

Information Exchange Workgroup
Draft Transcript
July 25, 2012

Presentation

Operator

Ms. Robertson, all lines are 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 Committee's Information Exchange Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself when speaking. I'll now take roll. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Micky. Hunt Blair? Tim Cromwell? Jeff Donnell?

Jeff Donnell – NoMoreClipboard

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jeff. Peter DeVault?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Here.

MacKenzie Robertson – Office of the National Coordinator

Seth Foldy?

Seth Foldy – Centers for Disease Control and Prevention

Here.

MacKenzie Robertson – Office of the National Coordinator

Jonah Frohlich? Larry Garber?

Lawrence Garber – Reliant Medical Group

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Larry. David Goetz?

Dave Goetz – OptumInsight

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. James Golden? Jessica Kahn? Charles Kennedy? Ted Kremer? Arien Malec?

Arien Malec – RelayHealth Clinical Solutions

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Arien. Deven McGraw? Stephanie Reel? Cris Ross?

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Cris. Steven Stack? Chris Tashjian?

Christopher Tashjian, MD – River Falls Medical Clinics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Chris. Jon Teichrow? Amy Zimmerman?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yes, I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Amy. And is there any staff on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle.

Kory Mertz – Office of the National Coordinator - Challenge Grant Director

Kory Mertz, 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, Micky, I'll turn it to you.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, great. Thanks, MacKenzie. Thanks everyone for joining, this is Micky Tripathi, Chair of the Information Exchange Workgroup. In our ongoing effort to massively confuse you we have done a number of things, one is we've just tacked on an hour to this meeting time without asking your permission, so I'll explain that in a second, we've got two agendas for those two hours and we've just sent you another document in the last 30 seconds I think, so hopefully all of you are fully and massively confused.

M

Micky, that's real class.

Micky Tripathi – Massachusetts eHealth Collaborative

Yes, and I'll tell you I'm only slightly less confused than you, so, talk about leading from behind here. So, here's what's going on with all those changes. We've got ongoing work with the various subgroups that we've created and we need a little bit more time with the sub-workgroup on transitions of care and so the most convenient time for us to do that was in the hour just following this one, so and then for a variety of logistics reasons it was just a lot easier to extend this time rather than try to set up a whole other meeting to follow right after this one.

So, in the first hour we'll have the full workgroup meeting where I'll discuss the agenda for that in a second and then the second hour is going to do a deep dive for the Sub-Workgroup 2 which is the transitions of care, any other workgroup member who would like to stay and has a perverse desire to have yet another hour of ONC call you are more than welcome to join and help with that conversation, otherwise we can, you know, you can drop off at that point if you're not a part of that sub-workgroup and we'll just continue on with the sub-workgroup work.

So, stepping back then for a second, we've got a number of things we wanted to cover in the full workgroup call today. We have the HIT Policy Committee meeting is next week on August 1st and we want to be able to provide at least, you know, initial set of recommendations, whatever those are, coming out of our workgroup, and, you know, again those can be, you know, very, very preliminary and high level because as you all know we're really just beginning at the beginning here. But, that said, we want to get as far as we can and as concrete as we can.

So, we've got some output from two of the sub-workgroups. One of the sub-workgroups has just had, you know, about literally about a half hour to meet and they did that about 3 hours ago and that's the one that Dave Goetz is helping with and that's the Quality Efficiency and actually I'm not even sure that was a real sub-workgroup.

Dave Goetz – OptumInsight

No, I think it's going to be a surprise to our members.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, so that was actually not a sub-workgroup meeting; that was actually just an organizational meeting.

Dave Goetz – OptumInsight

That's correct.

Micky Tripathi – Massachusetts eHealth Collaborative

So, those who are actually on that sub-workgroup, I apologize we didn't meet without you; we just had a meeting just to get ourselves organized and Dave is going to share a couple of slides at the beginning, because he has to drop off at 2:30, that just sort of tees up some of the high level issues there and just invites a little bit of workgroup conversation related to that and I think we want to try to schedule a meeting of that sub-workgroup on Friday, if I'm not mistaken, that's something we're going to be working toward, but we can do that scheduling off line. That sub-workgroup is focused on three things, it's kind of a grab bag it's administrative simplification, clinical decision support and ePrescribing, and as Dave will describe we want to have a little bit of conversation I think about the administrative simplification part and then perhaps defer those other ones to a future date, but I'll let Dave cover that in a second.

The Sub-Workgroup 2 discussion is on transitions of care and just to, you know, sort of frame this a little bit, you may recall, as we were just beginning this work, really mid to late June, one of the things that we were, you know, recognizing was that the Meaningful Use Workgroup was out ahead of us, you know, as you might imagine they are the Meaningful Use Workgroup and so they really had sort of begun work in earnest in thinking about the Stage 3 recommendations, and so our hope at the time was that they would be able to get something to us that we would be in a mode to sort of respond to in early July.

That didn't quite, you know, sort of work out that way, you know, as we can all imagine these issues are complex and so, you know, that sort of full schedule didn't kind of roll out as we thought it would, and so we kind of embarked as a workgroup on, you know, sort of our own thought process to say, well, you know, we don't have quite that much to, you know, kind of respond to here, so let's really just sort of embark on own, think about those principles and then start to lay out what we might think of as, you know, sort of our own roadmap, and then we'll, you know, intersect that with the Meaningful Use Workgroup as those thoughts start to develop from there.

And you may remember, you know, we talked about, you know, sort of the idea of, you know, consolidating our gains and then administrative simplification and query being two other things that we wanted to think about as, you know, sort of the bumper sticker kind of principles that we wanted to move forward on. In the meantime, the Meaningful Use Workgroup has been hard at work coming up with, you know, fairly, at least for where we are in this sort of timeframe, a fairly concrete now set of recommendations that they're going to be bringing forward to the HIT Policy Committee, while those aren't... you know, they're certainly not finalized and, you know, I say "concrete," I put that in quotes/ Those are still kind of in flux.

And so, you know, I think one approach that we might want to think about here is that given that what they're coming up with and what you're going to see from the Transitions of Care Sub-Workgroup here, there is a lot of overlap on those and so one of the things that we might think about, as we think about a sort of focus area for the HIT Policy Committee meeting next week, is to try to, you know, focus a little bit more on the areas that they haven't really thought about at all and I think you'll see that when Larry covers the transitions of care part, which is, you know, right off the top of my head, it's query in general, they don't really sort of tackle that as a function, none of, you know, the ways that they've sort of developed their recommendations sort of tackle that, and then lab orders isn't there and I'm sure there's a bunch of, you know, other small kinds of things, but, you know, query, you know, sort of and lab orders for me are the big ones.

The Transitions of Care Workgroup got a little bit into the query conversation as we thought about, you know, sort of consent and authorizations, and, you know, perhaps that's something for us to tease out and to speak about with a little bit more sort of elaboration on this workgroup call, but, you know, I certainly invite, you know, the workgroup to weigh in on, you know, where we should head as we think about recommendations.

But it maybe that the best use of our time and the limited time that we have at the HIT Policy Committee meeting would be to say, there's a bunch of stuff coming out of the Meaningful Use Workgroup we'd like to, you know, spend a little bit more time over the month of August aligning ourselves with and being able to, you know, sort of once that's settled from their workgroup being able to sort of figure out what that is and then getting alignment on that, in the meantime we have some initial thoughts on query, which is a huge area that they haven't really thought much about, and again, these are just, you know, preliminary sort of thoughts that we might offer, because that can then set us up for, you know, sort of a deeper discussion of that amiability to develop and deliver more sort of fine grained recommendations for the September and October meetings.

So, that's, you know, kind of the framing for the transitions of care. We also want to talk about patient driven communication which Jeff Donnell is going to talk about as well. So, that's a pretty heavy agenda. Let me first turn it over to Dave, because I know his time is going to run out and then maybe we can open up the conversation once Dave has talked about his Sub-Workgroup to this question of how do we want to frame the transitions of care conversation with an eye toward the Policy Committee meeting next week. Okay, so, Dave, let me turn it over to you quickly.

Dave Goetz – OptumInsight

First apologies to Chris and Cris for not having been available to kind of get this group going in the same way that Larry has done such a great job with Subgroup 2. I've been out of the country for 2 weeks, so I apologize, that I was unable to get it going. The idea this morning was though that at least with Kory and Micky, and I that we could at least talk about I think broadly what does this look like and so we obviously want...with an idea of throwing it up to everyone on the call today to say, okay well what guidance do you have as we then really try and make this more meaningful. So, this really is very, very preliminary and very much just a broad schematic to think about. So, next slide please.

So, the second one, there we go, so again, as Micky said we have three areas that are kind of in this group as they are kind not necessarily directly associated with each other, administrative simplification, clinical decision support and ePrescribing. And, Larry, again, I stole from some of your thoughts a little bit fairly freely about questions to ask. One of the interesting things about administrative simplification is there really is nothing in Stage 1 and 2 about that, so that can we... or while it may be impacted by it it's not as directly addressed.

So, how can the framework in the way that this has evolved as we've gone through Stage 1 and 2, and are looking at Stage 3, what, you know, what would be meaningful to consider to help drive administrative simplification, I know it's certainly something all of us want to see occur. Then, when it comes to clinical decision support and ePrescribing I think the other questions apply that there are objectives surrounding those already, are there new objectives that we ought to be thinking about in terms of, again, purely around the idea of exchange and how would we propose to deal with the existing objectives. Next slide, please.

So, again this is very much just thoughts and we spent most of our time on, just to skip to the...I'll come back to the first bullet, clinical decision support it seemed again, as Micky was talking about, we have the Meaningful Use Workgroup, we have the regulations that will come out that really are addressing a lot of these and our role in terms of exchange is really perhaps to react to that and to think about how Stage 3 exchange goals could be wrapped around what those are.

On ePrescribing it seemed primarily to deal with what areas remain unaddressed and the examples we thought of again this morning were the controlled substances, mail order pharmacy, certainly we've talked about those in the context, and there again maybe others. But, back up to the top bullet and then we'll throw it open for questions and/or discussion real quickly.

You know, when you think about administrative transactions what are the ones that really kind of seem to have the most pain points and certainly prior authorizations are one, eligibility checks are other, people not necessarily knowing that and maybe around then claims processing, and editing, and making sure that claims are as clean as possible upon submission.

There are a lot of things out there already addressing some of these things in the marketplace. So, what would be the role again of Meaningful Use in trying to do that and how would you, given that there's so many other players in the system who are involved, how would you use Meaningful Use given that the people who largely are subject to it are EHR vendors and providers not the payers, not the clearinghouses, not, you know, a lot of the other entities that certainly have a large role to play in administrative transactions in the system.

