okay, that's close enough, and it doesn't quite have—it almost all fits. All right.

So this is, so this is one of the, um, this is a measure where we talked about providing a summary of care record for each transition of care or referral. And so what I was proposing here, based on what we had talked about is that, um, that when there is a, a transition that an appropriate, that one of five transition documents, transition datasets are sent, um, and it's got the two thing broken up, whether it's a certain percentage for being done on paper or a certain percentage for being done electronically.

But it expands the notion of that you're not just sending a CCD but you're actually spending, sending one of five data sets, whether it's the referral for testing, the report back from testing, the consultation request, the note back from the consultant or a transfer of care summary. And those five data sets are in the process of being finalized through the SNI framework, um, will be validated, you know, through HL7 over the course of the next, you know, year or so. Um, and what I was saying is that, you know, it's really just adding the fact that one of these appropriate ones should be done, I was saying, on paper 50% of the time and electronically 10% of the time.

I think in the discussion that—if it's not here it should be listed, talk to address what Arien's point was, which that if these are in response to say a referral or an order that there ought to be a unique identifier carried through. So I'm not sure if I see that here, but it definitely should be. So thoughts on this?

Jeff Donnell – No More Clipboard – President

So you're saying that 10% is the minimum threshold, right?

Lawrence Garber – Reliant Medical Group

For the electronic transfer, which is basically, I think, where we were at before. The fact that we're-we're changing this from just sending any old summary document to some specific, transfer-specific summary document I thought that it didn't-I didn't want to push it any higher. And the fact is if you can do 10% you can do 100%.

Okay, hearing-hearing no major objections, um, let's go-let's then go down to the next one right below it. And this is the one where I had talked about communicating, um, or actually, I'm sorry—

Peter DeVault – Epic Systems – Project Manager

Larry, sorry to interrupt you, um, I'm probably being exceedingly dense, but I'm not exactly sure what we're looking at.

Arien Malec – RelayHealth

Yeah, I'm a little lost as to where we are. So a lot of the silence has been just trying to find the right place.

Lawrence Garber – Reliant Medical Group

All right. So do you have—do you have a spreadsheet?

M

Yep.

Lawrence Garber – Reliant Medical Group

Okay, so I was on, um, I was on row 17, column I. And what that was, was these were suggestions for Meaningful Use Stage 3 when they first come out in the fall of 2015.

Peter DeVault – Epic Systems – Project Manager

Suggestions that you created or somebody else created?

Lawrence Garber – Reliant Medical Group

So I basically created—I mean we have to have something to present to the rest of the information exchange committee tomorrow—

Peter DeVault – Epic Systems – Project Manager

Understood, I just wasn't sure what was our—

Lawrence Garber – Reliant Medical Group

I basically tried to—I took what we had from our discussion document and tried to transload those into what might be reasonable suggestions.

Arien Malec – RelayHealth

Um, so again, are we on the—you sent out a Word document and a spreadsheet.

Lawrence Garber – Reliant Medical Group

Right. This afternoon I sent the latest version.

Arien Malec – RelayHealth

Okay, and we're on the spreadsheet.

Lawrence Garber – Reliant Medical Group

Correct.

Arien Malec – RelayHealth

So if I look at row 17, column I, it says, "Ability to ... patient generated data such as." Am I in the right place?

Lawrence Garber – Reliant Medical Group

Let me pull it up here. EP obj—EP/... objective, that transitions our patients to another setting of care, refers their patients to another—are you seeing that?

Arien Malec – RelayHealth

My-my-my row 17 column I is relating to engaged patients and families in their health disparities, SGRP 204?

Lawrence Garber – Reliant Medical Group

Interesting.

Jeff Donnell – No More Clipboard – President

You should be looking at two—I think—

M

213.

Lawrence Garber – Reliant Medical Group

Yes, 213.

M

213.

Lawrence Garber – Reliant Medical Group

You're probably using a Microsoft product.

Arien Malec – RelayHealth

Wait, I don't even have a 213.

Lawrence Garber – Reliant Medical Group

It's in—row C has the numbers. Well, actually if you'd have known that.

Jeff Donnell – No More Clipboard – President

Column C, yes.

Arien Malec – RelayHealth

Okay, I'm—

Lawrence Garber – Reliant Medical Group

These are huge rows.

Arien Malec – RelayHealth

Oh, you know, this is why. Never mind. I-I'm looking at a previous spreadsheet that bears a familiar resemblance with the old one. All right, "The EPEA should provide care transition dataset, transition of care," dot dot dot.

Lawrence Garber – Reliant Medical Group

Right. And what I'm suggesting we actually look at, if, after, if you feel comfortable with that was looking to the one that said the column J on the same row, which is sort of what I was thinking as a subsequent, in subsequent years, um, or depending on how long phase 3, Stage 3 gets delayed. And, um, what that would bring in, um, is to provide updates. So that if there are, um, if there are corrections or amendments or if results come in after discharge, um, and after the summary documents have already been sent that those be-those be sent as a follow on.

Arien Malec – RelayHealth

So this is a, this is a scope question. And this is where, you know, what's the appropriate boundary for the meaningful use program versus information exchange requirements that are useful for, for example ACO or PCMH? Um, and I don't, I think these are, um, appropriate for the latter.

