

**Information Exchange Workgroup
Subgroup #2: Care Coordination and Patient and Family Engagement
Draft Transcript
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Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Information Exchange Workgroup Subgroup #2, Care Coordination and Patient and Family Engagement. This is a public call and there will be time for public comment at the end and the call is also being transcribed so please make sure you identify yourself when speaking. I'll now take roll. Larry Garber?

Lawrence Garber – Reliant Medical Group

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Larry. Jeff Donnell?

Jeff Donnell – No More Clipboards

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? Micky Tripathi? Are there any other workgroup members on the phone?

Dave Goetz – OptumInsight

Dave Goetz is here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Dave. And any staff on the line?

Emma Potter – Office of the National Coordinator

Emma Potter, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Emma.

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

Kory Mertz, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Kory.

Tari Owi – Office of the National Coordinator

Tari Owi, ONC.

MacKenzie Robertson – Office of the National Coordinator

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

Lawrence Garber – Reliant Medical Group

Great, thank you.

Micky Tripathi – Massachusetts eHealth Collaborative

Sorry, this is Micky Tripathi.

MacKenzie Robertson – Office of the National Coordinator

Hey, Micky, good timing.

Lawrence Garber – Reliant Medical Group

We held on just long enough. All right, so today I really want to focus on two things one was the collaborative care communication piece which we really haven't had much time to talk about and also finish up our discussions about the provider directory. So, actually why don't we start with the provider directory slides.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Did you guys do reconciliation yesterday after I dropped off?

Lawrence Garber – Reliant Medical Group

We very briefly talked about it, I mean we basically, you know, reviewed it and then said, you know, this really is very similar to what is being proposed by the Meaningful Use Group with the exception of a few extensions and I think Micky felt that we probably should not focus too much on this, although let the Meaningful Use Group know that we, you know, want to work with them to reconcile, you know, what we have is different.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Okay, very good, sorry to interrupt.

Lawrence Garber – Reliant Medical Group

No, that's okay. So, if we could pull up, let's see what we have, excellent, okay so this is where we had been talking before about the updating the provider directory and so based on the feedback I made some changes here and I generalized this to number one being updating a provider directory that is from a separate legal entity, so that's one changing of the verbiage here. Second is that instead of talking about 10% or anything like that, that it was to perform at least one test update using certified EHR technology. And then we broke out a separate one, which we'll show next after this, that talks about querying the provider directory. So, are you guys comfortable with this piece, this change?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I'm still digesting it.

Micky Tripathi – Massachusetts eHealth Collaborative

So, one thing Larry, this is Micky, that I would just raise because I heard some concern discussed about it yesterday, is the question of when we say legal entity that means that if you have a hospital let's say, I'll just pick Exeter Hospital up in New Hampshire, they're on MEDITECH in the hospital but their employed practices are on NextGen and if they were to create a provider directory across those that would not count for fulfillment of this objective the way we've constructed it, which I personally am fine with because that's consistent with what we're talking about with transport for example, when they do transport across those that doesn't count toward their Meaningful Use because they're part of the same legal entity, but I thought I heard, at least one person, register a little bit of concern about that, so just wanted to raise that.

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

Yeah, I believe that was Arien.

Micky Tripathi – Massachusetts eHealth Collaborative

And he's asleep, so...

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

Yes.

Lawrence Garber – Reliant Medical Group

You snooze you lose.

Micky Tripathi – Massachusetts eHealth Collaborative

Exactly.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

This is Peter, I guess I'm kind of wondering what it is that we're trying to accomplish by suggesting that it needs to be a separate legal entity. So, for example, what if one group wanted to post the directory for all of the regional groups around them, it sounds like that organization would not be meeting the requirements.

Micky Tripathi – Massachusetts eHealth Collaborative

I think it would. What do you mean by groups; maybe I'm not clear on that?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

A healthcare organization, a hospital let's say.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, so as long as those were...where those groups are just affiliated but employed, ambulatory practices you would say?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Or let's say they wanted to host the directory for all of the other providers and hospitals in the region.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, well I guess I'm confused on why you think that wouldn't count toward this as that is across legal entities.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, the hosting hospitals would not get credit.

Micky Tripathi – Massachusetts eHealth Collaborative

Oh, right, right, right, right I see what you're saying. Right, I hadn't thought about that part.

Lawrence Garber – Reliant Medical Group

Well, again with this being the menu, I mean granted that's going to be...that case may exist but that's not going to be the majority. So, you know, wouldn't there be other options that they could, you know, other menu items that they could pick from and just in that case they wouldn't pick this one?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yeah, I always wonder what else is on the menu when it's a menu item, but...

Micky Tripathi – Massachusetts eHealth Collaborative

Right, right, and also, do we want to...in way that sort of penalizes them in a way by reducing sometimes an option for them for doing something that I think we would all agree is a good thing.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Right.

Lawrence Garber – Reliant Medical Group

Should we add to this that... or that they can be the hosting providing directory that others can do updates with so that either you're the host or you're doing the updating.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Sure, I think that would work.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I mean is there a way to generalize that, say that... I mean, essentially say that you get credit for either direction, so if you provide access according to the standards you get credit or if you consume you get credit.