So, with that I wanted to stop and beg for thought and input on how we might proceed with this group.

Arien Malec – RelayHealth Clinical Solutions

This is Arien. As you might know another part of RelayHealth actually is one of the clearinghouses so I just want to put that out there so that everyone knows the perspective that I comment this from. I've got two concerns in this area, number one is to the extent that there is market failure in some of these areas it's not clear to me that Meaningful Use is the appropriate policy lever to address the market failure.

So, for example, our experience is that there's pretty robust use of electronic claims because you've got to do it... you've got to submit claims to get paid and it's clearly more efficient to do that electronically.

Where you have significant problems right now is lack of clarity in terms of what constitutes a clean claim and that lack of clarity is deliberate ambiguity on behalf of, you know, there's this game that's played between providers and payers where payers are both deliverably, contractually obligated not to disclose prices and so can't often times disclose all of the underlying rules that they have and secondly have an interest in not disclosing the rules because they know that if you have clarity on the rules you're going to get gaming the claims and likewise providers on the other side sometimes reverse engineer the rules, play games with bundling and unbundling.

And the gamesmanship that gets in the way of lack of clear claims is a problem, it's a market failure, but it's not clear to me that Meaningful Use is an appropriate policy lever or an effective policy lever for addressing that.

If you look at the eligibility, eligibility is an area where there is significant lack of market adoption and what we've seen as the driver of that is that since we can't do real-time adjudication of benefits determination often times in the medical claims field in the way that we can in the pharmacy world, pharmacy everything driven off the claim, but you effectively do the eligibility check and the claim all at the same time.

The benefit to an eligibility check sometimes doesn't raise, doesn't get to the level of the cost for that eligibility check, that is, if all you can tell me is the patient's eligible, but they've got a card, you're not really reducing your major financial risk, what you really want to know is how much is the patient, the member responsibility, the patient responsibility versus the plan responsibility so that you can figure out where you need to do collection and if you can't address those issues you're not really addressing the value side of eligibility, and again, it's not clear to me that Meaningful Use is the appropriate lever for that.

And again, prior authorization you've got an issue where payers do not have often times electronic systems that would drive electronic PA, it's a market failure, it's not clear to me that Meaningful Use is the appropriate lever. So...

Micky Tripathi – Massachusetts eHealth Collaborative

But, in contrast...

Claudia Williams – Office of the National Coordinator

Micky, I'm wondering if this is at process level thinking that we only have 40 minutes left.

Dave Goetz – OptumInsight

Yes.

Claudia Williams – Office of the National Coordinator

I wonder if it would make sense for folks to agree with the basic framing and then obviously, they'll be a need to dig in hugely on what's in and what's out of Meaningful Use, but basically it's like, you know, clinical decision support will defer to the MU Workgroup, ePrescribing let's look at gaps, and admin sends the question about the role of MU and kind of... if we can agree on that then the workgroup can proceed with thinking through these important issues. I'm just... I know there's a lot you need to cover.

Arien Malec – RelayHealth Clinical Solutions

Okay, thanks, Claudia.

Dave Goetz – OptumInsight

But, I agree with what you said, Arien. I think these are real serious, knotty problems that would be hard to figure out how to get a handle on here.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, so, this is Micky, but, yeah, I mean, I think that if we can sort of just agree on that, on the framework and the disposition of the clinical decision support and ePrescribing then maybe the sub-workgroup can meet hopefully on Friday and maybe talk through a little bit more of, you know, where we are talking about the administrative simplification and all the great points that Arien raised.

I mean, I think that all of those were questions as we were sort of putting this together, there was just that bigger meta question of, you know, does any of this apply to Meaningful Use at all and the related question of, even if it does could Meaningful Use help to solve any of these issues and those seem like real and valid questions for us.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

So, does...

Micky Tripathi – Massachusetts eHealth Collaborative

Go ahead.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

I'm sorry, this is Cris Ross, so I'm trying to figure out what is in here that I might disagree with, I don't mean that in an obnoxious way, I'm just trying to figure out how to improve this, because I think it sounds like survey questions around administrative simplification and Arien has already illustrated some issues that we've addressed, I can think about things we could add here like maybe claims attachments as a tactical issue, but it looks like on the other two it's sort of, you know, clinical decision support hold tight and ePrescribing is, again, inventory issues unaddressed.

I don't mean to be, you know, sound in any way critical or anything, I guess I'm asking what kind of input... the framing looks fine, is there any input that you'd want prior to us meeting? Otherwise, I'd say let's meet, let's go for it.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I think that right. I agree.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

Okay, I just wanted to be clear to see if you guys wanted preliminary...some other kind of feedback.

Arien Malec – RelayHealth Clinical Solutions

And Cris, I'd say before for the administrative simplification, I'd say you could ask the inventory but probably the more leverage question is to what extent Meaningful Use is the appropriate lever.

Dave Goetz – OptumInsight

Right.

Lawrence Garber – Reliant Medical Group

And this is Larry. I would just, you know, in contrast to Arien's opinion, I respectfully disagree, that if formulary checking is that important for ePrescribing in order to control the cost of healthcare those same issues apply with prior auths and eligibility checking that we actually can control the cost of healthcare and direct people to the correct testing procedures instead of just ordering the most expensive.

Arien Malec – RelayHealth Clinical Solutions

So, Larry, I just want to be really clear, I completely agree, my only issue is, is again, is Meaningful Use the appropriate lever or should we recommend that there be...that this is an area where CMS and ONC need to look for other levers to address these issues.

Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability

This is Cris. I'm not sure that Meaningful Use is necessary or sufficient, but it's a perfectly useful tool it seems to me, especially if we were to focus on the components where clinical touch is administrative in particular. I mean, if this was just HIPAA transactions that clean up, you're right, but I think it's more than that, and yeah, I've been on the payer side as well, Arien, and I totally understand what you're saying and I think there are some issues that we need to set out of scope.

Micky Tripathi – Massachusetts eHealth Collaborative

So why don't we...you know, we're certainly not... we don't want to resolve any of this now and we're certainly not even going to resolve it before next week, but being able to at least tease out, you know, some of the...as Cris, as you said, there are probably some other categories, I'm sure there are, that we missed like claims attachments and others.

And then maybe having a little bit of that focus group attention on these questions of, you know, the appropriateness of Meaningful Use and whether we think there might be a "there" there which I think would just be helpful to then tell the Policy Committee we think that for these particular types of transactions or take 2 or 3 of them Meaningful Use might not only be relevant but actually have a little bit of leverage to offer in things that up until now have gotten a whole lot of traction for example, you know, or not. I think that would be a helpful set of things to be able to say to the Policy Committee. Okay, so it sounds like Dave, is that given us...

Dave Goetz – OptumInsight

That's good for Friday; that gives us, I think we've had some good discussion and I think it helps frame this for Friday to come back to you with another grind through this process.

Micky Tripathi – Massachusetts eHealth Collaborative

Great, thank you. Okay, well thanks, Dave, and thanks in advance to the other members of that Sub-Workgroup for any flexibility you have, especially to have a call on Friday. So, let's now turn to the transitions of care and I think that was the deck that was sent out earlier from Larry, if I'm not mistaken, and then there is also one from Jeff.

Lawrence Garber – Reliant Medical Group

So, okay, yes, so actually if you can, yes, I think that was it, yeah, care coordination, if you could take it down to like the next to the last slide, go all the way down. So, we've really framed a lot of our work recognizing that there are three times when communication needs to take place, one is when there is a planned transition of care and in that case, you know, clinical data can be pushed to follow the patient. Then there are the times when there are unplanned transitions of care and in that case there is nothing that has been pushed to the person who now is taking care of the patient, so we need to have a way to query and pull information.

And then the third time is when there is a need for communication but there is no transition of care taking place, you know, the patient isn't necessarily moving, there's sharing of the care of the patient yet information needs to be communicated and so a lot of this stuff we've done focuses in on those three different areas. So, if you can go up just one slide.

So, this is the request for information, so this is something that has not been part of MU 1 or 2 and it's not part of what the Meaningful Use Workgroup has been thinking of for Stage 3. And what we were thinking is that we wanted to... there are lots of different mechanisms to do queries and we don't necessarily want to be prescriptive about how it has to be done, but we do know, you know, and thanks to Peter DeVault for sort of laying out, you know, one possible mechanism for doing this where a query can actually be done through a matter of a series of pushes almost, a pushing of information and/or messaging back and forth and such that there's not a need...you don't have to have a master patient index to do this. You don't have to have a record locator service or a centralized consent registry.

And so the way this would work is that if I'm an emergency room and a patient has shown up here, and the patient say, well, you know, Dr. Garber is my primary care physician, I can use my EHR to send a message to, you know, to Dr. Garber's EHR saying I need whatever release authorization you use so that I can have the patient sign it and then I'll go ahead and pass that back to you, and then you'll go ahead and pass the information that I need.

And, so what's actually happening is the authorization form is being held by the organization that's going to be doing the releasing and the beauty of that is that, you know, if we're talking about interstate requests for information, for release of information it's really the holder of the information that is bound by their state and their state's laws as to what they can release, and what authorizations are necessary from the patient.

The second thing is that, you know, as we get into whether there is going to be some sort of data segmentation, you know, whether HIV is allowed to be included, mental health substance abuse that it's the holder of the information that knows what segmentation capabilities they have and that can be part of this authorization as well. So, you know, there clearly is a need to further define how these authorizations, what authorizations ought to contain and what's the format, and also some standards about how this communication can be done. Peter has worked out a mechanism that works using the IHE profiles. There is debate about, oh, actually this didn't get pulled up here, there's debate about whether Direct can also be used for doing this, but that sort of definition is up to the Standards Committee and what we're really responsible for is defining where we'd like to see Meaningful Use go if it can be done.

And, so what we're proposing here is that when a patient is received by an eligible professional or a hospital and they have not been pushed the care summary document or the appropriate data set, that they perform an electronic query to obtain that information and that they do that, we're proposing here 10% of the time that they don't have information on their patient. Any discussion?

Claudia Williams – Office of the National Coordinator

I'll just say from the ONC end, this is something that we've been thinking about and looking at and it seems like potentially a very viable way to achieve, you know, a really critical goal we all have which is to accommodate unplanned care and it could be, like you said, either done with the, you know, traditional infrastructure that people think of with HIE or potentially in other scenarios with folks using kind of what's already in the EHR, so I think it's exciting and really pushes toward a new capability that I think people weren't sure we would get to. So, I think it's interesting.

Lawrence Garber – Reliant Medical Group

Thank you.

Micky Tripathi – Massachusetts eHealth Collaborative

So, this is Micky, is there a technology component to this? Is there something that would translate into technologies that need to be certified to enable this or is this basically just saying that, you know, that authorizations, however they exist, in the wild will be used and you need to do it 10% of the time.