I'm not sure that it's, especially given how much, ah, incentive or-or, um, or penalty will be in place for 2017 or 2018 or whatever, um, I'm not sure it's appropriate that this-this is-this is very much a practice of medicine issue, as opposed to an appropriate standards issue, um, and I'm not sure that meaningful use has the right levers at this point for dictating clinical workflow.

So that's really where I'm struggling. I think this is appropriate. I think this is a good thing to do, obviously, and to the extent that I'm a patient-centered medical home, um, I think it's highly, ah, appropriate and required for me to do that as part of my goal of closing the loop on referrals. I'm just, I don't think it belongs as part of a meaningful use measure.

Lawrence Garber – Reliant Medical Group

Well, I mean, I agree. I have two perspectives on meaningful use. I mean one is to get, you know, the hospitals and doctors to actually use things meaningfully. And the second one is, and my apologies to Peter, is that it's also a way to make sure that there's some common standard functionality of electronic health records so that, um, so that there could be some coordination.

Arien Malec – RelayHealth

That's right. It's a basic, it's a basic minimum floor that everybody, that if I buy technology, um, it's the floor capabilities that are acquired support advanced capabilities right? And so, and so if I can send, if I can send an original document electronically I can presumably also send an updated document. I may not have the standards support and there may be an issue of whether there's the appropriate standard support to update a document.

Um, but, so I agree that there may be a standards gap and may need to be a functionality gap for E, or additional functionality for EHRs, but meaningful use as a measure says—at this point, what's a 2% penalty? I will get penalized by 2% of my Medicare payments if I don't send updates for some-for some percent. And that's the distinction that I'm trying to draw is—

Lawrence Garber – Reliant Medical Group

But the thing is, but-but-but if this was an EHR ... this isn't EHR functionality. You shouldn't actually have to do anything. In other words, if-if Peter goes fixes ... so that it automatically—I mean it knows which referral has been, you know, which-which documents it's already sent. It knows when there's been an amend-amendment or a correction to addendum or-or a correction to that particular document or it knows that's in there and it should automatically be able to send this without anybody doing anything.

M

It's actually a little bit more complicated than that because when things get amended in the patient's record, you're not amending a document. You'd have to have some process that was constantly looking at all the documents you'd ever created and seeing if any of the underlying data had changed so that you'd have to send an update.

And whether that's clinically-clinically appropriate to send an update or whether it's creating—I, I, I, like where we're going with the—I, I, where I think we're going with this column I in terms of specifying the appropriate document types to send for certain kinds of transitions, but I do think that the sending amendments is opening a pretty thorny problem up that might be a little too soon.

Arien Malec – RelayHealth

And, again, the distinction that I'm trying to draw is I think it may be appropriate from a certification perspective that EHRs have the capability to send and accept amendments, but from a measurement and penalizing providers for not doing those activities, that's where I think

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Aren't, um. this is Micky. Aren't some of these—I'm just looking at the number two—some of these are already covered aren't they as sort of care summary? And, so I'm just wondering how this, you know, how this dovetails with, um, Stage 1 and the proposed Stage 2 requirements. So for example to the extent that there is, you know, a requirement now for 50% of transitions of care to be accompanied by a care summary and 10% of them are going to have to go via direct, that would seem like it covers some of these cases doesn't it?

Arien Malec – RelayHealth

This is the case of updates when I've referred you for care and then I've then added a medication to your record and your referral has yet to be completed. Um, it would be good for me to send the updated record so that the referred-to provider has access to it.

Lawrence Garber – Reliant Medical Group

And I think the notion that I was saying is, is it's probably not well written here. In other words, I'm not really thinking that, "Okay, I sent you what the med list was and then I changed, you know, I sent the consult request and then I subsequently changed what their medication list is. I guess I wasn't thinking of sending an update to the medication list to them. I was thinking more of the scenario where there was actually a mistake, at that moment in time, um, and, and there's been a correction.

Because we get that, you know, a radiology report gets sent and then, you know, and then some attending second reads it and says, "Oh wait a second; that really wasn't true. Um, there needs to be," you know, "guarantees that there's some-some sending that takes place of-of that correction." Um, and then of course there's the results that happen after discharge.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

So is this focus just on those corrections? I'm just not seeing it in the language and maybe I'm—

Lawrence Garber – Reliant Medical Group

Are you looking at column J, Micky, because that's what the second half was, was column J?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

I'm looking at what's on the screen.

Lawrence Garber – Reliant Medical Group

Okay, yes, so that's the thing. So that, so that, we already moved to the next column over, which was sort of the second page. And to answer what, so to answer what you're talking about, we were, we were sort of moving over to that one. But, but, Micky, what we were talking about is that the, the care summary right now is too vague and that, um, and doesn't really replace the need for paper transition forms.

Um, and so, what this was designed to do was to actually, you know, and there's probably some detail that needs to fall behind this, but this-this is to take it to another level where there's a more sophisticated and clearly defined, you know, dataset that's supposed to be sent beyond just, you know, send a CCD.

Arien Malec – RelayHealth

... already-already covered the case of, at least for laboratory results, already covered the case of correction, um, where there's a requirement on the certified lab, , to make sure that any EHR that connects to it, , supports the correction report and that it can send that correction report.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

So, Larry, when you say—this is Micky again—when you say, um, a dataset you're still talking about a structured document, right?