Lawrence Garber – Reliant Medical Group

Okay, I'll work on some kind of language that does that, that reflects that you can be on either end.

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

This is Kory, just a quick question; does that then address the employed physician issue that Arien was raising?

Micky Tripathi – Massachusetts eHealth Collaborative

It doesn't.

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

That's okay, I was just curious.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I mean, again I'd love other people's thoughts on that, it seems to me like, you know, with the transport, you know, we very specifically said that, you know, there are part of the same legal entity, you know, it's a fine thing to do but that shouldn't count toward this. I would argue that we ought to be consistent in the way we think about provider directory is all.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, I don't know how much you guys talked about this after I dropped off yesterday, so I apologize if I'm rehashing discussions you've already had, but I think we need to back up just a little bit here, because this is couched in terms of an individual provider directory and I think what we were suggesting yesterday or at least I suggested it, is that if what we're trying to do is develop directories that support the query model it's really the entity level directories that we're concerned with.

Lawrence Garber – Reliant Medical Group

So, actually, can we go to the next slide, please, no not that slide, the query one, yes. So, this is where I brought in the entity level addressing that when querying the provider directory that they do one test query from a separate entities provider directory to obtain entity level addressing information.

And, I think, you know, the notion that we were talking about is that while, I mean at least in Massachusetts, while we're going to be using entity level, you know, direct addresses when we send something because it's typically the entity that has the EHR, when I look it up I may be looking it by the actual provider, and so that provider information would... you know, we want to have mechanisms...it's a lot harder to update provider information and keep that up-to-date than it is entities.

So, that's why for the updating the provider directory I wanted to be able to get down to solve the more difficult problem, which is keeping provider directories up-to-date, provider listings up-to-date, provider level listings up-to-date whereas, you know, keeping entity level listings up-to-date really is much less of an issue.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

But it still needs to be done.

Lawrence Garber – Reliant Medical Group

Correct, but that one I think would be... you know, that would be relatively simple compared to maintaining the provider detail.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yeah, simple but not required is maybe not getting done.

Lawrence Garber – Reliant Medical Group

So, would you suggest that for the updating of the directory that we update both provider and entity?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Actually, I'd like... so because the update to the menu item I'd actually like to see entity level be core.

Dave Goetz – OptumInsight

It requires a different type of data structure than you have in a lot of these address books is my point to relate the entity and the doctor.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, yeah, I wonder whether we should have two similar requirements, one is to update the entity level directory and have that be core and then have the menu item for updating individual level provider directory.

Lawrence Garber – Reliant Medical Group

But, I don't know that that needs to be an EHR functionality to update the entity level.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I don't know that either one needs to be an EHR function actually.

Micky Tripathi – Massachusetts eHealth Collaborative

So, Peter, when you say that it should be core are you... is it that you're saying that this should be a Meaningful Use objective but not an EHR function or you're just saying, well if we're on this path then this is the right way to do it, but you're still concerned about the path?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Maybe a little bit of both.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, that's what I was sensing.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I haven't completely solved this one nor have I reached the bottom of my first cup of coffee this morning.

Lawrence Garber – Reliant Medical Group

Well, we can come back to this in about 30 minutes I think.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, I guess my concern is that the query model is not going to work unless there are entity level provider directories available and consumable, and so we need to get those built, and maybe it will just happen naturally because it's easy, so maybe we don't need an objective to have that. And, then separately from those considerations, I'm still not convinced that it's even a good thing that updating directories is an EHR function.

Lawrence Garber – Reliant Medical Group

Well, I'd buy into the notion that if we created yet a third provider directory related objective that specifically talks about updating entity level addressing, but that if we...I mean entity level entries, but if we take out using the EHR certified technology I'd be okay with that if you felt that that was appropriate for Meaningful Use.

Micky Tripathi – Massachusetts eHealth Collaborative

So, EHR related technology for the population of it? I mean, I think it's...I think it would be odd to make it a Meaningful Use requirement without saying the technology has to do something.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Well, so the technology comes in being able to consume information in the directory.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, so we're just talking about the consumption piece of it.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Well, in order to consume it there has to be something there and maybe we can roll the consumption and the population into one requirement.

Lawrence Garber – Reliant Medical Group

This query one?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

To me it seems artificial to make the population an EHR function simply so that it seems natural that it's a Meaningful Use thing. Does that make sense? On the other hand, it needs to be done.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, right, although I thought we were headed to actually separating them because we all agreed that consumption should be an EHR function but there seemed to be mixed views on whether population should be an EHR function.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Agreed. I guess, I'm responding to the concern that having a Meaningful Use objective that doesn't fit on top of some EHR function is a bad thing.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, so we could...if we divided up the consumption it seems like, you know, that we could talk about that being an EHR function and, you know, whether it's a core or an MU objective we can talk about that. Because it's only if it's available that they can do it.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Sure, well we could have exceptions.

Micky Tripathi – Massachusetts eHealth Collaborative

And then on the population side I don't really know what we would say if anything because...unless we think that that ought to be an EHR capability, which I'm still open to, but it sounds like you're concerned about that and I think Arien was concerned about that as well.