Arien Malec – RelayHealth Clinical Solutions

So, this is Arien, I think there's a middle ground between those two statements which is saying that we're sending out set of policy objectives and explicitly kicking over to the Standards Committee, and potentially the S&I Framework to figure out the how.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

This is Peter. I agree that that's probably what our role should be. We will also find, after the Standards Committee does it's work, that there will almost certainly be some technology implements that need to be certified.

Lawrence Garber – Reliant Medical Group

Right and we do have some... there's another more detailed document that does talk about some of the pieces, you know, some of the pieces that belong in an authorization, you know, that may need to be defined down the road, but again, I didn't want to put it here because I agree with those two comments that I think we can kick that... we should be able to kick that part over to the Standards Committee.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Our belief was that there's existence... that there is a doable capability from a technology perspective and I guess I'd editorialize that probably one of the appropriate roles is to start standardizing around those existing rules.

Claudia Williams – Office of the National Coordinator

I mean, one question for this group that lies at the edge of that is what the assumptions, the one piece of this I think that might go a bit kind of huge or little is whether you're assuming that you have an out of band way of getting the end-point like the Direct address or whether you're baking in the requirement that there be a way to query for that and I think there's a... so to the extent this group has preferences about how to scope, I think it would be helpful to hand that over to the Standards Committee.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

We definitely discussed, yeah we definitely discussed that item.

Lawrence Garber – Reliant Medical Group

So, actually could I have the next slide, next two slides, please? So, I broke out one of the things that we had talked about in our subgroup and actually put it out here as a candidate objective, because we had talked about that, that it is important in order to facilitate this, you know, in fact all of the health information exchange we're talking about, is to have a provider directory and an accurate one, one that is up-to-date.

And so, you know, it's clear that the best source of truth about a provider's whereabouts and existence, and home in terms of an EHR to send things is actually within that EHR itself, you know, that the EHR has all of the knowledge of who as of this moment is a physician that can work and access that system, and who no longer works there. And so, there are some standards regarding how to update a provider directory, although there is maybe not necessarily agreement on what the right standard is.

But I wanted to throw out here the notion of Meaningful Use to have an eligible provider update a central provider directory when there are changes in their own EHR regarding the status of that provider, and so I called out here, you know, if there are changes to their name because they got married, if there are changes to their credentials because the PA is now a PA Certified or now they're a physician, or whatever, a nurse has become a nurse practitioner, or that contact information has changed, or their affiliation has changed, they no longer work in that organization, that 10% of the time those changes are propagated up to a central provider directory external to their EHR.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Larry, this is Peter, I think we probably still need to have some more discussion around, I know this is dreadful, but an entity level versus individual level provider directories and which ones support these different kinds of uses.

Claudia Williams – Office of the National Coordinator

I just got a flashback.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I can't wait to have that conversation. So, this is Micky, the one thing that occurs to me, I mean, I completely agree with needing to move forward on something to standardize provider directory exchanges, all the administrative transactions required to maintain provider directories, so from the technology side and even certification side that seems to makes sense to me.

The part that I'm more concerned about is on the Meaningful Use objective side because how are individual providers, members of communities or regional entities that have provider directories, I mean, this in effect says that they have to be because it says more than 10% of the time, how does that become applicable to the solo provider out in rural Kansas who, you know, isn't a part of any regional entity, health information exchange or otherwise, what's the community?

Lawrence Garber – Reliant Medical Group

Right, so there clearly need to be exemptions, but, you know, maybe Kansas is doing a state-wide provider directory.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, but again, I'm not sure that we want to require that they participate in that, right or do we? I mean...

Peter DeVault – Epic Systems Corporation – Director of Interoperability

We definitely, we explicitly discussed that and one of our suppositions was that there would be a range of actors that will provide provider directory services, it might be my EHR, it might be my regional entity, it might be my state and so a means to accommodate for those range of actors which is why discovering who's the authoritative source of truth for me or for you needs to be an important part of that transaction. But, you definitely raise a good issue about what is the Meaningful Use, is there a Meaningful Use requirement to publish my information in some directory.

Lawrence Garber – Reliant Medical Group

Well, there are certainly meaningful use requirements to publish to registries; I mean that's out there, so, you know, this is analogous. I do have the very last sentence of the bottom of this page is the talk about the fact that there ought to be a directory of the directories as you pointed out to know where to go for the source of truth and Micky would you feel more comfortable if we threw in... if there was a sentence in there that talked about that there needs to be exemptions or exclusions from this menu objective?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I mean, I'm kind of either, you know, do you take it to the top and then carve out the exemptions or do you try to build your way up and say we want to make sure that the technologies have the capability to do this and then leave it open to the providers to do it where they find it makes sense for them from a business perspective.

Seth Foldy – Centers for Disease Control and Prevention

Yeah, Seth Foldy here. I mean, I think the public health reporting case is instructive, you know, we simply created exemptions, so where a directory does not fit, you know, does not exist that covers your piece of geography you are exempt, you know, it's kind of simple as that. But, I have more concern about the 10% of changes and it seems to me that any directory process would ideally involve no less than an annual updating or if necessary certification that no updating is needed, it would also be far easier to attest to and to audit.

So, in other words, this 10% solution doesn't make much sense to me and I would think that any directory would ideally require that some check be made on an annual basis so that everything was up-to-date and that that seems much simpler.

Lawrence Garber – Reliant Medical Group

Yeah, I debated about the 10% because the fact is if you're doing it 10% of the time you're probably doing it 100% of the time and I think you're right that this does imply that it's a real-time process whereas it may make more sense to be doing this as a batch annual process.

Seth Foldy – Centers for Disease Control and Prevention

Or what I might say is no less than annually.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Seth Foldy – Centers for Disease Control and Prevention

So that everyone...at least one kind of says...presses the button so to speak or the button is automatically set by alarm to update the directory.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy and I have a question, and I mean, I've been listening, but I may have missed this, depending on how provider directories are structured if there is a regional or central, or state-wide one, I don't know enough in terms of, and it gets into that real-time sort of a batch issue, where they're getting their data from and how they're structured to update it, and what their precedence rules are. So, I think in terms of whatever requirement... you know, if we want to go down this road we have to be really careful to put in enough flexibility that the precedence rules of where they're getting, you know, where the provider directory is getting updated data from works, because I'm going to assume that there's some variability in that across provider directories.

Lawrence Garber – Reliant Medical Group

Undoubtedly.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, so I guess, this is Micky again, I guess... and just as I'm thinking about this the concern, I guess the concern that I have with doing it from the top down, meaning that we say that it's a Meaningful Use objective and then you have carve outs or exemptions is that then the onus is placed on us to define all of these things that frankly I'm just not sure are really definable in a way that isn't going to just create a morass, meaning what is a community provider directory, is it the provider directory that Epic maintains just for that... you know, just for a particular, you know, IDM or across entities, or is it a state-wide HIE, or is it the Department of Public Health, or, you know, there is just so much variation already in the market and there is going to be so much more that we start to then have to get into these issues of defining it rather than the opposite approach, which you just need to say, we want to make sure that the technology is capable of doing it according to a set of standards and then leave open how it happens.

Lawrence Garber – Reliant Medical Group

But, Micky, if this is a menu item doesn't that by default mean that you can use it if you want but at least it ensures that the EHRs can do it?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, but again, it doesn't remove us from the responsibility of defining what is an authorized provider directory from our perspective, you know, in order to meet the objective and we ran into this a little bit with the registry conversation I think some of that is still open, we'll see what the final rule is, but at least from the... I guess it was the oncology registries and Seth, you can correct me here, we at least were able to have the hook that there are in each state designated public health oncology registries, so there was a hook there, but then for some of the other categories it was still, you know, wide-open what would be an authorized registry and felt like that was going to be a complicated thing to sort through.

Arien Malec – RelayHealth Clinical Solutions

This is Arien, and apologies if we don't have agreement on the sub-workgroup, but by explicitly calling out this notion of a directory of directories the intent was that the provider or hospital could designate their authorized directory and not have to create a predefined set of authorized directories, and as I said, you know, I might publish my own, I might rely on my EHR provider to publish mine, I might be part of a regional entity, I might be part of a state entity, but as long as I'm designating who's hosting my authorized directory shouldn't that be sufficient.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy, I'm not sure... that worries me a little bit, I mean I understand from a provider perspective, but from even a state perspective if every provider is identifying who... I mean, this is what I was trying to say before, if every provider is identifying who they want to send provider directory information to then you're sort of the authoritative source and integrating that authoritative source you're very constrained on timeframes. I'm kind of with Micky; I think this is more complicated than... it worries me a little bit.

I understand wanting to capability of the EHR to do this and we had this discussion a little bit in one of the Meaningful Use Workgroup meetings, I think it was the Pop Health one where are we trying to figure out the capability of the EHR in what we're doing for these objectives or are we trying to say how we want physicians to use them and then the capability has to be there.

Lawrence Garber – Reliant Medical Group

Well, let me throw in my perspective, this is Larry again, I can see clearly that, you know, right now, you know, nobody has a provider directory, very few people have provider directories that are being updated by EHRs, I'm sure that most of them are being done through, you know, other manual heavily administrative tasks and, you know, from my perspective the most efficient way to have done it, if, you know, the magic was that the standards were in place and everything was talking was to come from an EHR.

So, in a way it's a failed marketplace, I mean, wherever you go everyone says, well we don't really know which doctors are working in where they work, you know, the state, the board of registration doesn't know, you know, medical societies don't know.

So, the ideal way would be if the EHRs would be able to do that and automate the process, and again, so it's a failed marketplace and so how do we promote this to move in the right direction and if we can do something that gets the EHR vendors to at least put in the capability to update a provider directory, you know, the provider directories will come in the sense that they will be able to migrate over to this automated updating process and in the end you'll build the system that we should have had from day one will eventually evolve into it, because now all of a sudden the tools are there.

Micky Tripathi – Massachusetts eHealth Collaborative

So, this is Micky, just looking at the time and just from a process perspective I'm wondering if right now where I'm feeling like there is agreement is on the technology certification side, right? That we all agree that EHRs ought to have the capability to do this and the real question is about whether and how it would be substantiated into a Meaningful Use objective as well.

So, I know the sub-workgroup, I think, has a call tomorrow, perhaps there is further discussion to have there and either, you know, resolve it within the sub-workgroup or come up with something or not, I mean, I think it's also totally appropriate for us to go forward to the Policy Committee just with that to say here's a part that we have consensus on with respect to the technology ought to enable that and we are still in conversation about the question of the Meaningful Use objective related to that.