Lawrence Garber – Reliant Medical Group

Exactly. It's a CDA-based document.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

So it's a CDA, right, okay. So I guess where I'm headed is, I'm wondering if these, if these individual concepts here could, if we, if we sort of unpacked them and then looked at each one as with respect to well now this is, you know, translating it to meaningful use speak right? I mean, I think, I think you're right. If we think about information exchange and what we want to accomplish, you're looking at the holistic perspective, which completely makes sense.

But then as we think about how we unpack these and translate these into meaningful use objectives it seems like, if I'm understanding correctly, um, that for each one of these it's almost asking the question, "All right, how are we broadening or deepening the types of exchanges that are already being required for Stage 2?" So for example, you know, some of those transitions of care for, you know, referrals for example, that's already covered by a meaningful use objective.

But if I'm understanding you correctly, you're saying, well, that, you know, there aren't, there's still too much optionality, too much vagueness in what that is so we're saying that for Stage 3 we want to, um, further specify the contents of that and perhaps further specify the frequency of it as well. And then with some of these other things, they're more about summarizing some of those in-in-individual transactions in ways that we haven't really talked about as part of meaningful use.

So that's a, you know, maybe that's a whole other level that we either decide is something that's more relevant to ACOs, as we were talking about before and doesn't have a real good place in meaningful use, or we decide that there is a real place in meaningful use and then we figure out how to, um, you know, sort of build a hook in.

Lawrence Garber – Reliant Medical Group

So that is correct. That is correct. Yep, that is correct. I mean, if-a-on-one option might be, you know, if-if the five datasets are, you know, say too complex, you know, or too far reaching or too much overlapping with the, you know, filing discrete lab data one, um, you know, in theory, you know, 1 and 2 could be removed and focus on just 3, 4, and 5. I mean, 'cause that, you know, that would be sort of deepening the, you know, the summary dataset without going too overboard.

Peter DeVault – Epic Systems – Project Manager

So, this is Peter. At various times I think this is what various people have been saying, but I want to make sure that I-I'm in alignment here. What I thought, um, at least column I was going to be saying, and maybe it still is, is that for different transitions of care there are different document types that once specified are the appropriate documents to send for those transitions. So a discharge summary for a discharge, and a referral summary and a consult summary for referral closed loop. I-is that what we're trying to do here? Because if so, I think that's the right thing for this, this row.

Lawrence Garber – Reliant Medical Group

That's correct. That is what 3, 4, and 5 are, and then 1 and 2 are for when you're ordering, um, you know, someone, sending someone for a colonoscopy or a, or a PET scan or, or an upper endoscopy. There are, this is a set of information that needs to be sent so that the person can perform the procedure safely.

M

Yeah, and that sounds like a huge scope if we try to figure out for every kind of procedure what the dataset is.

M

Well we do have, sorry, we do have an S&I and CHCF orders project that's focused, I think, primarily on lab orders, but it also includes RAD and other kinds of imaging orders. In terms of the generalized set for what do you need to legally create a, any kind of a hospital based procedure, um—

Peter DeVault – Epic Systems – Project Manager

Sorry, you know there are two kinds of ways that we could approach this, I think. And one of them is to specify the format that you use when you're sending information about an order from one place to another. And then you let the hospital who's going to perform it work it out with community physicians and say, "This is—when we get an order for this kind of nuclear medicine test, this is the information that needs to accompany it." Or, alternatively we can try to figure out the national standard for every kind of procedure and the accompanying dataset and standardize that across the country as part of meaningful use.

M

Yeah, let's do that.

Peter DeVault – Epic Systems – Project Manager

I think that would hurt, which is kind of where we're headed is way too much.

Arien Malec – RelayHealth

Yes. And as I said also, there is activity underway that, um, CHDS and ESI framework are trying to take on to at least address the common cases for lab and RAD order, but by taking on the case for hospital-based procedures, as a generalized case, is, um, it's super hard.

Lawrence Garber – Reliant Medical Group

Well actually there—there's a different SNI group that actually was taking that part on, which is, um, is part of the longitudinal coordination of care. So—so Terry O'Malley's already, you know, defined, or identified those—the dataset, ah, for outpatient procedures, um, you know, that are done at the hospital.

Um, and so I guess where I'm going with this is that there is some standards work underway. At this point, we're, you know; let's make believe standards are done. Let's—let's say come, let's say next year there're, there're standards actually out there and in place for lab, radiology, um, you know, outpatient procedures. And then we'd say, "Well, gee, we might as well use them." Or it may be that when this needs to, you know, get finalized some time next year, we say, you know, "It doesn't look like there's any prayer that there's going to be some standards. Let's drop those."

But I assume that we need to, you know, it's probably, and Micky you can probably, or somebody can tell me if I'm wrong, but I think it might be better to error on the side of including something and getting public comment and then taking it out later, later, than not putting it in and then wishing we had. Does that make sense? Because it can fall out later, I mean, this—this isn't, this isn't carving in stone in any way at this point.

Peter DeVault – Epic Systems – Project Manager

I'd rather pull back now, to be honest. Yeah, so, so, so, again, I go back to it took us three years to get from what I would consider Meaningful Use Stage 1 to Meaningful Use Stage 1.1, with actually standards. And so my, my preference is to say is there a really compelling problem of care where there's a really obvious solution that isn't yet supported?