Lawrence Garber – Reliant Medical Group

Yeah, my bigger concern again is that, you know, we recognize in the state here that no one's got a provider directory that's actually up-to-date and that this is a huge problem, you know, if it's that way in Massachusetts I'm sure it's in most states and that, you know, the only solution I see is to be able to, you know, connect to, you know, a true source of information, you know, a source of truth which really is the EHR, I mean we all keep that up-to-date because that's our access and so, you know, and it just makes perfect sense to then be connecting those, you know, electronic, you know, sources which are kept up-to-date to the directories that, you know, that we need to be up-to-date, you know, that this is a system, a market that's failing that, you know, there's a relatively simple solution to.

And the benefits will be huge, I mean, because the whole... all the HIE messaging relies on, you know, this being good that I can go find out where Dr. Garber is working, you know, I can go find out, you know, where John Halamka is working where I can send messages that I know will eventually get to him and whether it's directly to his mailbox or whether it's to his organization I know that that's how I can get to him.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, okay, I don't disagree with what you're saying about the good of the use case that you're describing. I do have serious concerns that individual level provider directories have been hard, we don't expect that to be true of entity level provider directories, I don't want to see entity level provider directories get dragged down by the hardness of individuals. So, if we can separate those notions out and push on both of them, but make sure that we have the entity level things to be able to do the query response model I think I would be okay with that.

Lawrence Garber – Reliant Medical Group

But, by the fact that we're talking about querying at an entity level does that not imply that there have to be directories that have entity level provider directories?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

It implies it, but I'm not sure it makes it so.

Lawrence Garber – Reliant Medical Group

So, I guess I see two options, one would be somehow folding that into the query objective, although I think that that might be difficult and the second would be to just create a third objective that specifically talks about populating an entity level provider directory.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I think that's the direction I'm leaning.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, that's what I was thinking, it sounded like it made sense as well. So, Peter, it sounds like you're comfortable with something that says that EHR technology ought to be able to populate at least or entity level information in another provider directory, and we either...

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Here's where I keep balking on the population part being an EHR function. We have to develop new standards to make that work.

Micky Tripathi – Massachusetts eHealth Collaborative

Yes.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

As opposed to filling out a spreadsheet or going to a website and entering that information in which we could do today.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, and is HPD not mature enough in your experience?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Not really, it may be and I'm not the expert on that, but...

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

So, this does again get back to the point is if we didn't make it with certified EHR technology can it still be a Meaningful Use objective, in other words, because you're right, you're not necessarily...

Micky Tripathi – Massachusetts eHealth Collaborative

Well, so if the concern is the standards I guess one way to do this is to do it... to construct something along the lines that we were just talking about, that second option, Larry, that is just about the population of the entity level information from the EHR and we can start with that, and then reach out and ask the Standards Committee for a read on that, either, you know, we can just reach out directly to Jonathan and John Halamka or, I'm on a call this afternoon with John Halamka on provider directories in Mass, I could just ask him them.

Lawrence Garber – Reliant Medical Group

Sure.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Okay.

Lawrence Garber – Reliant Medical Group

All right, so I'll do that, I'll be updating the... I'll do the update provider directory first of all making it so that you can be the updater or the host, and then I'll create a second version of that which specifically talks about entity level population.

Dave Goetz – OptumInsight

In both cases would it not be just a simple export to and consume from and then you can figure out how to do that rather than the receiving entity has to figure out how?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yeah, I guess that is a question for...

Dave Goetz – OptumInsight

In many cases you're going to entity level and the provider, I think you're going to want, the relational data set that doesn't exist very well currently in the market that relates the individual provider information and the entity level information. It's complicated but it needs to be done.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

It does and I guess again, my concern is just that we don't drag down the simple and useful piece with the complex piece, which may take a while.

Dave Goetz – OptumInsight

I understand that.

Lawrence Garber – Reliant Medical Group

Okay.

Dave Goetz – OptumInsight

But, that's not that intense a build, it's the gathering of the information that's the long pole in this, it's not the build of the data set or the data structure underneath it.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Sure.

Lawrence Garber – Reliant Medical Group

Are we okay with the query piece here?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Let's see here, so...

Lawrence Garber – Reliant Medical Group

And should this be a core measure, but I'd say probably not because... unless we put exceptions in there.

Dave Goetz – OptumInsight

Right, it doesn't exist anywhere.

Lawrence Garber – Reliant Medical Group

Right.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I think it's okay.

Lawrence Garber – Reliant Medical Group

Okay, Micky, do you think we should stay away from core, keep it as menu?

Micky Tripathi – Massachusetts eHealth Collaborative

I'm sorry, what was the question, Larry?

Lawrence Garber – Reliant Medical Group

This query to provider directory should we keep it as menu or should we consider core but offer an exception?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Well, actually, you know, one of the problems with Meaningful Use Stage 1 was that "test" thing that we had with exchanging records and I think we collectively decided that that wasn't that useful. I wonder whether we should put a little bit more teeth to this.

Lawrence Garber – Reliant Medical Group

I'd be fine with that, you know, if the others are okay.