Claudia Williams – Office of the National Coordinator

Hey, Micky?

Micky Tripathi – Massachusetts eHealth Collaborative

Yes?

Claudia Williams – Office of the National Coordinator

Back to Amy's point, just one more thing to think about though, is to the extent that there's let's say at a hospital that's dealing with a regional directory and they basically do a batch download every month with the updated information, I would just be a little cautious in assuming that it has to be an EHR function, because I think a lot would depend on how you're populating that even if it's coming from the EHR itself. So, I think it's fine to bring that forward, I just, you know, I think there's probably questions both on the technology and on the MU side.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Lawrence Garber – Reliant Medical Group

So, Micky, how much more time do I have?

Micky Tripathi – Massachusetts eHealth Collaborative

Well...

Lawrence Garber – Reliant Medical Group

How do you want to do this?

Micky Tripathi – Massachusetts eHealth Collaborative

Well, I was thinking... is there more related to access, I mean, related to query, I mean it strikes me that we've got one that you've talked about which is essentially the push/push form of query as we've been calling it and then another important one which is link to the provider directory. Are there others related to... specifically focused on query, because what I would suggest is the ones that really have direct overlap with the Meaningful Use Workgroup recommendations, you know, we may just want to defer that and say for the purposes of the Policy Committee meeting next week that those are things that we're going to work out in the future and we don't need to engage in that right now, because there is a lot of the overlap of the Meaningful Use Workgroup and we're not going to sort that out with that workgroup, you know, before next week.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Micky, I have a request, which is that when we talk about query response I think it's misleading if we talk about something as being push/push, I have a fundamentally different model and I think we should use query response or something similar. I don't want people to think that we can just shoehorn Direct for example into that process.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, yes, fair enough, sorry for over simplifying that.

Lawrence Garber – Reliant Medical Group

Let's list it as request for information, is that okay?

Micky Tripathi – Massachusetts eHealth Collaborative

I like that.

Seth Foldy – Centers for Disease Control and Prevention

Isn't the term query the commonly used term?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I think so.

Seth Foldy – Centers for Disease Control and Prevention

Rather than request for information.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

All right, that's fair.

Micky Tripathi – Massachusetts eHealth Collaborative

And I guess the only thing, then there's just the spectrum of whether we're talking about their needing to be a person in the loop or it being automated in some way which is, you know, the goal ultimately.

Lawrence Garber – Reliant Medical Group

Right.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yeah, the goal should definitely be that this is automated.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

I mean, I don't have any problem with calling it query; I have that terminology in the objective itself.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. So, Larry and the sub-workgroup, is it okay if we move to the patient conversation?

Lawrence Garber – Reliant Medical Group

Sure.

Micky Tripathi – Massachusetts eHealth Collaborative

I mean, it seems like we've gotten, you know, had some good conversation and actually have two good things to move forward with that are directly related to, I'm not going to say push/push, directly related to query response, namely the model as well as the provider directory conversation.

Lawrence Garber – Reliant Medical Group

Yes, so let's go over to Jeff's.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, great, thank you.

Jeff Donnell – NoMoreClipboard

Okay, and Larry do you know if my slides are further down in this deck we're looking at?

Lawrence Garber – Reliant Medical Group

Yes, they are.

Jeff Donnell – NoMoreClipboard

Oh, great. Okay, keep going. Yeah, just a couple of guiding principles, again, well we'll, never mind, we'll, go ahead and we'll get right into the meat here. Next slide, please. Okay, so there were kind of four things that we looked at in regards to patient and family engagement, and the first one is this concept of making certain that a certified electronic health record can consume and reconcile patient supplied data.

And the objective that we outlined here is to be able to use that technology to bring in that patient submitted data with the idea that the EP, the hospital or critical access hospital that gets patient generated and/or patient aggregated data in some sort of a standard electronic format like a CDA that comes in from some sort of a patient facing application, that the EHR would be able to consume, compare and reconcile that data for 25% of the patients who submit it.

And, you know, this is the probably, of all the things we looked at, you know, we place this as the highest priority because we're seeing that patients are significantly frustrated at their inability to easily submit their electronic data to providers and, you know, whether they're frustrated because we're seeing multiple providers each of which has a different tethered patient portal or if it's, you know, just the situation where you have providers who are either unable or unwilling, or uninterested in accepting patient provided data, it is something that, you know, the patients are pretty unhappy about.

And as we looked at this we felt like, you know, Stage 1 and 2 really lay the groundwork in terms of setting up the, you know, the standards for transmission and payload, and, you know, starting to lay down requirements for consumption and reconciliation between providers with providers sharing data, so you sort of have the train tracks built here. This also should complement what we're looking at in Stage 2 around transmit, the patients, you know, are likely going to have the ability to transmit their data from the one EHR to a designated address and you know, no reason that that can't go back the other way.

The other thing that we felt was very, very important is part of this is that the data provenance be addressed, you know, certainly you have to be able to identify the source of the data whether or not it's patient generated, whether it's a clinical source or that sort of thing.

And I know, I did have a chance to look at a couple of the outcome of the Meaningful Use Workgroup activity just before this meeting and it looks as though there has been a little bit of work within that group as well, you know, looking at sort of this idea of consuming patient submitted data. So, we'll have to do a little bit of work to harmonize, you know, this with the work that they've done, but, you know, this is certainly one of the more critical things that we feel should be addressed. Any comments on this one?

Arien Malec – RelayHealth Clinical Solutions

Yeah, this is Arien, one place where the tracks haven't been laid down yet are the issues of identity assurance for patients and I don't know if the Tiger Team has looked at the issues related to inbound transmission from patients, but one way to address this would be to make sure that EHRs have the capability for example, to white list patient direct addresses or similar mechanism to ensure that there is some kind of in-person identity or appropriate identity assurance for the patient prior to this level of transmission. I just want to bracket out that there is a set of policy issues and then possibly sort of technology issues relating to identity assurance for any kind of patient inbound transmission.

Lawrence Garber – Reliant Medical Group

Yeah, this is Larry, I've got to second that, I mean that's a huge issue that we've been dealing with and I think it's really important to highlight that.

Micky Tripathi – Massachusetts eHealth Collaborative

Yes, I agree.

Jeff Donnell – NoMoreClipboard

Good, we'll make sure that that's in the next round.

Seth Foldy – Centers for Disease Control and Prevention

So, this is Seth Foldy, and I don't know to what extent we want to ask the question, you know, what types of data are we talking about, but I do know that there are a couple of use cases that we're hearing from the public health realm where from experience we know it's often difficult to get doctors to record information and in fact patients are the authoritative source of the information, but they often don't have the information or the time to lay it all out at the doctor's office and one example of that is the occupational history. We've talked in the past about the family health history, as you may know, the Surgeon General recommends that the patient's families get together and type in their family health history at Thanksgiving when they're all gathered, I'm kind of fantasizing about using Labor Day for people to contribute their occupational history.

So, I wasn't sure to what extent we wanted to leave it wide open or attempt to use patient contributed data to meet very specific needs that we know that clinicians often have a hard time accessing.

Michelle Nelson – Office of the National Coordinator

So, this is Michelle, I just wanted to speak up and say that a lot of the things that have just been discussed have already been discussed by the Meaningful Use Workgroup and I'm sure coming out of next Wednesday's meeting there might be things that they refer to this group to dive into a little bit deeper. So, I would just suggest that we, you know, make sure that we coordinate well with the Meaningful Use Workgroup because they've already touched upon a lot of these things.

Seth Foldy – Centers for Disease Control and Prevention

So, good, I apologize that I have to leave the group, but thank you everybody.

Jeff Donnell – NoMoreClipboard

Okay, can we go to the next slide please?

Micky Tripathi – Massachusetts eHealth Collaborative

So, what would we all enter on April Fool's Day?

Lawrence Garber – Reliant Medical Group

Aliases.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Jeff Donnell – NoMoreClipboard

Kind of building on that concept of patient supplying information would be patient supplied device data, and the objective here would be to use EHR technology to consume patient submitted home monitoring device data with the idea that the EP, hospital or CAH would receive device data from an authorized patient and here we did put in that authorized piece, but you'd have to be able to consume data from at least one device or one type of device for 10% of the patients who submit this data. And again, you know, we're in a situation where patients are increasingly using these devices to monitor and manage their health information, certainly fits in with the new models of care like ACOs where patient's management and monitoring is critical, obviously we need to reflect any Standards Committee work around patient ID/Auth/Match which would apply to the previous one as well.

And again, here provenance is important including LOINC codes, you know, as we talked about in our group, you know, one example is that a blood pressure collected at home is viewed very differently from a blood pressure taken in a clinical setting, so you want to be able to delineate between those two.

The other thing that we talked about is just, you know, we would probably want to coordinate with work that has already been done at the continued alliance around, you know, the appropriate standards for this kind of information sharing. So, any thoughts, comments on that one?

Lawrence Garber – Reliant Medical Group

This is Larry, as a provider, I mean, this one is also so important because our staff spends so much time on the phone having patients call in their results and we're typing them into our system and it's inefficient for the patient, it's inefficient for our staff, prone to error, so this would be a huge benefit.

Arien Malec – RelayHealth Clinical Solutions

Just a question on the threshold and you've addressed a lot of the standards issues, the question is will there be an ecosystem of ready devices that would allow somebody to meet a 10% threshold or is this a good one for, you know, maybe the first phase 3 measure is a do some and ramping it up over time or at least to do some creates a market driver for at least some devices, glucometers and scales, and the like to be EHR integration ready.

Jeff Donnell – NoMoreClipboard

Yeah, I think that's a good point and I think this is, you know, while I think this is a fairly important and obvious thing for us to do, it's one that, you know, I think it's definitely a crawl, walk, run. I think there will be an appetite for it, but I'm with you, you know, I would say, let's keep that initial threshold low and, you know, and again, I know we had some discussion in our workgroup, do we even at the outset want to maybe specify, you know, certain device types, you know, kind of going after the ones that, you know, would be the most obvious like scales and glucometers and those sorts of things, you know, and really go after the ones that are going to have the broadest applicability.

Micky Tripathi – Massachusetts eHealth Collaborative

I like that, thinking about it, you know, as a phasing, because I was also concerned about the thresholds as well, so maybe there is a way of just sort of breaking that out then. In this case the incentives would be completely aligned as well, because if any provider who made the effort to set up this kind of, you know, device process, they did it once they would be accepting the whole stream, because like in Larry's case, they, you know, are seeing the benefit of it.

Arien Malec – RelayHealth Clinical Solutions

Right, doing it once enables you to do it from time to time.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, yes. Okay, great.

Jeff Donnell – NoMoreClipboard

Great, comments. Okay, next slide, please.