And that's really where you should be, where you—the—the problem is if you have, if you want to solve all problems, um, it becomes hard to focus efforts in a particular place. And I have a preference for saying, "There is a clear policy goal of doing X." Um, and if the most prominent policy objectives that we should focus our efforts on X, then I would saying, "Here's a bunch of things that want to happen," because I think you get different behavior if you're focused up front.

Lawrence Garber – Reliant Medical Group

Okay, so do you want me to yank out one and two then, documents one and two?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

I just, I just wonder whether it's more about, you know, um, teasing these out and dealing with them one by one because some of them have some legacy in Stage 1 and Stage 2, right? So if we think about, you know, lab results delivery there's a, and, and transition of care summaries, there's a legacy there that we can build on and not, you know, sort of try to all of these in one broad sweep, whereas orders, it seems like that's the next, you know, that's the next step as we're thinking about where this stuff is headed.

Um, I, it does seem to me that we haven't yet, um, that there seems to be, you know, sort of a progression in the way we've dealt with these types of things, which is to address format in one stage and then, but not—not try to do format and content in the same stage. Right? Um, because it seems like it's just too hard to—to make that kind of leap, which is what I think I'm sensing is, you know, kind of buried in some of these things here is that what people are feeling uncomfortable with. I don't know if—is that a fair generalization?

Peter DeVault – Epic Systems – Project Manager

Actually what I'm most uncomfortable with, Micky, is, not that—I-I am comfortable with having a referral summary, as opposed to a generic care summary and a discharge summary as opposed to a generic care summary. But I think that's a much more attractable problem than coming up with minimum datasets for all the orderables.

M

Yeah.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Right. And that-that seems to me that that's just an extension or a refinement of something that's already in Stage 2 right? So we sort of feel comfortable that that's the next step of it.

Lawrence Garber – Reliant Medical Group

Okay, so I'll take, I'll take the, as I said, the first two datasets, which are really surrounding orders and, and yank those out. Um, I do have a column, which is hidden, which is basically, you know, some day in the future column and I can, I can put those out there.

Arien Malec – RelayHealth

And again, just to re-reiterate what Peter said. No objection to saying that when you admit somebody there should be a minimum dataset and maybe a more structured document that's specific to that case. So that's different from saying, you have all the information in a, in a structured format to fill and complete the order.

Lawrence Garber – Reliant Medical Group

Now how about the, how about the-the piece in this-in this column to the right where we had, we talked about, um, the updates. Is there, is there a way to con—should we focus on the major area of problem, which is just results after discharge?

Arien Malec – RelayHealth

When it comes to—I think we're trying to solve the, solve the ... problem. So when it comes to recording of lab results, which is very different from the discharge summary right? Um, when it comes to recording of lab results, um, or radiology reports, there are already well-defined standards and well-defined operational policies for handling corrections.

Lawrence Garber – Reliant Medical Group

Right, but how 'bout the other piece about sending results after a moment of discharge? After the summary's already been sent, um, there's not, there's, there's not a good process for ensuring that now that the patient is gone that someone actually sees this results. You know, tuberculosis results could take six weeks to come back. Blood cultures can take several days to come back. Um, you know—

Arien Malec – RelayHealth

There's a huge, right, there's a huge difference if I'm sending as the lab to the ordering provider or as a, or a copied to provider. In which case I've got a clear obligation, in fact, to send the corrections. Um, and—and there are well-established standards and well-established processes for sending those corrections and ... any corrected or amended results.

Lawrence Garber – Reliant Medical Group

Right, except for the fact that the ordering provider's no longer caring for the patient, that's the—

Arien Malec – RelayHealth

It's, no, it's-it's-it's irrelevant at that point. I have a clear obligation if I sent it to you, as the ordering provider, I have a clear obligation to also send you the corrections. And the EHRs that connect to that lab, before they connect to that lab, um, the lab is required to test or verify that that HER can actually handle the correction.

Lawrence Garber – Reliant Medical Group

Yes, I'm dropping the connection piece, the correction piece. I'm specifically talking about—I'm not talking about corrections anymore. I'm-I'm-I'm suggesting yank out the corrections amendments, all that stuff.

What I'm specifically saying is should we narrow the scope of that one to just the, you know, when you've sent a summary, um, and after the patient is gone, they've transitioned to somebody else, um, you now get a result back that occurred during that stay—not a correction but actual results, because they will often come back days after the patient's gone and it typically is being resultted to the ordering provider who no longer is responsible for caring for the patient. Now we have a process that automatically we send an updated, you know, this result that came after the patient is gone, not just to the ordering provider but to the person who's now caring for them.

M

Right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

So is this, is this, is the way to handle this, um, this is Micky again, um, to expand the, you know, the definition of the discharged information that has to be provided, so that it really captures everything related to that episode of care? And so you make that part of the meaningful use requirements of the "discharge summary," if we're going to put that in quotes?

Lawrence Garber – Reliant Medical Group

Well we do actually, that's, if you look, if you look at the datasets that we're proposing for, you know, for number, you know, the discharge summary, essentially, we are saying that you're supposed to list what tests are pending at the time of discharge. But it's one thing to list that it's pending; it's another to actually send it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

No, that's what I'm saying. That if right now a meaningful use requirement is the content of the discharge summary—I don't, I don't, I don't know what they're supposed to do right now, but there is a, there is a content requirement, right, on the discharge summary for Meaningful Use Stage 1 and 2?