Micky Tripathi – Massachusetts eHealth Collaborative

So, if...

Lawrence Garber – Reliant Medical Group

Okay, and Micky in terms of the core versus, core with exceptions versus menu in the query?

Micky Tripathi – Massachusetts eHealth Collaborative

I guess it's hard to answer that without looking at, you know, at everything else.

Lawrence Garber – Reliant Medical Group

All right, well we can always leave it at menu for now and...

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah.

Lawrence Garber – Reliant Medical Group

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative

Or, you know, maybe this is one of those 3A, 3B things. So, it's menu then core or something like that.

Lawrence Garber – Reliant Medical Group

Okay. Because this really is core functionality, you know, to be able to query the directory.

Micky Tripathi – Massachusetts eHealth Collaborative

Right and that's what I was thinking without looking at sort of that entire thing, but if we decide as a principle that query has got to be a part of core then this is going to be one of the, you know, the required components.

Lawrence Garber – Reliant Medical Group

Would you have an objection to us putting in that it's a core and that I just add an exception, you know, where no directory exists?

Micky Tripathi – Massachusetts eHealth Collaborative

I don't.

Lawrence Garber – Reliant Medical Group

Okay, so I'll do that and we'll see how it looks. All right, so I'll make those changes and I'll send those out some time, maybe later today, hopefully by tomorrow. All right, so can we move up to... anything else on provider directory before we jump up to the collaborative care communication? Okay, so let's move up to collaborative care communication, it's a few slides up, there you go, excellent.

All right, so again, just to bring this back, the notion is that there are care transitions which to a large degree we're defining as a patient moving to the care of a new provider, you know, so whether that's to a consultant, whether that's to an emergency room, whether it's to a hospital admission, whether it's transferred to a nursing home, whether it's transferred to a home health agency, you know, those are what we've been considering as transitions.

But there are other points in the care of the patient where important clinical information is being revealed or updated where there really isn't a transition based on those other definitions, but communication still needs to take place and that's really the key point to, you know, the collaborative care.

And so what I was trying to bring out here is that there are, you know, these other points in time where important things are happening that communication ought to take place and I was calling them key clinical activity points, and I'm certainly game for any other description that anyone can come up with. I Googled clinical activity points and it really doesn't have a heck of a lot of other meanings, so I think we could at least steal it if we wanted to.

And, you know, the one that the Meaningful Use Workgroup had already addressed was lab results that occur after a transition has taken place, specifically, you know, the use cases where someone has been in the hospital and they've been discharged, and you know, the order, the result of something that was done in the hospital goes to the ordering physician, which is these days typically a hospitalist, yet the hospitalist no longer cares for that patient or for that matter, you know, may not even necessarily know where that patient is.

And that, you know, wherever the transition of care document went after the patient left, you know, this new lab result that just came should probably follow that same path, and so if they went home, you know, and the PCP is the one that got that transition of care document, well then the PCP is going to end up getting this lab result. If the transition of care documents was sent to a skilled nursing facility then, you know, this lab result will follow that same path.

I'm not at all addressing what the message should be, you know, whether it should be a separate type of message, whether it should be something that readily exist like an update to the care transition summary that was sent, you know, I think that those are things that the Standards Committee could figure out, but the notion would be that, you know, at least with that line item is that when there's information that didn't become final until after the discharge that that information is passed along to a person who is now taking care of the patient.

Other points of, you know, key clinical activity points would be that, you know, some of the administrative stuff that may be able to be taken out of here and moved over to the administration side, which is, you know, the process of order tracking, you know, so the order is placed it needs to get, you know, it needs to get approved, an approval needs to be told to the person who placed the order, it needs to be told the person who is going to actually perform whatever task got approval.

There has to be communication around the scheduling, because I need to know that if I ordered something and it may have gotten approved, but if it hasn't been scheduled I need to track that down to make sure that it gets... you know, I'm the one that's responsible, you know, for that failure and so I need to know that it failed at getting scheduled or if it got scheduled in a timeframe that's not appropriate for what I needed I need to know that as the ordering physician and I otherwise these days do not know that information.

And then, you know, when someone arrives for an actual visit most importantly would be if they show up in the emergency room, I mean that's something that we do in my organization is we get notified, I get a message in my in basket saying that someone showed up in the local hospital and that gives me the opportunity in real-time to contact them, the emergency department, and try to intervene in their care to make sure that they get the right care or that they know that this guy has been hopping around to different emergency rooms with the same complaint. So, you know, that's another key point which communication of the fact that they've arrived is important.

At the time of discharge there is the discharge instructions and disposition that are important not just to the patient but also to me to know the patient was admitted from the emergency room or that they were discharged from the hospital to go to a nursing facility and those are also real-time important things to make sure that I can, you know, arrange follow-up for that patient, you know, we do this again in my organization, is at the moment of discharge we actually automatically send a message to care coordinators so that they call up the patient and make sure that they've got all of the post hospital follow-up that they need, you know, and again, this is something that is so important to ACO success.