Micky Tripathi – Massachusetts eHealth Collaborative

How many, Jeff, I forget, how many more do you have?

Jeff Donnell – NoMoreClipboard

Just two more.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. So, if you could just bear with us, hopefully, yeah, go ahead Jeff, I didn't mean to cut you off.

Jeff Donnell – NoMoreClipboard

Okay, oh, no problem. Okay, so this next one, again just tying into the fact that, you know, a lot of the work around transitions in care and care coordination has to do with care plans, and a lot of that discussion has been around, you know, sharing those care plans and updating care summaries between providers just making certain that the patient and the family are also involved in that.

So, the objective would be to provide care plans to patients and families with each transition of care or referral so that as the medical professionals transition a patient from one setting of care to another that care plans are updated, care summaries should be made available within 24 hours for 25% of those patients.

And again, this one just seems logical, again, to the extent that in Stage 3, you know, we include, you know, more focus on transitions in care and exchanging these documents, again, just making absolutely certain that the patient and the family are not left out of that because quite often, you know, they are going to play, you know, either the central role or a critical role in coordinating care between providers. Any comments on that one?

Arien Malec – RelayHealth Clinical Solutions

So, this is one where we've already met it in Stage 3 in the sense that we're already requiring instructions and goals to be provided to patients and families, so what's the list for Stage 3?

Jeff Donnell – NoMoreClipboard

I will have to go back to my notes and check on that one.

Lawrence Garber – Reliant Medical Group

I mean, if you look at the Meaningful Use suggestion they do have, you know, a dozen things listed out for, you know, for what constitutes a care plan and even looking at that it looked a little bit patchy, but, I think there clearly is a notion that the care plan needs to be further advanced in Stage 3 than how it was simply spelled out as goals and instructions, which...

Arien Malec – RelayHealth Clinical Solutions

I am 100... you know, I'm in total agreement with that.

Lawrence Garber – Reliant Medical Group

Yes.

Arien Malec – RelayHealth Clinical Solutions

And also agree with your other point about the kind of scattered nature of what's being asked for right now, but I guess what I suggest is we've already got the mechanism for giving the care plan to the patient as we upgrade the plan of care we should also make sure that we're also submitting that to the patient, but it doesn't necessarily need to be a new measure.

Jeff Donnell – NoMoreClipboard

Right, yeah, and I think that's the key point here is that as these documents get upgraded and it becomes a more actionable, you know, or valuable care plan, you know, so much in the language, you know, tends to be about, you know, sharing those among providers and we just want to make certain that the patient and family are included in that, so, yeah, I mean, clearly we can just... we can just inject some of this language into whatever measure is appropriate.

Micky Tripathi – Massachusetts eHealth Collaborative

So, it sounds like at least at the minimal construct is that this is really just enriching what was in Stage 2 to saying that that information ought to be richer, more comprehensive and perhaps better defined than in Stage 2, correct? And then maybe there's a measure, of course finding threshold adjustments that we make as well.

So, the part that I feel less comfortable with and we have to have further conversation about this is the idea of, you know, sort of multi-entity or multi-provider care plans, because we get back to this question of where does that come from and how does that get brought together. I mean, I'm an individual patient, I'm Medicare, regular Medicare fee for service, I just go to the dermatologist. What is the dermatologist supposed to produce by way of a care plan?

Lawrence Garber – Reliant Medical Group

I've got that in one of my document slides.

Micky Tripathi – Massachusetts eHealth Collaborative

Well, that doesn't realize that the dermatologist now has to figure out all those other people because Medicare doesn't require that the patient even have a PCP.

Lawrence Garber – Reliant Medical Group

I think I might have used the word known care team.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Lawrence Garber – Reliant Medical Group

If not I'll just stick that in there.

Micky Tripathi – Massachusetts eHealth Collaborative

Yes, yes, that's fair enough.

Jeff Donnell – NoMoreClipboard

Okay, last slide please. Okay, this final one is, you know, has to do with, you know, kind of looking at what's going on in terms of quality guidelines and, you know, this one is thinking a little bit outside the box, but, you know, we're looking at the idea that, you know, we have an opportunity to notify patients when they are due or overdue for things like preventative services, screenings, vaccinations or if they're out of compliance with quality of care guidelines.

So, the idea is that you would be able to use EHR technology to notify and, you know, at least we're starting here with 10% of the patients when they are due for one of these things or overdue, or out of compliance. And again, you know, the thinking is that given the emphasis on preventative care, the already embedded functionality in certified EHRs it seems like a logical extension, you've already got certified EHRs that are building in clinical decision support, you know, to support quality measures.

And, you know, in terms of being able to notify, you know, that should be doable, you know, as an extension of secure messaging or as an extension of things like view, download, transmit, you know, so things that are either already in place or being put in place as part of Stage 1 and 2.

And, again, this could...one of the discussions we had in our workgroup is that this could be also tied again to some of this work around transitions and care, and care coordination where quite often you're going to have a care plan that will identify a gap in care, a goal or objective, or a task, and again, you know, using this secure messaging or other functionality to be able to communicate that back to the patient and make sure that those things are clearly identified. So, any thoughts or comments on that one?

Micky Tripathi – Massachusetts eHealth Collaborative

Well there already is, isn't there a patient reminder's requirement? So, is this just further refining that?

Jeff Donnell – NoMoreClipboard

Yeah, this is further refining it and I think, you know, again, really, you know, tying into, you know, is there a way to link that to, you know, for example some of the quality measures that are, you know, that are already included in terms of Meaningful Use requirements, so that, again we start to make sure that the patient and their family is a little bit more engaged, you know, in what they should be doing, you know, in order to play their part.

Arien Malec – RelayHealth Clinical Solutions

So, is this an extension of the existing reminders measure?

Jeff Donnell – NoMoreClipboard

It certainly could be.

Micky Tripathi – Massachusetts eHealth Collaborative

That's what it feels like to me. Okay. Is there any comment from the workgroup on either this one or on any of the patient engagement one?

Lawrence Garber – Reliant Medical Group

The only other thing is with this one that we're seeing on the screen here, this is Larry, is that I think the Meaningful Use Workgroup was also talking about, you know, further pushing the patient preference, preferred mode of communication and whether that should be folded into here.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Right and so this could mean... this could fit the Information Exchange Workgroup's mandate if the goal is to send it electronically which isn't currently part of the measure.

Micky Tripathi – Massachusetts eHealth Collaborative

The reminder's measure you mean?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yeah.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah.

Lawrence Garber – Reliant Medical Group

So, it could be that, you know, 10% of patients whose preference is to receive it electronically or whatever percentage.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yes.

Jeff Donnell – NoMoreClipboard

Yeah, that's a good point.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, well I'm sure, you know, there's going to be some smoothing out of some of the edges around all of this stuff I think as we give more thought to them, but it sounds like there is a fair degree of consensus around the thrust of, you know, each of these patient engagement ones, is that fair to say? That's a resounding "yes."

Jeff Donnell – NoMoreClipboard

It must be.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, well, so I would... if it's okay with everyone I would propose that I think that we've got, you know, in terms of the first sub-workgroup related to administrative simplification, I think that, you know, we engaged in the guidance to them and we had a good conversation about the query response, you know, approach that we're talking about as well as talks around provider directory with more discussion to be had there and then I think some very good conversation here as well on the patient engagement recommendations.

What I would propose is we've got the remainder of from now until 5:00 I think for the Sub-Workgroup 2 to remain on and continue the conversation and what we'll do is, as a workgroup, refine, you know, what we've just discussed here and then, and I apologize for doing this, but, you know, try to aim for, you know, for the end of Friday getting something out to the entire workgroup that reflects, you know, kind of what we talked about today and where those sub-workgroups are, hopefully in alignment with, you know, with what was articulated today and ask for the workgroup to, you know, either gives a thumbs up or thumbs down in terms of what we'll present to the Policy Committee next week.

So, if everyone can just look out for that e-mail, that would be great and MacKenzie, do we need to sort of have a formal break here and public comment or how do we do this logistically?

MacKenzie Robertson – Office of the National Coordinator

I would say we should do a brief one just because we have the agenda out with public comment listed and then we can just keep everyone on and go forward from there.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

MacKenzie Robertson – Office of the National Coordinator

Operator, can you open the lines for public comment?

Rebecca Armendariz – Altarum Institute

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

MacKenzie Robertson – Office of the National Coordinator

Okay, thanks.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, great. So, for the entire workgroup, thank you very much, anyone who is interested in staying for the Sub-Workgroup 2 conversation to continue the conversation about query response, provider directory and the other issues there in transitions of care more than welcome to stay, otherwise, we'll give a moment for those who don't want to participate further to drop off. Thank you, very much.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Micky, it's Amy, and I'd love to stay, but I do have to get on another call that I'm late for, so I will talk to you soon.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

And, I just need to connect with you on where you want to go with the Public Health Subgroup, so we can talk maybe later tomorrow, okay?

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. All right, great. Thanks, Amy.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Bye.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, so should we... MacKenzie do we want to do a formal start to this and do a roll call? How do you actually handle this?

MacKenzie Robertson – Office of the National Coordinator

We can do a quick roll call. The Subgroup 2 list is quite small.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

MacKenzie Robertson – Office of the National Coordinator

So, I'll just do a quick roll of Subgroup 2. Larry Garber?

Lawrence Garber – Reliant Medical Group

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Larry. Jeff Donnell?

Jeff Donnell – NoMoreClipboard

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jeff. Peter DeVault?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Peter. Jonah Frohlich? Arien Malec?

Arien Malec – RelayHealth Clinical Solutions

Still here.

MacKenzie Robertson – Office of the National Coordinator

All right, Arien. And Micky, I know you're here. Okay, just go.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I have to leave at the bottom of the hour so I've only got about 10 minutes, this is Peter.

Lawrence Garber – Reliant Medical Group

So, is there one that you would prefer that we go to first before you leave, Peter?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

What's on the agenda, actually?

Lawrence Garber – Reliant Medical Group

So, I was going to rehash the summary of care record, the reconciliation, which we may not have talked about and then the collaborative care communication.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Well, reconciliation sounds interesting.

Lawrence Garber – Reliant Medical Group

Okay, reconciliation it is.

Micky Tripathi – Massachusetts eHealth Collaborative

Can I?

Lawrence Garber – Reliant Medical Group

Yes?

Micky Tripathi – Massachusetts eHealth Collaborative

Larry, if it's okay, I just wanted to, just to apologize to everyone for the conversation we just had on the provider directory, I apologize for raising some concerns as I was reading it, I mean I should have engaged earlier when we were having the sub-workgroup conversations and somehow it sort of eluded me and only occurred to me as we were reading it with the entire workgroup. So, I apologize...