Lawrence Garber – Reliant Medical Group

It's probably vague. I don't, I'm not sure if, I'm not sure if in 1 and 2 it specifies that it ought to say what tests are pending. I know definitely what we're proposing for 3, what's going to have that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Right. So that's all I'm saying. That if what we're doing then is just further specifying something that's already there in Stage 1 and 2 to include an actual summary document that says what tests are pending but then you further the requirement to say that you need to send those results once available as well.

M

And that's, that's the meaningful use requirement on the eligible hospital.

Lawrence Garber – Reliant Medical Group

Are you guys okay with that?

M

Maybe. So if the, if the, for me it's just, , there's a fine, there's a, there's a scale of good medicine, um, and good clinical practice that I'm not, I'm thinking we're in a bridge too far in terms of where meaningful use, as a program, should go. So I can, I can imagine all kinds of cases where it's clinically appropriate to update the responsible pro-, the currently responsible provider, um, that, that the test, relevant test occurred. Um, there are ways of handling that in the labs, the lab area.

For example, in including the primary care provider as the, as the copy to, um, for those results, that does make sure they get that lab, um, or other kinds of tests. I worry about minor, you know, how do you do this in a way where you're not holding hospitals on the hook for minor corrections where the mechanics of meeting meaningful use overwhelm the clinical utility that you're driving.

Lawrence Garber – Reliant Medical Group

We're not talking about corrections at all here. And this is a major patient safety issue.

Arien Malec – RelayHealth

No, I under, I, I understand the use case, right, but there are cases where there are pending labs and they come back negative and you're going to be on the same hook for sending those negatives, um, as you are—

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Isn't, isn't that, Isn't that a good thing?

Lawrence Garber – Reliant Medical Group

Yeah, and, and also not only is it a good thing, but if we have it in this document it becomes a standard functioning, functionality of the EHR and no one actually has to do anything to make it happen, if Peter does his work right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

There's an analogous situation that actually happens right now and you tell me whether it's analogous and whether this, um, could help resolve this. So there are EHR vendors, and one particularly prominent one, who's name I won't mention, not, not someone on this call, um, or not a representative of this call that does not include the vast majority of lab results in its post-encounter CCD because they say that lab results, even though it may have been ordered as a part of that episode, the lab result is not a part of the encounter. And so we, for those, um, for that particular company we have to get a separate lab feed aside from their post-encounter CCDs because they say that the lab was not a part of the episode, of that encounter.

So that seems like there's, that's a similar problem, um, that we're describing here and, and many other vendors do, you know, they do a variety of things to make sure that it is included, and that one of which is hold on the-the CCD, the post-encounter CCD until the lab results come and then they send it. Now that's probably not going to work for a discharge summary because we have certain requirements about, you know, the amount that they, um, that they have to release them.

Arien Malec – RelayHealth

Right. The distinction that I'm trying, that I'm trying to make is that clear compliance, clear compliance lab reporting is not well-handled through the consolidated CDA. It's not what it's designed for. It's not what it's intended for, and we're solving problems that are well solved, um, by, by other standards. Um—

Lawrence Garber – Reliant Medical Group

Where's the, where's the standard that a, the ordering physician has to forward to results to the person who's now taking care of them? Because CLIA doesn't go beyond that, CLIA doesn't—

Arien Malec – RelayHealth

CLIA, yes, CLIA does not, you're right, CLIA does not go, go beyond that. But then I, what I worry about is are we, are we, trying to legislate good practice of medicine through a meaningful use program where there's not that much money on the table.

Lawrence Garber – Reliant Medical Group

But we're talking about building EHR functionality to make this happen efficiently. So that, so that our health care system is safer and that the money we've invested in these EHRs

Arien Malec – RelayHealth

Again, I've got no objection to that. What, where I, what I would say is that if you were trying to solve that problem the way that I would recommend solving that problem would be to make sure that the primary care provider is included as a CC provider on the lab piece. So they can get the stat labs and they can get the, they can get the, the critical labs, um, the panic, the panic values. They can get the, the corrections and updates and that's the way that I'd solve that problem.

Lawrence Garber – Reliant Medical Group

Well le-let me, let me tell you why that won't worked, because we do that. That's exactly what we do. We have—I'm a primary care physician and I'm interfaced at a hospital and every inpatient lab result does come to me and I make sure they, none of them show up in anybody's in basket, except for the ones that come in after discharge and, , we have an interface that's monitoring whether the patient's inpatient or outpatient. We've had to build the sophisticated, you know, monitoring tool to figure out are they're inpatient, outpatient, did somebody already know about this? No? Okay, now I'll show it to the primary care doc.

But you know what? We can't have everybody in the country build that and you can't have every primary care doc have every single result that happens as an inpatient 'cause they'll completely get buried and kill all of us.

M

So, Larry, ... totally agree with that.

Peter DeVault – Epic Systems – Project Manager

Let me see if I understand what you're actually asking for. Since what we're sending at the end of discharge is a discharge summary, whatever that ends up being, something like a CCD but for discharge, when a new result comes after the discharge document has been sent, we can't just send the result we have to produce a new discharge summary document. Otherwise we're talking about a completely different standard that we'd be talking about right?

Lawrence Garber – Reliant Medical Group

That's right.