Change in primary care physician, this one may be... you know, it's a bit controversial and thought is it's really important except it's the health plan that, you know, tends to hold the source of billing truth for who the primary care physician is and, you know, so much of what we do is based on, you know, if we're not the primary care physician we're not going to get paid, and so this maybe something that would have been generated by the health plan and they're not an eligible professional or a hospital so I can see where this one might need to fall off, but we can talk about that.

Healthcare proxy activation, that's not the fact that healthcare proxy exist, you know, healthcare proxy being, you know, a surrogate to act in the place of a patient's decision making when the patient can no longer make decisions. So, even though an advance directive or healthcare proxy may have been filled out in advance it doesn't become activated until the patient is no longer competent and everyone on the care team needs to know when that activation takes place because they now need to know not to talk to the patient, but they need to talk to the proxy who is going to act on behalf of the patient, again, that's something that does not exist in the healthcare system today, which is a huge problem.

And then last thing is death notification, you know, this is something we'd addressed in Massachusetts as a high priority message not that there are necessarily any standards for this that I know of, but again it's the Standards Committee that whack us over the head and say you can't do this, but this is always a huge problem is that people die in the hospital, we don't know about it and we're calling up the patient trying to find out why they didn't show for an appointment or that they're due for their colonoscopy or something like that. So, this is something that would be important to notify the care team when that takes place.

So, let me stop at this point and first get feedback on the general notion of communication at these other points beyond transitions and let's start with that.

Micky Tripathi – Massachusetts eHealth Collaborative

Well, this is Micky, I can start. So, I guess I'm...the question I still have and I'd love if you could, you know, sort of walk through this concern, is, and I think I mentioned it yesterday, is okay so we're not Reliant Healthcare...Clinic or Geisinger or, you know, any of those really, you know, sort of very, very high end settings, we are, you know, a solo or very small practice in Kansas who is... you know, who most of who's patients are regular just Medicare fee for service and I'm a dermatologist or whatever it is. How does...and then thinking about, you know, the Meaningful Use Workgroup, you know, kind of criteria and I'm thinking about the one specifically that's about broad applicability, is this something that we can generally say has that broad applicability across all care settings, geographies and specialties?

Lawrence Garber – Reliant Medical Group

I would say it's actually quite broad. I do have in here notice the known members of the care team. I believe the Meaningful Use Group was pushing more to have care teams identified, I believe that was in one of their or several places in their objectives, in fact, I think that might be in Meaningful Use Stage 2, is, you know, identifying care team members.

Micky Tripathi – Massachusetts eHealth Collaborative

Can I just ask a question on that one?

Lawrence Garber – Reliant Medical Group

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative

So, on that one, just on the base of it is likely to be way beyond the stuff in Meaningful Use, because you're basically telling even a solo practitioner or individual practitioners that they... for whom the business model is now, as you said, the customers where the patients, are not required to be anything like... a care team and more... that way, you know, for those who are not... that way... so it just seems like, I just don't understand how Meaningful Use imposes that on those solo practitioners who are just out there, they've got a patient panel of, you know, 5000/6000 or take the guy from Kentucky yesterday on our... call he's got a patient panel of 9000 so is he supposed to identify a care team for every single one of those when none of those are a part of any kind of sort of accountable care or any kind of value-based community program?

Lawrence Garber – Reliant Medical Group

Well I think the key thing is, what's the definition of care team? And so... and maybe my definition isn't the same as others. My perspective is that, you know, it involves, you know, who is the primary care physician, you know, who are the, you know, who are the known specialist involved in the care of this patient, you know, and then potentially, you know, are there others like social workers, nutritionist, you know, therapist, case managers, I mean those are extensions.

But so, in the case of the dermatologist they're not going to know about any of these other people, they probably don't even exist, but they will know who the primary care physician is and in my mind that's sufficient for this to work as long they know who the primary care physician is then they should be doing some of this messaging that they scheduled the appointment, you know, they received an order or a referral from, you know, Dr. PCP out in Kentucky and when they scheduled the appointment there should be a messaging that comes out automatically from their EHR back to, you know, Dr. PCP saying this appointment has been scheduled.

So, you know, that's... and maybe that does come down to the wording of this that it doesn't necessarily have to be the whole care team but, you know, I think that there are key notifications back to the PCP, you know, referring providers that, you know, would be sufficient, you know, even for Stage 1, you know, for the first stage of introducing this. So, would that make you feel better if we change that to instead of saying care team if we specifically talk about referring physicians or PCPs, would that be better?

Micky Tripathi – Massachusetts eHealth Collaborative

No, I mean, I think that, you know, that can be...it seems that can be handled just by, you know, a relatively loose definition of care team or just by specifying that the care team, you know, is going to be different in every setting.

Emma Potter – Office of the National Coordinator

This is Emma, go ahead. Go ahead.

Micky Tripathi – Massachusetts eHealth Collaborative

Well the other thing I was thinking, so if we went with that then for every particular encounter there is a lot more information being generated and then sent to others and so there is that requirement on the EHR technology to be able to generate all of that and then send it, and then on the consuming end the ability to consume that and integrate it as a workflow in a way that's going to be meaningful and not overwhelming.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

That's exactly where I was about to go, Micky, is that I think maybe my biggest concern of many on this stage of very useful things is that we've got to figure out what to do with this fire hose of information that's going to be coming in.