Arien Malec – RelayHealth Clinical Solutions

Somehow I have the same issue, is sometime it only happens when I'm sitting there and going, oh, wait...

Lawrence Garber – Reliant Medical Group

Well, the thing is we had talked about it and we hadn't broken it out like that, so, you know, I think I broke it out a minute before our presentation so it's not your fault, that was the first time it was ever actually broken out clearly like that.

Arien Malec – RelayHealth Clinical Solutions

By the way, Larry, I sent you an e-mail on this, there was a meeting that was scheduled, a sub-workgroup that was scheduled for 6:00 a.m. sometime and I get grumpy on 6:00 a.m. start times, so...

Lawrence Garber – Reliant Medical Group

Is that tomorrow.

Arien Malec – RelayHealth Clinical Solutions

Yeah, so if there is a way to look at that and move it or...

Lawrence Garber – Reliant Medical Group

Wasn't that the... Micky, I think that was the only time or MacKenzie that was the only time available?

MacKenzie Robertson – Office of the National Coordinator

Right, so for tomorrow it's 9:00 to 10:00, I think that's just the time that was discussed and chosen yesterday.

Jeff Donnell – NoMoreClipboard

And I believe everybody said that would be really tough for Arien, so let's do it then.

Micky Tripathi – Massachusetts eHealth Collaborative

That's how I remember it as well.

Arien Malec – RelayHealth Clinical Solutions

That's right, that's right.

Micky Tripathi – Massachusetts eHealth Collaborative

You've got to pay some penalty for living in California.

Arien Malec – RelayHealth Clinical Solutions

This is true, as long as we can have some that, you know, have start times of 5:00 p.m. my time.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

Well, you'll notice we're all still on e-mail at that time, so...

Arien Malec – RelayHealth Clinical Solutions

This is true.

Lawrence Garber – Reliant Medical Group

All right, so reconciliation, if we could jump to, it's slide 4 of my deck.

Micky Tripathi – Massachusetts eHealth Collaborative

Larry, I'm wondering if there... just on this provider directory thing...

Lawrence Garber – Reliant Medical Group

Yes?

Micky Tripathi – Massachusetts eHealth Collaborative

Is there a way of just simply, and maybe if this isn't simple than lets go with, you know, with reconciliation right now, but I'm just wondering if we just said something like, you know, the provider directory with respect to this question of what the heck is an authorized provider directory that what we're really saying, if I understand it, is that it's about being able to populate and maintain entries in a provider directory that is in another legal entity from yours.

Lawrence Garber – Reliant Medical Group

Right and do you want to turn it down to just one test of it? Would that make is simpler so that we're really just making sure that the EHR has the functionality?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, so those are two separate questions.

Lawrence Garber – Reliant Medical Group

Right.

Micky Tripathi – Massachusetts eHealth Collaborative

So, you know, I'm happy to talk about it, but I was just thinking is that a way of at least getting after this question of, well what is an authorized entity and there is a precedent for that which is with the transport requirement that it has to be across legal entities.

Arien Malec – RelayHealth Clinical Solutions

And what would... I just want to play devil's advocate there and say, what would be the downside if an EHR vendor said, look we're going to publish, as part of the service we provide, we're going to publish the provider directory for all the providers that we support.

Micky Tripathi – Massachusetts eHealth Collaborative

Well, I think that would qualify because you're basically saying...they're saying that they are going to do it across legal entities so we can say that's fine, that's across legal entities, so that would qualify.

Arien Malec – RelayHealth Clinical Solutions

Okay.

Jeff Donnell – NoMoreClipboard

But would hospitals not be able to establish one then?

Arien Malec – RelayHealth Clinical Solutions

Right.

Micky Tripathi – Massachusetts eHealth Collaborative

No, so a hospital... so again, I mean, if a hospital is just establishing one on its own, well how does this even apply?

Arien Malec – RelayHealth Clinical Solutions

Well, so could a hospital establish a directory on behalf of the employed providers for the hospital health system entity? So, what I'm getting at is, is the policy objective that the directory... there are two ways just giving the policy objective, one is that there's a policy goal that the directory information is available, at least at the entity level, so that other participants can at least have the mechanism for looking up patient information.

Micky Tripathi – Massachusetts eHealth Collaborative

Ah.

Arien Malec – RelayHealth Clinical Solutions

The other policy objective that you might be looking for is that there be an ecosystem of independent directory providers who might be state-based, who might be regionally-based and that EHRs should be able to publish to those entities, and depending on which of those two policy objectives is the more important one you might be looking for very different kinds of capabilities.

Lawrence Garber – Reliant Medical Group

Well, I think one of the... I thought... that's very interesting except for one problem which is I think if we put in here for instance, that, you know, you could do either one than that means that EHR vendors are going to have to be able to support their EHR being a regional directory and receive inputs from outside to update it. And so, I don't think we could take that approach.

Arien Malec – RelayHealth Clinical Solutions

Why would they need to get updates from outside, why wouldn't they just get updates from the providers they support? I think if... I'm just keying in... I think your assumption is that it's regional and my assumption is that it's available.

Lawrence Garber – Reliant Medical Group

Yes.

Arien Malec – RelayHealth Clinical Solutions

And, as long as I've got a way to figure out who maintains your directory for a patient I can look it up without needing to worry about whether that's a regional entity or your EHR vendor who is supporting you, whether it's Epic who is supporting you or whether it's... who is supporting you.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I agree with what you're getting at Arien, it seems like the requirement for the system is that the EHR system should be the ability to use directory services wherever they are available, which I think should be our focus as opposed to how the directory gets populated, it's not obvious to me, anyway that populating a directory needs to be an EHR function.

Arien Malec – RelayHealth Clinical Solutions

Yeah, I would agree with that.

Lawrence Garber – Reliant Medical Group

But, on the other hand, while it's not necessarily, you know, going to be a requirement wherever we have directories, it certainly would be the most efficient way to update a state-wide directory if that capability was there.

Arien Malec – RelayHealth Clinical Solutions

If you assume that the directory has sufficient information to do so. So, again, a couple of issues about whether we're talking about entities or individuals and that will be a fun conversation, and if it's entities many EHRs don't have or wouldn't have structured information about the legal entity that they're supporting. And they wouldn't necessarily have... if it's the individual they wouldn't necessarily have all of the information about the individual providers that they support, they would have just the information they need to enable clinical care.

Lawrence Garber – Reliant Medical Group

I would think they would have that information or should have enough information regarding the credentials of that person and contact information of that person, and specialty of that person in order to be able to do, you know, role-based security and things like that.

Arien Malec – RelayHealth Clinical Solutions

Yeah.

Lawrence Garber – Reliant Medical Group

I agree that they may not have the whole entities, but we're not necessarily requiring that they update the entity piece of this.

Arien Malec – RelayHealth Clinical Solutions

Well that's... maybe we should figure that question out first.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Right, so I mean, I think having the discussion about directories independent of the exchange use cases that we're trying to support is probably not productive, so if we're talking about directories for the support of the query response kind of model that's typically going to be most useful as an entity level directory.

Arien Malec – RelayHealth Clinical Solutions

I agree.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

If we're talking about looking up someone's direct address, which is a HISP type function, then that could be entity and/or individual level.

Micky Tripathi – Massachusetts eHealth Collaborative

So, are we in agreement that being able to consume directory information is something that we want? It sounds like there is agreement on that and really it's this other question about whether the EHR ought to be able to populate and maintain directory entries, which is the question that we're talking about right now.

Arien Malec – RelayHealth Clinical Solutions

Well, so, as Peter says, there are at least, and I'd add one more use case, we need to decide also what the use case is that the directory is enabling. So, if we're focused on use cases of query retrieve versus use case of looking up somebody's direct address, versus use cases of finding out who, you know, what cardiologist are available in a region, you're going to look at very different kinds of capabilities when you're looking for support.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

Agreed, and I think directories need to, as a minimum, support entity level, I mean, I guess there's no question about that. Is that fair to say?

Arien Malec – RelayHealth Clinical Solutions

Yeah, I would agree. I would advocate for confining to directory, to focusing on not confining to, I'd advocate for focusing on directory level to support query retrieve.

Jeff Donnell – NoMoreClipboard

Agreed.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yeah, let's have a cohesive set of recommendations that are Meaningful Use supported.

Lawrence Garber – Reliant Medical Group

I think my only concern with that is that, you know, I look as Massachusetts as an example, and Micky, you can correct me if I'm wrong, but while on one hand I think the state wants to have a directory of all entities, I think they also want to have... extend that to know who all the providers are and which entities they work for.

Micky Tripathi – Massachusetts eHealth Collaborative

Well, yeah, so that... and actually Peter and I have talked about this as well, so, I mean in Massachusetts it is entity level to the extent that the primary key is entity.

Lawrence Garber – Reliant Medical Group

Correct.

Micky Tripathi – Massachusetts eHealth Collaborative

But the idea is that every provider organization would submit the name of the individuals who would map up to the entity with the understanding that that is going to be as robust as the provider organization decides to make it, but at the end of the day that the thought will be that it goes to the entity level and so there is no centralized responsibility to maintain those individual entries. So, ideally an EHR would be able to, you know, consume that whatever information is available in the provider directory, some of which may allow some of them to look up, you know, a direct address, but, you know, again, if some provider organizations decide that they don't want to make those individual addresses available, just being able to find the entity is all that they would need to do in that case.

Lawrence Garber – Reliant Medical Group

So, what if we said... if we changed this, updating the provider directory that they can either update at an entity level or at an individual provider level so that in terms of an actual individual organization they get to do what is appropriate for them, in terms of EHR vendors they would incorporate the ability to do both.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I'm still not convinced that using the EHR to populate the directory is the right thing to do or even the most useful thing to do. I could be convinced otherwise, but...

Lawrence Garber – Reliant Medical Group

Just like in my organization...

Peter DeVault – Epic Systems Corporation – Director of Interoperability

It seems to me that with regards to directories what we need to make sure is that the EHRs can consume the directory information.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

I agree that that's also absolutely important.

Micky Tripathi – Massachusetts eHealth Collaborative

I agree with that.

Lawrence Garber – Reliant Medical Group

I mean, I think that clearly...

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I apologize, I have to drop off, so I will talk to you guys in the morning.

Lawrence Garber – Reliant Medical Group

Thanks, Peter.

Micky Tripathi – Massachusetts eHealth Collaborative

Thanks, Peter.

Lawrence Garber – Reliant Medical Group

Yeah, I mean I agree there are really two clear separate use cases, one is making sure that you've got a provider directory that's up-to-date and accurate and then another is to consume the information that's in the provider directory and I don't know that they can all fit into one objective and I was debating about whether we should have a separate objective that talks about, you know, automated access to provider directories or whatnot or integrated access.