Peter DeVault – Epic Systems – Project Manager

So, so you'd be, for every result that comes back after discharge producing a brand new discharge summary and sending that whole document out to the community doc and having some way of highlighting what changed. So we're getting into uncharted territory here.

M

Well or the hospital could CC the primary care provider and be responsible for making sure that that process works, unlike what's happening to Larry.

Lawrence Garber – Reliant Medical Group

Right.

Peter DeVault – Epic Systems – Project Manager

Seeing them on what though? So we've got one tool for the discharge transition of care, which is the discharge summary. We don't have another tool in our belt for sending individual results from the EHR.

Lawrence Garber – Reliant Medical Group

Unless, unless, you know another option is to create that tool. I mean we're talking about, I-I've got this in the next column so this is not for, you know, fall of 2015, but this would be if there is a delay in Meaningful Use Stage 3, um, that there may be more time such that there is another document. Just like we were talking about potentially making, you know, these other messaging types. Letting them know of different status changes. Maybe this is one of them.

M

And, or, I guess you-you couldn't just send it HL7251?

M

You could print an HL7251 and you could include the filters that-that Larry's talking about where—

M

You guys, HL7 messages only work within an organization where you've got an NPI and you can't send HL7 interface messages out to the community.

Lawrence Garber – Reliant Medical Group

And you want this to be able to work with a direct message.

M

I've said my piece, which is, I think, I think these are good things. I think they're good practice. I don't believe that they are appropriate for a meaningful use program, and I agree with Peter that I don't believe that we have the, the elegant standard support for, for solving this in a general way.

Lawrence Garber – Reliant Medical Group

So we had a time check here, um, we've got about a minute to go and-and, Micky, I don't think we're going to have consensus. I mean we got a lot more talking that we need to do. Um, and now I know we've got a meeting tomorrow?

M

Is it tomorrow?

MacKenzie Robertson – Office of the National Coordinator

The meeting tomorrow, this is MacKenzie, is the full workgroup.

Lawrence Garber – Reliant Medical Group

Exactly. So in theory, our work would have been done by tomorrow, and, and, wh-and-I think this is a great discussion and I'd-I'd love to spend several more hours on this, um, if you guys are okay with that. And the question is, Micky, can we do that somewhere, um, you know, over the next week, um, and-and-and still get things done in time for you to bring something, , to the Policy Committee when you have to report on it?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Yeah, definitely. I mean, I again, I think that the, you know, the Policy Committee update is really just, you know, sort of a, is a check in point and is just really there to, well this is how I'm defining it. ... It's just a check in point and there's no expectation that we have, you know, a set of preliminary recommendations, I don't think.

And I think it's completely fair for us to just tee up here are the areas that we're investigating and here are some of the, you know, high level, you know, concepts and principals and we're talking about each of those and we're refining those further. And, you know, if there's any high level, you know, steer or course guidance that the Policy Committee has for us great, if not, we just keep on moving.

Lawrence Garber – Reliant Medical Group

And when is that policy meeting?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

That's on the first.

MacKenzie Robertson – Office of the National Coordinator

August 1st.

M

Sorry, guys, I have to drop abruptly. I'll talk to you guys tomorrow.

Lawrence Garber – Reliant Medical Group

All right, thanks a lot. Okay so maybe, maybe at tomorrow's meeting, Micky, we can talk about, um, you know, the game plan for subsequent meetings to, to keep hashing this out?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Okay, yeah, I think that makes sense. Maybe we can just talk through some of the things that we talked about here really just to give, you know, sort of, just everyone, you know, broadening the conversation really. If there's some way of taking what feedback we've gotten today and refining this a little bit further, at least on the things that we've reached some consensus on, Larry, and I think it's, you know, totally fair to say, you know, in general, the sub-workgroup felt that there were a lot of great things here, but struggling with the question of whether it's appropriate for meaningful use.

And if I understood it sort of on two levels, one from a principle perspective, whether meaningful use should even be, you know, sort of, um, in these areas with respect to, um, policy scope. But the other, um, related to how could you make some of these more concrete and achievable even if we thought they were within the scope. And I thought I heard both of those issues sort of floating around the conversation.

Lawrence Garber – Reliant Medical Group

Yep, okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Does that, Arien—would you agree with that?

Arien Malec – RelayHealth

Yep.

Jeff Donnell – No More Clipboard – President

Sounds good. And this, and this is, this is Jeff. I will, I'll do a little bit of additional work on the patient engagement piece in terms of plugging-plugging that work into the spreadsheet.

Lawrence Garber – Reliant Medical Group

Excellent. That's great.

Jeff Donnell – No More Clipboard – President

I'll do, I'll do that tonight.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

That's great. Okay, then we can, and if you can send those, well I guess we don't have enough time to do any internal reviews. So if you can send them, just copy me when you send them to MacKenzie, for distribution and then we can, um, just go, go through it real time tomorrow.

MacKenzie Robertson – Office of the National Coordinator

No, this is MacKenzie. Just so I know what to be on the lookout for, are we going to have multiple spreadsheets coming in or is it going to be compiled into one?

Lawrence Garber – Reliant Medical Group

So actually you're going to have two spreadsheets. Um, I'm only going to be—

M

I have to go.