Emma Potter – Office of the National Coordinator

This is Emma from ONC, the Meaningful Use Subgroup #4, I believe, Public and Population Health has actually put up an objective that allows the patient to designate what lab results or what transitions of care documents are sent to who and so they sort of have it set up under the auto Blue Button function so that the patient can designate that every time I have a lab result or every time I'm admitted to the emergency room I want my, you know, document summary to be sent to my primary care physician, and then they can also set it up as a onetime function, so they can say, well this one time I would like my dermatologist to get this information as well. So, there is talk of having that patient generated data to allow the patient to designate who their care team members are as well as what care team members are included in certain functions of the medical sort of transitions.

Lawrence Garber – Reliant Medical Group

So, my perspective, and my apologies to Jeff, is that, you know, patient directed health information exchange, if we relied on that is going to be a bottleneck, it would be sort of like, you know, I go, you know, write a check and I give it to someone and I say, you can't do anything with that until I go back on my computer and identify where that can be sent and then you can go ahead and cash it. I mean, I think it's a good supplement to a baseline system, but I think, at least my opinion, is that we ought to have an automated baseline system that moves things around and that the patients can supplement, you know, where things ought to go, you know, with that Blue Button technology.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

But, I think Peter brought up an excellent point and so did Micky about addressing how does this come in, because you're right, do I want it to come to my in basket that an appointment was scheduled, absolutely not, I would, my wife would kill me if I did that, she's a physician too, if we did that, but on the other hand, do I want that information stored discretely in my EHR so that I can run reports saying okay who's orders did I place that haven't been scheduled in a timeframe that I'm expecting it to be done, that's the kind of thing that I would want to see.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Absolutely and we've just entered into an extremely complicated realm which I can tell you from experience, because we've just done this between Epic systems only, where we had to roll our own standards to do that keeping of that kind of information in sync between different systems is extremely complicated. And so, we've gone from being able to discretely file at a clinician's will medications, problems and allergies to filing sort of an arbitrary data set in disparate databases.

Lawrence Garber – Reliant Medical Group

But, you know, some of this does link back to original orders. So, if this really was just additional metadata tied to an original order, because when these...you know, for...one of the notions, and somebody brought this up, maybe it's Arien I think was talking about it a lot, was the fact that there should be some unique identifier for that original order that started this whole process of, you know, scheduling a consult or scheduling a PET scan and that that order number should be carried through the documents, you know, so that when there is an approval it ties back to the original order number, when it's scheduled it should tie back to that original number, when they arrive for that appointment it's tied back to that original order number if it exist. When the consult note comes back or test report comes back it should tie back to the original number and, you know, and that is a notion that ought to be part of this even though it's not explicitly written here, you know, it's written in some of the other, you know, the back detail behind this.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

You've touched the surface of what is actually an extremely complicated problem though, Larry, which is...and as you know from implementing interfaces within a healthcare organization.

Lawrence Garber – Reliant Medical Group

Right.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Even within a healthcare organization those things are fragile and interdependent on a whole bunch of other moving parts and we're talking about doing something very similar to that across arbitrary organizational boundaries.

Lawrence Garber – Reliant Medical Group

I mean, it is true...you know, that's a great point and one of the things that we've seen is that, you know, while we placed one order it's a different order that actually gets performed.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Yes.

Lawrence Garber – Reliant Medical Group

A different test or procedure that gets performed, you know, maybe it doesn't have contrast and so, you know, and then the question is, is that still the same thing when you're trying to attach it back to that original order.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

And a solo practitioner's office is not going to have somebody monitoring an error field for all those messages that don't match.

Lawrence Garber – Reliant Medical Group

So, you think that this is a Meaningful Use Stage 4?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I tend to, I think it's all awesome stuff, but I think it's going a bridge too far for this phase.

Micky Tripathi – Massachusetts eHealth Collaborative

I would agree with that.

Lawrence Garber – Reliant Medical Group

I wonder if a few of these could be pulled out as being less complex. So, the order, the administrative piece would potentially have to get dumped and the PCP change, which I think would... do you agree that the PCP change really comes from the health plans and since it's not really... they don't have EHRs that can require to send that then that probably is not going to happen.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, well and also, again a lot of people are, you know, in products that don't require that they have a PCP named, so the health plan doesn't even know.

Lawrence Garber – Reliant Medical Group

So, what if we just focused on three messages, so one is results that come in after the transition has taken place, healthcare care proxy activation and death notification? Might that be something that's possible?

Micky Tripathi – Massachusetts eHealth Collaborative

So, the first one I agree with, I know Peter has some concerns with, but I think that's a really important one. The third one seems pretty important as well; as we talked about in Massachusetts the physicians thought that was really important. Who would that be on, is that just on... I mean I would think the reality is that that's mostly hospital, the hospital would be the source of that information, but I don't know that for sure.

Lawrence Garber – Reliant Medical Group

Most of the time it's the hospital or emergency department that is the source of that but there are, you know, there are a lot of patients who die at home and then it's the primary physician that knows that.