Micky Tripathi – Massachusetts eHealth Collaborative

I think it is separate, because, I mean just in Massachusetts, again, you know, the way we're thinking about that is that the population of it will be a completely manual process at the beginning and maybe sometime in the future there is a pub-sub, you know, kind of model that could allow even the initial population or the ongoing maintenance of it, but they've sort of said that what we would like is the ability for an EHR to consume the information that's there and we'll assume that it's going to get populated, you know, kind of the way NHIN does it, which is, you know, they say to Partner's give me a big CSE file and we'll take it from there.

Lawrence Garber – Reliant Medical Group

Right and... because in my organization the source of truth is our EHR, I mean that knows better than anybody... when we want to know if someone still works for us we go look in the EHR.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. So, yeah and I'm going to guess that that's true in most organizations, but I don't know that for sure.

Arien Malec – RelayHealth Clinical Solutions

That's going to be true for enterprise EHRs generally.

Lawrence Garber – Reliant Medical Group

Because as soon as someone leaves the first thing they do is they remove their security access.

Arien Malec – RelayHealth Clinical Solutions

Right.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, so where would that not be the case, Arien? I mean, if I have an EHR?

Arien Malec – RelayHealth Clinical Solutions

So, I'm thinking about the 700 or 800 EHRs that are sorted by in the CHAPL.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah.

Arien Malec – RelayHealth Clinical Solutions

And, you know, I'm thinking about, I don't know, does Amazing Charts have sufficient information to populate directory, does and I'm going down the list, but there is, you know, Dexter EHR, do they support that.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, but aren't we...

Lawrence Garber – Reliant Medical Group

Well, can they feed a...

Micky Tripathi – Massachusetts eHealth Collaborative

Saying that they should.

Lawrence Garber – Reliant Medical Group

Right and can they feed an oncology registry, they're going to have to.

Arien Malec – RelayHealth Clinical Solutions

No, they're actually not, they're okay there because that's a menu set and they just pass on it.

Lawrence Garber – Reliant Medical Group

Well, not as an EHR vendor, is that right? If it's menu set it at least has to have the capability?

Arien Malec – RelayHealth Clinical Solutions

No, you need to get certified for the measures that you support.

Micky Tripathi – Massachusetts eHealth Collaborative

Well, what? For a menu set objective an EHR vendor doesn't have to get certified for those?

Arien Malec – RelayHealth Clinical Solutions

So, the certification...so that was the big change in certification between 2011 and 2013. For 2011 you had to get certified for everything.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, yeah, yeah, yeah.

Arien Malec – RelayHealth Clinical Solutions

For 2013, for 2014 rather you get certified for only...you need to have certified EHR technology for only the measures that you support.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, yeah... that's right, that's right. I'm even on the Implementation Workgroup and I forgot, but you're right.

Lawrence Garber – Reliant Medical Group

Micky, how could you let that happen?

Micky Tripathi – Massachusetts eHealth Collaborative

It's I know... it's a different day I just can't... I forgot... okay.

Lawrence Garber – Reliant Medical Group

So, I'm hearing a few things, what do you think about making this objective a, first of a do one test and it's a do one test of either individual or an entity update, and that it has to be a separate legal entity that's being updated, and then we talk about a separate objective, you know, whether or not to do a separate objective that talks about actual access to that directory?

Micky Tripathi – Massachusetts eHealth Collaborative

I think in broad brush that makes sense to me.

Lawrence Garber – Reliant Medical Group

Arien, what do you think about a separate objective that talks about actually querying the directory? Does that...

Arien Malec – RelayHealth Clinical Solutions

Yeah, I think that makes sense for entity level information.

Lawrence Garber – Reliant Medical Group

Okay. Okay, so maybe I'll... and do you want to make that also a one test?

Arien Malec – RelayHealth Clinical Solutions

Yes.

Lawrence Garber – Reliant Medical Group

Okay. All right, can move on, what do you think?

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, back to your agenda, Larry, sorry.

Lawrence Garber – Reliant Medical Group

No, no, I mean this is all my agenda. How much time do we have, we have another 20 minutes.

Micky Tripathi – Massachusetts eHealth Collaborative

Yes.

Lawrence Garber – Reliant Medical Group

Okay, so I don't think we had talked about reconciliation, so that's fair. So, the notion here... you know, so there have been medication reconciliation in phase 1 and phase 2, the Meaningful Use Group suggested that in addition to medication reconciliation they added allergies, which they also talk about allergies and contraindications, and intolerances, but I'm just going to leave that as allergies, because it took up too much space, and problems.

And, I was thinking that there are many other things that, you know, that are important to consider to reconcile when you're getting information during a transition, you know, so when someone is being sent home from the hospital and they have their Pneumovax or flu vaccine given during that hospitalization, which they are doing more and more, that's something that I need to really update my record with and so, you know, immunization updating and essentially reconciliation is almost as important as allergies, well, okay not quite that, but it's still important.

Similarly, you know, plan of...problems is really just a start, you know, problems and medications are just the start of a plan of care, those are, you know, those are some of the health concerns, those are some of the interventions, and that there are other pieces of the plan of care that are essentially being updated during transitions, and that, you know, assuming that there is this notion of plan of care being defined for phase 3 that we use that same notion whatever it settles out as being, that that also is getting reconciled and updated.

And then the part that maybe controversial or most controversial is the significant test results, you know, the fact that there are a lot of things that take place in the hospitalization as they're being sent out, you know, they've had a lot of expensive testing done and if I don't have a notation of that somehow in my own electronic health record I'm going to order those same things over again and, you know, at the risk of injury to the patient, at the cost of society all of those things, and also wasting time when I should be moving on to the next level of step-wise testing.

So, I thought that generic significant test should be, you know, included as things to be reconciled during the transitions of care. What do you guys think?

Arien Malec – RelayHealth Clinical Solutions

I agree with it, I'm still stuck on... and just for disclosure, we support a lot of hospitals in providing tests results of lab and radiology out to community providers where I think the... and our discussion yesterday was really great for me to understand the distinction between a test that was ordered in facility that is relevant for the referred back to provider even though they may not be the ordering provider, most of our providers turn off acute-based test results for the reason that you mentioned yesterday, you just get, you know, who cares about the umpteenth chloride that you received.

Lawrence Garber – Reliant Medical Group

Right.

Arien Malec – RelayHealth Clinical Solutions

And in most cases... so most cases I'm not going to receive that electronically, if I do I've got a reconciliation burden, so those are the people with the reconciliation burdens that actually get hit, that is they're going to have to say, okay I've already got these things so I don't want to report them. For most everybody else it's going to be a no-brainer, yeah I want to select these things and move forward. So, I'm just thinking out loud in terms of whether we're creating operational burden or not and I don't believe that we are.

Jeff Donnell – NoMoreClipboard

Well, I would add that, you know, I really like the addition of, you know, at a minimum allergies and problems, you know, if you're already having to reconcile the medications, which makes sense, you know, it would also only seem to make sense that you would want to update the allergy list and the problem list, and even starting at 10%, again it's one of those that if you know the functionality and put it in there it's likely that people will over perform there.

Lawrence Garber – Reliant Medical Group

So, should we keep this in here and give it a shot and see what, you know, what the Policy Committee says?

Kory Mertz – Office of the National Coordinator - Challenge Grant Director

This is Kory, just one thing to throw out, Larry, one of the population health objectives that the Meaningful Use Workgroup is looking at is actually around bi-directionality with immunization registries to be able to actually get the information back from the registry on other immunizations the patient has gotten, so I don't know if that directly kind of correlates to what you're suggesting here, but just wanted to put that out there that that is an objective that the Meaningful Use Workgroup is considering.

Lawrence Garber – Reliant Medical Group

I think if that gets through then this may not be necessary.

Kory Mertz – Office of the National Coordinator - Challenge Grant Director
Yeah.

Lawrence Garber – Reliant Medical Group

But, until I see it, I don't believe it.

Micky Tripathi – Massachusetts eHealth Collaborative

I guess this one, I'm just wondering whether we just put this one into the category of let's wait for after the Policy Committee meeting, because I think there is a lot more workgroup conversation, because, you know, just thinking ahead to the Policy Committee meeting it feels to me like we've got now, you know, something that we're able to say about the query response and the provider directory albeit with some further refinement, and the patient engagement, and a little bit of, you know, wherever we get on the administrative simplification which would be a high level thing, and that it seems to me is a good opening set of preliminary recommendations with where we're able to frame it as we specifically not address any of the issues that the Meaningful Use Workgroup is going to talk about right now because we want to be able to vet that at the working level before airing any differences with the Policy Committee.

Kory Mertz – Office of the National Coordinator - Challenge Grant Director

This is Kory. I think that's a really good point, Micky.

Lawrence Garber – Reliant Medical Group

I mean, I'm basically okay with the reconciliation one doing that, I have less of a problem because I think, you know, the Meaningful Use Group is going in the right direction on this one and so I don't have a problem with that. I think that for the one where we're talking about the summary of care record, I think... and also their care plan, I think they're going in the wrong direction and, you know, so, I'd have... so let's see how many minutes do I have, I've got a few minutes left, can we go up to the first or maybe it's the second slide.

Arien Malec – RelayHealth Clinical Solutions

Yeah, I completely agree with you. I think that they just don't know the work that's been done in the Transitions of Care Workgroup and in the LCT Workgroup.

Lawrence Garber – Reliant Medical Group

Right and I hate to have them, you know, get too far ahead in the wrong direction, you know, and maybe I'm a little biased, you know, obviously since I run one of those sub-workgroups, but I'd like to at least get it out there.

Arien Malec – RelayHealth Clinical Solutions

And I'd also say that when I was leading the S&I Framework one of the explicit reasons that we wanted to do that work was that we knew these were important areas for the Policy Committee and we wanted to make sure that we were getting things done ahead of time so they're not divorced and disconnected...

Micky Tripathi – Massachusetts eHealth Collaborative

Right, so we're trying to coordinate a call for me to touch base with Paul Tang and I wonder whether, you know, I can raise with him that we've got just some general concerns with that, what I don't... I guess what I feel like won't be particularly productive is for us to come with a specific recommendation in the same categories and then have that be, you know, sort of, you know, just both of those things presented at the Policy Committee at such an early stage, that just doesn't feel like it would be particularly helpful to either of the workgroups or to the process at large.

But if there is, you know, a way for us to... I mean I can certainly communicate with Paul about, you know, we've got this difference... we want to be able to work this out at the working group level so we should figure that out and whether it is appropriate for us to just, you know, say as a general statement, I mean I don't care whether it's appropriate, if we can say as a general statement at the Policy Committee that we have a general concern about that, but we have talked with the Meaningful Use Working Group and we are going to work on that, you know, over the next month at the Working Group level.