Lawrence Garber – Reliant Medical Group

Okay, thanks a lot. I'm going to be send-touching the rows that pertain to, ah, care coordination and Jeff will be sending you, touching the rows that pertain to patient and family engagement. So it'll be two spreadsheets, separately probably, um, but we'll only, we'll be touching separate rows.

MacKenzie Robertson – Office of the National Coordinator

Okay. So ... are you on the line or, Kory, are you guys going to compile those into one or do you just want to leave them as two?

Kory Mertz – Office of the National Coordinator

Um, I mean I can compile it into one. This is Kory.

MacKenzie Robertson – Office of the National Coordinator

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

And, Kory, was that-was that fair what I said about the expectations for the Policy Committee meeting?

Kory Mertz – Office of the National Coordinator

Well, Micky, I worry a little. I think the more definition you can have going in the better shot that the thoughts of this workgroup are actually going to make it in. I think the Meaningful Use Workgroup, you know, recognizing that they started earlier in this process, is going to have a lot more definition, um, behind what they're coming forward with. So I think the more definition and direction and, if possible, language we can have coming out of this group, um, for the August 1st meeting the better. But recognizing kind of where we are time wise, um, I know that's a challenge, but I think the more concreteness we can have, um, the better it's going to be for August 1st.

Lawrence Garber – Reliant Medical Group

And when does, and when does the doctrine have to be finalized for the August 1st meeting?

MacKenzie Robertson – Office of the National Coordinator

So we'll need, um, we're going to conversations with Paul, this is MacKenzie, Paul in advance of the meeting just to tee him, just to get him in the loop of, , what's going to be presented, um, so ideally by early next week. Um, the print deadline will be the day before.

I'm just looking at my calendar now and there is time on Thursday if you guys do want to schedule another call.

Lawrence Garber – Reliant Medical Group

There unfortunately, I mean, well what time exact—what time do you have?

MacKenzie Robertson – Office of the National Coordinator

I mean the ... calendar is open between 9:00 and 11:00, so 9:00 to 12:00, sorry. And I'm just throwing out the availability. I know you guys have had tons of meetings already so.

Lawrence Garber – Reliant Medical Group

I mean, I could do between 9:00 and 11:30.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

I could do 9:00 to 10:00.

Jeff Donnell – No More Clipboard – President

Um, yeah, I can do 9:00 to 10:00.

MacKenzie Robertson – Office of the National Coordinator

You want me just to have an appointment sent out for 9:00 to 10:00 for the same people on the call today?

Lawrence Garber – Reliant Medical Group

We can try.

Jeff Donnell – No More Clipboard – President

Sure.

MacKenzie Robertson – Office of the National Coordinator

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

You know, maybe, if we can accomplish a little bit offline maybe that will, um, help forward it. Um, and we do have, you know, the opportunity if we can get it to some more concrete language to get, even though we have the workgroup meeting tomorrow, you know, I don't have any problem with asking for offline comments based on what we get tomorrow. Try to refine something that's a little bit more specific, getting offline comments, um, from the entire workgroup and then being able to wrap that up into a set of, you know, preliminary high-level preliminary language that we can deliver to the ONC staff early next week.

MacKenzie Robertson – Office of the National Coordinator

So do you think, um, I'll just throw out one other option, the-the call tomorrow is at the end of the day. It's from 3:00 to 4:00. Do you guys want to extend that instead or are your calendars already booked?

Lawrence Garber – Reliant Medical Group

I mean I can extend—

Jeff Donnell – No More Clipboard – President

Yeah, I can do that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

I probably can.

MacKenzie Robertson – Office of the National Coordinator

Would you guys prefer to do that and then we don't have to schedule another call?

Lawrence Garber – Reliant Medical Group

To be honest, my hunch is there's so much to talk about I think we probably should do both, but I'll let, I'll let Micky call that one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Yeah, yeah, you may be right.

Lawrence Garber – Reliant Medical Group

I mean I was, I was going to also suggest if we have anything Friday morning.

MacKenzie Robertson – Office of the National Coordinator

Friday is booked.

Lawrence Garber – Reliant Medical Group

Okay.

Jeff Donnell – No More Clipboard – President

Let's, let's, let's do, let's put them both on the calendar and then if we don't need the one Thursday morning great, but, , I-I suspect you're right. We probably will.

MacKenzie Robertson – Office of the National Coordinator

Kory, you're on the line too. Are you okay with that?

Kory Mertz – Office of the National Coordinator

Yeah that works for me. One-one other thought I would just throw out as far the approach here, um, particularly recognizing kind of the time constraints we have. One way we could look at this is, um, so, you know, Michelle sent the, , a couple of recommendations specifically of new, um, objectives and measures that the Care Coordination Subgroup of the Meaningful Use is looking at and has developed kind of rough language, or not rough, you know, it's kind of their preliminary recommendations on.

I don't know if we want to look at those and say, "Okay, there's language going out around those already. Let's turn our attention to the areas that we have already talked about that are not covered there." Develop, um recommendations around that and then at a later cycle we can go back and provide feedback, um, in the areas that already have language existing. I just-just a, just a thought.

Lawrence Garber – Reliant Medical Group

Actually, well, so that was, what was in one of the hidden columns. Am I correct, MacKenzie or whoever sent that, Michelle?