Micky Tripathi – Massachusetts eHealth Collaborative

So, in that case, how does the primary care physician... how do they know that they are the original source of that information in terms of, you know, the healthcare delivery systems knowing about it and who do they send that information to?

Lawrence Garber – Reliant Medical Group

So, in terms of knowing there is a death certificate that gets filled out so it's typically whoever fills out the death certificate. So, there is only one death certificate and so we could add to that by a person who completes the death certificate.

Micky Tripathi – Massachusetts eHealth Collaborative

So, if I just died at home who would actually sign the death certificate?

Lawrence Garber – Reliant Medical Group

Typically they're calling the... they're trying to track down the primary care physician.

Micky Tripathi – Massachusetts eHealth Collaborative

Oh, really?

Lawrence Garber – Reliant Medical Group

Yeah, so exactly and then there may be some communication with the medical examiner in case there is some suspicion, you know, that your wife killed you or something like that.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, right.

Lawrence Garber – Reliant Medical Group

But, you know, and they may or may not accept the case, but, that's just something that's on our death certificate is, was it referred to the medical examiner and was the report available.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, well I do feel incredibly blessed that I know nothing about how this process works.

Lawrence Garber – Reliant Medical Group

Yeah, well after 26 years I've had no choice but to become familiar with it.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I'm just going to address the test results after discharge piece. It's obviously useful and I certainly have no objection to doing it, I think we do need to recognize though that we don't, at this point, and we've got a couple of years to, oh well, probably not, but we've got a little time to create it, but we don't at this point have a good tool for communicating updates. So, we've got a discharge summary document type, we don't have a good tool for communicating an update to a discharge summary, so that's something that would need to be developed and the consumption of that would need to be developed as well, what the right way to consume that is.

Lawrence Garber – Reliant Medical Group

Agreed and would that be something that we would leave up to the Standards Committee to decide how that would work?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Well, we've given them a whole lot of work haven't we?

Lawrence Garber – Reliant Medical Group

That sounds good guys.

Micky Tripathi – Massachusetts eHealth Collaborative

Well, Peter let me just ask is there another... could this not just be sort of, you know, thought of in a different way which would be that well this was something that was ordered internally and so it was within the hospital domain but now because of the change in care setting it should be thought of as an outpatient lab and so it should just be delivered as an HL7 just like other outpatient labs, and I know you had expressed a concern about MPI but I didn't quite follow that whole thing.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, in order for HL7 messages to be received correctly they have to have several identifiers match up and the most important of which is the patient's identifier, so that's kind of as a message header of an HL7 message and if that doesn't match the system doesn't know what to do with that message and it goes into somebody's error queue.

Lawrence Garber – Reliant Medical Group

And the other thing...

Micky Tripathi – Massachusetts eHealth Collaborative

But, I think what happens, sorry didn't mean to interrupt.

Lawrence Garber – Reliant Medical Group

Sure.

Micky Tripathi – Massachusetts eHealth Collaborative

I mean that happens all the time doesn't it? I mean, I know that, you know, lots of practices get stuff that, you know, it's got the hospital name on it and the hospital version of the name and so they either match it up within their own system or, you know, they do something else. It just doesn't seem like lab results delivery has been based on, you know, an assumption of common MPIs in the industry because I mean, I just know that that doesn't happen.

Lawrence Garber – Reliant Medical Group

You know, I think if we focused just on the solution for lab and didn't generalize it to, you know, other tests, you know, whether it's echocardiograms, you know, imaging studies that I think that we would... you know, we'd be sort of hitting a dead end and not really solving the bigger problem and so I do like the idea of having a more generalizable solution for other things that are coming back after the patient has moved on and so I think that would probably be an argument against doing the HL7 approach and using a... you know, trying to figure how to modify the summary of care documents or care transition documents to be able to accommodate versioning and flagging of what's changed and that could then allow the receiving systems to know how to handle or who to tell.

Micky Tripathi – Massachusetts eHealth Collaborative

Yes, that's a great point, I agree, that's a really good point.

Lawrence Garber – Reliant Medical Group

Is that okay, Peter?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, I'm not sure what the proposal is.

Lawrence Garber – Reliant Medical Group

So, I guess what I'm proposing is we don't say anything about the technology and let the standards group figure it out, but I think just one thing is if we do change the word lab to test then that does make it, you know, more generalizable and also probably less likely that HL7 would be the solution because there could be imaging, there could be echocardiograms, there could be lots of different tests that are coming out and that probably the intuitive solution would be to come up with enhancements to this CDA document that's being sent around so that it can do versioning, so that it can flag that there is a change, it can flag what's been changed, you know, who knows maybe how important this change is, I mean, or what's new so that the receiving system will know how to consume it.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

I think I'm okay with that basically except that we have, we've punted on a lot of these things to the Standards Committee. I'm going to be very surprised if they come back and say HL7 messaging is the way to do this. I think what will happen is that it will be some modification to CDA which is on its own going to be very complex, hopefully they'll figure out a way to do it.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Lawrence Garber – Reliant Medical Group

Let's see, time check. So, we've got 5 minutes. So death notification, are we okay, we're comfortable with that if we specify that's whoever completes the death certificate and the Standards Committee can figure out what kind of standards would be used to message that.