Arien Malec – RelayHealth Clinical Solutions

I would phrase it a little differently, I don't think we have concern so much as we want the Policy Committee to be aware of all of the work that has already been done in the S&I Framework that's actually done a lot of the, you know, the hard labor and present that back to the Policy Committee to reduce the amount of work that the Policy Committee would potentially need to do. Just positioning it as a benefit as opposed to a problem.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, yeah, yeah, right.

Lawrence Garber – Reliant Medical Group

Okay, so that would cover, you know, sort of the reconciliation that we need to do with the Meaningful Use Group over the next few weeks I guess, is that right, between what they've got for summary of care documents and care plans and how we've listed that.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

So, that would be fine. Now, let's just then also jump down to slide 6 thereabouts, it should say collaborative care communication. This may fall into the same kind of category, so they've also addressed, you know, they also had the same notion that there needs to be, you know, more points of communication and so they specifically called out on the left here, you know, to communicate during referrals, the consults reports coming back, and then again they said care summary, which I don't understand how it's listed in two places, but really the three of those fall into what we had in the prior slide about the summary of care records or in the summary of care objective, which has these care transition data sets.

They called out what we had talked about on our meeting, they specifically called out lab results after transition and so, you know, I guess I can let them fight that battle and it can be debated about whether it should be labs or tests, but the notion that I was bringing here is that, you know, there are a lot of communication points that are important even though no transition has taken place and that was... I think they really are kind of... not really getting that in what they've been proposing, you know, for their collaborative care communication.

You know, they just started to do it and then they didn't really go in the direction that, you know, to go full enough for all the different kind of communication that needs to take place without a care transition, you know, events that happen, you know, that the care team needs to know about, you know, and whether it's death, whether it's healthcare proxy activation, whether it's someone showing up in the emergency room, those are key points that are valuable pieces of information, you know, in the new healthcare system that, you know, we could facilitate by calling them out.

And, I was calling them key clinical activity points, you know, these are points of clinical activities that are important that some information needs to be communicated at that moment that's not necessarily part of the normal flow of communication right now between organizations.

Emma Potter – Office of the National Coordinator

This is Emma from ONC and one of the questions that the Meaningful Use Group has come up with has been what exactly counts as a transition and what doesn't and so I think that that's the reason why there is sort of vagueness with some of their objectives is because that is one of the questions that they're posing to the Standards Committee is what exactly counts under sort of this umbrella term of transitions.

Lawrence Garber – Reliant Medical Group

So, in the Transitions of Care Workgroup with S&I we're talking about different kinds of... there is actual handing off transitions, and then there is shared-care transitions, and that's what we had created our data sets for in that summary of care slide. And then there are times when things happen that, you know, that may not necessarily be at the hand off, you know...and some of this is administrative granted, you know, the fact that you're placing and perhaps could be moved over to the administrative group, you know, the fact that there is the process of placing an order and how does that actually get authorized.

And you know, I'm the one that places an order, I need to know that it got scheduled because I'm the one that needs to find out if it didn't get scheduled I need to go track this down and make sure it gets scheduled, and then after I know that it's scheduled I'm the one that's also going to have to track down and make sure I got the closed loop result. And so, you know...and there's debated about, you know, it's probably not a universal definition of transition of care, but wherever that ends there are clearly other points of care where we need to pick up and communicate.

Emma Potter – Office of the National Coordinator

Okay.

Lawrence Garber – Reliant Medical Group

And so that's... Micky, this is one thing where I think the Meaningful Use Group started but didn't quite fit through the goal.

Micky Tripathi – Massachusetts eHealth Collaborative

All right, so let me just ask in terms of process, I mean, we haven't had this level of conversation obviously with the workgroup, we just had our workgroup call, but as I recall I'm not... are we... is there sub-workgroup agreement on this level?

Lawrence Garber – Reliant Medical Group

I'm not sure.

Micky Tripathi – Massachusetts eHealth Collaborative

Or is there... I'm not sure either, so it seems like there is further conversation on that and then the second step, conversation about could we actually, via e-mail, get, you know, sort of the workgroup to, you know, kind of at least nod their heads that yeah it's okay to go forward with this tentatively or do we, you know, have to wait. These are just process questions.

Lawrence Garber – Reliant Medical Group

Because, I'd like to talk, you know, if we could I'd like to talk about two things at tomorrow's meeting since I guess this one is running short, one would be to talk about, you know, the collaborative care communication objective that we've got here and then the other is to talk about the querying the provider directory.

Micky Tripathi – Massachusetts eHealth Collaborative

And, I'm sorry, Larry, what was the first one? I just got distracted from someone.

Lawrence Garber – Reliant Medical Group

That's okay, sorry, the first one is the one we're looking at right now, which is the collaborative care communication, because we really haven't talked about this, I agree and there's a second slide right after this which I called the stretch ones, which are a little bit more controversial I think and probably even less well defined, but these all sort of lump together in one discussion. And then the second is to talk about, you know, I'll come up with some proposals tonight about querying provider directory.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Lawrence Garber – Reliant Medical Group

And, I would think that those are probably the two things that we just need to finalize before we give something to you.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, okay, so we can talk about these more tomorrow and see if there is enough there to share with the workgroup, and we can even, you know, sort of cordon them off and make clear that we haven't discussed this with the workgroup, if people are uncomfortable with our... you know, saying anything about it or even introducing it now fair enough, if people are okay with us introducing it as high level concept then really just to lay a stake in the ground that says there is an area that hasn't been covered by the Meaningful Use Workgroup and we want to, you know, just sort of make everyone aware of that for future reference that would be another way to go as well.

Arien Malec – RelayHealth Clinical Solutions

And I will be asleep.

Micky Tripathi – Massachusetts eHealth Collaborative

Sorry, and you'll be asleep?

Arien Malec – RelayHealth Clinical Solutions

I will be asleep...

Micky Tripathi – Massachusetts eHealth Collaborative

Fair enough.

Lawrence Garber – Reliant Medical Group

You've got to get your coffee to turn on earlier tomorrow.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, and apologies for that scheduling.

Arien Malec – RelayHealth Clinical Solutions

That's all right.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. So, have we accomplished what we can accomplish today?

Lawrence Garber – Reliant Medical Group

I think we have unless there are other comments from the sub-workgroup.

Micky Tripathi – Massachusetts eHealth Collaborative

At least for me, my only concern about the communication part is, and this is where I'm just not sure where we ended up on this or what the conversation with the full sub-workgroup is, you know, it's just another level of being able to, you know, document the exchange, you know, a level of activity that is just, you know, way too intense to really expect and I'm just not sure of the answer of that myself, but...

Lawrence Garber – Reliant Medical Group

And there is also the issue that there is a lack of standards for a lot of this.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

Maybe all of this and so I guess the question is, so let's say the Policy Committee says "oh, this is a great idea I think we should be doing this" Standards Committee says, you know, "there's no way in heck that there is anything close to a standard that can be used or developed in enough time." What happens at that point?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, well and I think that's, you know, that's happened before and I think that what they're trying to do as a matter of process is try to short-cut that a little bit by having John Halamka and maybe Jonathan Perlin weigh in with the Meaningful Use Workgroup I think over the next month basically on the question of maturity and appropriateness of the standards implied by a set of objectives so that some of those things may even get, you know, sort of taken out before they get to the Policy Committee just because, you know, John and Jon will basically weigh in and say, you know, standards aren't there and you shouldn't expect they're going to be there. So, you know, we can certainly ask them to provide some of that guidance to us as well.

Lawrence Garber – Reliant Medical Group

Yeah, I mean, I think that would be useful.

Micky Tripathi – Massachusetts eHealth Collaborative

But, I think you're right, I think he's going to say for almost all of this there are no standards, don't expect they are going to be there.

Arien Malec – RelayHealth Clinical Solutions

But, actually, Larry, I'm wondering whether it's appropriate to have the LTC Workgroup update the Policy Committee or at least a workgroup of the Policy Committee and also to update the Standards Committee on the work that's been done already, because I don't think...

Lawrence Garber – Reliant Medical Group

I believe there was an update to the Policy Committee; I don't know that there was an update to the Standards Committee at all.

M

No, John Derr and Bill did an update to them as well.

Lawrence Garber – Reliant Medical Group

To the Standards he did, okay?

M

Yeah.

Arien Malec – RelayHealth Clinical Solutions

Yeah, but it was focused on... that was focused on the long-term care aspects of the work, but not focused on the more general aspects of the work.

M

Oh, okay.

Lawrence Garber – Reliant Medical Group

Because we expanded our definition to beyond what the traditional long-term post-acute care, we include the primary care physician, you know, and the patient's centered medical home.

Arien Malec – RelayHealth Clinical Solutions

That's right, I just don't think there's awareness of the work that's being done on that plan of care, on representing the plan of care and the consolidated CDA.

Lawrence Garber – Reliant Medical Group

I would certainly be, you know, glad to do a presentation if that's appropriate.

Arien Malec – RelayHealth Clinical Solutions

Let me speak to the Johns.

Lawrence Garber – Reliant Medical Group

Okay. So, I think our time is done; we need to open this up to public comment?

MacKenzie Robertson – Office of the National Coordinator

Sure, this is Mackenzie, before we do that, I know we had discussed Friday afternoon there is an opening on the calendar...

Lawrence Garber – Reliant Medical Group

Unfortunately, I can't do that.

M

No, Larry, it's for the other subgroup.

Lawrence Garber – Reliant Medical Group

Oh, okay, sorry.

MacKenzie Robertson – Office of the National Coordinator

Okay, so that's not for this?

M

No, that's Subgroup 1.

MacKenzie Robertson – Office of the National Coordinator

Okay.

M

But what is the time, MacKenzie; we can reach out to the folks and see.

MacKenzie Robertson – Office of the National Coordinator

So 3:00 o'clock to 5:00 are open.

M

Three to five, okay, all right, we'll check and get back to you.

MacKenzie Robertson – Office of the National Coordinator

All right then, operator, can you please open the lines for public comment?

Public Comment

Rebecca Armendariz – Altarum Institute

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

MacKenzie Robertson – Office of the National Coordinator

Thanks.

Lawrence Garber – Reliant Medical Group

Great, thanks a lot everybody.

Micky Tripathi – Massachusetts eHealth Collaborative

Thank you.

Arien Malec – RelayHealth Clinical Solutions

Thank you.

Micky Tripathi – Massachusetts eHealth Collaborative

Bye-bye.

MacKenzie Robertson – Office of the National Coordinator

Bye, everyone.