Michelle Nelson – Office of the National Coordinator

So, Larry, this is Michelle. I joined the call late. Um, so the Care Coordination Group has been meeting a lot as well because they are ... changing their recommendations. So what's in the Excel document is old and outdated at this point, but I did send around yesterday, um, the PowerPoint that they reviewed today. I was on a clean so I did not share the conversation today, um, but there should be an updated document, um, as of today that I can reach out and try to get and share with your group.

Lawrence Garber – Reliant Medical Group

Yeah, if you could send that out, 'cause to be honest, Kory, exactly what I did was, as I lined up our suggestions with the suggestions from the-the-the Meaningful Use Care Coordination Group and tried to model a-as much as I could the-the objectives and measures to what they were putting in. There wasn't, there wasn't the one-to-one correlation, but I saw that we were actually moving in very similar directions and, in some of this maybe with a little bit different solution but the, but the same kind of direction.

Kory Mertz – Office of the National Coordinator

Okay, well and I-I guess in what prompted my thought there, in particular I was thinking, at least when I looked at what they, what Michelle sent, um, yesterday, the thing I didn't see was all the discussion you guys have had kind of around the unplanned piece and, um, what you're thinking is around kind of a query mechanism.

Lawrence Garber – Reliant Medical Group

Yeah that's the last—it's at the bottom of our spreadsheet because ... they hadn't talked about that.

Kory Mertz – Office of the National Coordinator

Yeah, right, and so that's the type of thing where I think maybe that makes the most sense to prioritize now for this group to talk about 'cause that's not being covered by anybody else. So I, that, you know, again, it's up to you guys, that's just what I was throwing out as a potential approach, um, with the time constraints we have.

Lawrence Garber – Reliant Medical Group

Yeah, that clearly is, you're right, that is the one piece that was, that was new-new that no one else was talking about. Good point.

Okay, so let's see, Michelle you'll send out as soon as you get an update from, ah, the Meaningful Use Care Coordination Group and you guys will book us for longer time on Wednesday and the hour on Thursday and, and we'll just keep ... this.

MacKenzie Robertson – Office of the National Coordinator

So the hour on Thursday, do you want that just to be a continuation of Wednesday where it's the full workgroup, not necessarily the subgroup, or do we want to keep it subgroup specific even though all the workers can still attend?

Lawrence Garber – Reliant Medical Group

Micky's call on that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Um, I'm sorry, you were just talking about the extensions?

MacKenzie Robertson – Office of the National Coordinator

Yeah, so we can extend, um, the meeting tomorrow for an extra half hour to make it an hour and half call, um, but that's the full workgroup call. So the call on Thursday do we want to make that a full workgroup call as well or do you want to break it back down into the subgroup level?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Yeah, no, I think that was just subwork, subgroup. I think it'd be hard to impose a full workgroup meeting with such short notice.

MacKenzie Robertson – Office of the National Coordinator

Okay. So I'll extend tomorrow's meeting an extra half hour. Is that good to give everybody an hour and a half?

Lawrence Garber – Reliant Medical Group

I can stay for a-the whole-whole hour longer. I don't—

MacKenzie Robertson – Office of the National Coordinator

Do you guys want two hours?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Sure. So that one, yeah, are we, are we saying that workgroup meeting is going to be two hours or that we're just going to have the sub-workgroup meeting the second hour?

MacKenzie Robertson – Office of the National Coordinator

We, we can do either really.

Michelle

It sounds like Micky wants to do the workgroup meeting for as, the way it is and then do a subgroup meeting from 4:00 to 5:00.

MacKenzie Robertson – Office of the National Coordinator

All right. So the only thing about the—

Lawrence Garber – Reliant Medical Group

So is this second invite? Is that what you're saying?

MacKenzie Robertson – Office of the National Coordinator

Yes, I'm going to have to talk to ... about how that's supposed to work, just to see, um, it might be just a little confusing to send out the invites that way. But let me ask them how they want to handle it logistically.

Jeff Donnell – No More Clipboard – President

Would people—

MacKenzie Robertson – Office of the National Coordinator

So people would just drop off after 4:00.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Yeah, we could, we could do that. You know, we could invite anyone who wants to stay, to stay, if anyone has some perverse, perverse interest in this.

MacKenzie Robertson – Office of the National Coordinator

I think what I'll do is I'll just update the appointment that we already have to be two hours and then in the, in the update message say the second hour will be for subgroup members so feel free to drop off if you, if you don't feel like saying. But we still have to do public comment so—

Lawrence Garber – Reliant Medical Group

Yep, go for it.

MacKenzie Robertson – Office of the National Coordinator

Um, operator, could you open the lines for public comment?

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

I'm going to to have to drop off. Larry, why don't we, we can touch base via e-mail offline.

Lawrence Garber – Reliant Medical Group

Okay, thanks a lot.

Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer

All right, thanks.

Public Comment

Operator

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have no comment at this time.

MacKenzie Robertson – Office of the National Coordinator

Okay, thank you.

Lawrence Garber – Reliant Medical Group

Thanks a lot, everybody.

Michelle Nelson – Office of the National Coordinator

MacKenzie?

MacKenzie Robertson – Office of the National Coordinator

Michelle, yeah, can you give me a call back?

Michelle Nelson – Office of the National Coordinator

Yes, okay.

MacKenzie Robertson – Office of the National Coordinator

All right, bye.

Michelle Nelson – Office of the National Coordinator

Bye.