Micky Tripathi – Massachusetts eHealth Collaborative

This is Micky, I am, I don't know enough about, you know, all those processes, but to the level that I know I'm comfortable with it.

Lawrence Garber – Reliant Medical Group

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative

I don't know if Peter or others have further thoughts on that?

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Larry, what were you proposing?

Lawrence Garber – Reliant Medical Group

Just that the death notification, you know, be sent by the provider who is completing the death certificate, they send it to whoever they know are members of the care team including the PCP, so it may turn out to be that they're not sending it to anybody, but...

Peter DeVault – Epic Systems Corporation – Director of Interoperability

As long as it's menu and we recognize that this actually does require there to be individual level provider directories that all these PCPs are populated in etcetera.

Lawrence Garber – Reliant Medical Group

Right. And then the question then is the healthcare proxy activation and that's typically the primary care physician, but it could be an oncologist that, you know, for instance is the one that identifies that, you know, or a neurologist that this patient is no longer competent, you know, and that their proxy will be the one taking care of them.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

So, who is the...what's the word I'm looking for... when you get an unsolicited proxy activation message from somebody how do you know to trust that and believe it?

Lawrence Garber – Reliant Medical Group

Well, that's a great question, I mean, since I'm within one organization I... you know, there are typically notes that I have access to that explain, you know, what's going on with this patient and I say, yeah, it looks like it's, you know, time that the proxy has been activated and so I trust it. If it came from outside organizations I probably would trust it, but I agree the confidence is less so.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

And related to that is sort of the policy legal trust fabric between organizations, you know, we hear concerns all the time about organizations trying to pouch patients from each other. I can imagine this being kind of an unfortunate back door for that kind of thing.

Lawrence Garber – Reliant Medical Group

Well it's not... it really wouldn't be for that... and the other thing is it's not truly an order, so in other words, I can receive this and then I can do with it as I think appropriate, in other words, I can decide, okay, you know, I'm shocked that this person has their healthcare proxy activation, I don't believe it, I'm going to, you know, have this patient come in and talk to them and decide for myself whether they're competent to make their own decisions.

I think there actually is a form that's often filled out, but I don't know that this is a standardized form, you know, state-wide or even nation-wide about actually the activation. So, you know, but again, it's really a communication to give me a heads up that this may be what's going on and I can decide whether or not to believe it or trust it and that the communication should probably have enough prominence for me to understand where it's coming from and maybe the standard is that there's also some note explaining why this is justified.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, and know that it's not just wishful thinking on someone's part.

Lawrence Garber – Reliant Medical Group

Right, right, so patient communication to me.

Micky Tripathi – Massachusetts eHealth Collaborative

I know some people who's proxies I'd like to activate.

Lawrence Garber – Reliant Medical Group

Right.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Well, I'm still skeptical about the workability of this one, but if you guys want to keep it...

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I am too, actually, it seems like there's the issue, this issue of, you know, sort of source of truth and to me there's just this issue of again relevance, you know, if we've designated a care team and let's just assume that we've got a very broad and rich care team, now, you know, does every member of the care team get the healthcare proxy notification.

Lawrence Garber – Reliant Medical Group

In theory.

Micky Tripathi – Massachusetts eHealth Collaborative

Maybe that's right and appropriate but is it, you know, therapists and, I mean not therapist... just to be more clear if it's... you know, I don't know who is on that list, there were like nutritionists and, you know, other sort of more ancillary providers and I guess the answer to that is yes, but...

Lawrence Garber – Reliant Medical Group

Okay, I guess I...

Micky Tripathi – Massachusetts eHealth Collaborative

It feels like a lot of noise.

Lawrence Garber – Reliant Medical Group

Okay, I think I'd be comfortable with taking that out as well, you know, I think... I understand there's a lot of controversy and I'd be willing to yank that one as well then. So, why don't we just do test and death notification then. So, really what we're doing is expanding what the MU Group had to include death notification.

Micky Tripathi – Massachusetts eHealth Collaborative

I'm comfortable with that.

Peter DeVault – Epic Systems Corporation – Director of Interoperability

Okay.

Lawrence Garber – Reliant Medical Group

Our work is done. So, I'll come up with updated slides and send them around to everybody.

Micky Tripathi – Massachusetts eHealth Collaborative

Great.

Lawrence Garber – Reliant Medical Group

Any other issues?

Micky Tripathi – Massachusetts eHealth Collaborative

No.

Lawrence Garber – Reliant Medical Group

I think we have to open up to public comment.

Micky Tripathi – Massachusetts eHealth Collaborative

This has been great, thank you.

MacKenzie Robertson – Office of the National Coordinator

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

Lawrence Garber – Reliant Medical Group

Great, thanks a lot everybody.

MacKenzie Robertson – Office of the National Coordinator

Hey, Micky, this is MacKenzie, could you just stay on the line for one minute?

Micky Tripathi – Massachusetts eHealth Collaborative

Sure.

MacKenzie Robertson – Office of the National Coordinator

Okay, thanks.

Lawrence Garber – Reliant Medical Group

Bye.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everyone.