

Meaningful Use Workgroup
Subgroup #3: Improving Care Coordination
Draft Transcript
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Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup, Subgroup #3: Improving Care Coordination. 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 before speaking. I'll now take roll. Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Charlene. Michael Barr? Jessica Kahn? David Bates? George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks George. Eva Powell?

Eva Powell – National Partnership for Women and Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Eva. Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Leslie. And Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Larry. Are there any other workgroup members on the line? And is there any other staff on the line.

Emma Potter – Office of the National Coordinator

Emma Potter, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks Emma. Okay, Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. Again I thank the workgroup; we do have our work cut out for us today. This will be a... what's really a two-part process. First of all, we're going to actually continue the work that we started on Tuesday to refine the objectives and the measures based on the feedback and we're going to use the PowerPoint to do that and we're going to kind of start at SGRP 305, that's the one we were having the discussion on, refine... provide any comments on the objectives and the measures. So the intention is to do that, and I would think we want to be through that, let's watch the time, so we'll have to be pretty quick today, by around 10 o'clock. Then we're going to switch over to the spreadsheet and just look at all the objectives and again, they're aligned with what's in this document, and make sure that we agree with how we've rated these. And at that point we need to prioritize our objectives. So, there have been some objectives that have either been referred to us or referred back, based on discussions with other workgroups and we just need to close them out for the purpose of this.

The next step then will be to review this with the broader Meaningful Use Workgroup and as we all know, Paul then is going to take the synthesis of our work plus the other groups and review it for the first time with the Policy Committee meeting on August 1. The other piece of this is included on the slides. We got some input from John Halamka, but we do know the standards groups are pretty aggressive in taking a look at what's on the table right now and will be providing feedback and again, we'll see some...we need to be sensitive to that as we're thinking through, prioritizing and refining these objectives. And I included that content on the bottom of the slide. So, any questions?

Okay, so... and again, the slide we were working on, and Eva, on this one Christine was working with us on this the other day and she represented your view from your briefing. But, we actually, on the care coordination objective, we just broke it out into two types again, in terms of closed loop information exchange, and, if we're okay with calling it for purposes right now, this closed loop information exchange. This is the ability to be able to track the receipt of either referral results, assuming that an order for a referral had been sent out earlier. Again, that was something we had asked to come out of the quality workgroup, as well as the acknowledgement of the receipt of a care record summary, so that when we get a patient, we actually know that there's a care record summary. And that actually provisions us so that in the future, if we don't get one, we might be able to ask for one. So, Eva, actually what we stopped on was actually the measures, okay, and I think Larry put a point, what we want to do is make sure that we've got the measurement correct here. So, these...right now you had proposed a two-part measure...

Eva Powell – National Partnership for Women and Families

Um hm.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...so I don't know if you want to walk through that and we can kind of agree upon, for purposes of now, what our measure should be.

Eva Powell – National Partnership for Women and Families

Okay. Thanks. And I did touch base with Christine yesterday, so she kind of walked me through the highlights of the conversation. I guess what I was thinking on this two-part measure is, because it is... and I'll preface it by saying, whatever we can do to make it clearer is fine with me, and I think adding the closed loop wording to it is a good idea. But as part of that and in acknowledgement of, I think, some of the points that Larry had made earlier, we need to somehow ensure that people acknowledge both sending and receipt, and of course that is the closed loop. And because there's really two portions to the closed loop, or two main portions I guess I should say; that's why I divided it into two parts. And you could... there are a number of ways that I've thought of that you could go about this. But I think the least, or the most palatable for most people would be to continue to hold an individual person or entity accountable for both and, if there's a way to automate the acknowledgement of sending, then that would be great. Because I can see from a process standpoint that that might be a relatively easy thing to automate and then not have to check a box or somehow do a bunch of clicks or something to add burden to providers. But consistent with the discussion we had about it's not enough just for the information to go into the EHR, that what really matters is that someone has taken a look at that, that the receipt acknowledgment needs to be something that indicates that the content has been viewed. And so, I think that that's my intent, or the reasoning behind what I put.

What I'm not clear on is how we could do that acknowledgment of receipt in a meaningful way that's not burdensome and ultimately not really meaningful. But I know that Christine suggested that there be some way to automate the fact that inform... automate the acknowledgment by tracking whether or not pieces of an incoming document were embedded into the, or integrated into the EHR, which I like that idea. I guess I don't know enough about the typical processes and workflows or the likelihood that that would happen for pretty much any... that something should be integrated into the EHR from pretty much any test or result. I don't know, I guess that's maybe what we need to discuss. Is that kind of where you all left off?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So this is Larry. Let me jump in with two thoughts or questions. One, I like sort of this process we're in now of kind of thinking through so what actually is the workflow process on the receiving side, so we can talk about what part of that we want to measure. And maybe that's the productive way that gets to my second piece here, which is, I'm still puzzled by the automate/not automate and the distinction that's being made with these two measures. So, maybe it makes sense to actually walk through the wording of the measures and make sure I'm putting my pauses and commas in the right places because maybe I'm just confusing myself with how I'm reading them.

Eva Powell – National Partnership for Women and Families

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I don't know what you think is a more effective way to pull us together, given that we've probably got about another fifteen minutes to sort this out.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And the other thing, as Eva walked through...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And this is... can I ask one question, this is Paul...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...that and I just want to throw one other thought out there, rather...in terms of looking at it, as we look at our next measure, there's reconciliation, right? So are we measuring the same thing? I mean, what Eva said was, she wanted to be reconciled. Now how many elements are reconciled is a whole separate issue, right.

Eva Powell – National Partnership for Women and Families

Yeah.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So... what you... so, the suggestion is that if reconciliation happens, then that is an implied, "I got the information and I did something with it," and that could generate a response to the sender.

Eva Powell – National Partnership for Women and Families

Yeah. And I think, and Christine and I also talked about that when we talked before the call that she was on. And what I wasn't clear on was whether that actually got at what you were hoping to get at Larry, of this notion of both sending and receipt. I can see how it would, in cases where there needed to be reconciliation. And maybe those are all cases, I don't know. I guess I just wasn't really sure that that covered us with the full intent of the sending and receipt.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, this is Leslie. And the syst ... so there's a couple of workflows, right, automatically when you send information into a system, there is just a system acknowledgment. Then, when that information is put in an inbox in EHR at that time, then the question is, does that get accepted into the record and we're trying to measure is it accepted into the record or is it acted upon, which is Larry's point. Accepted into the record, today we don't have a good way to say that's a duplicate. And so, some things don't get put into the record, because it's a duplicate. So, I think to get to what is it we want, we want it somehow to be incorporated, when material, into the clinical reconciliation process, or into the care coordination process. So, how do we, and maybe we don't have to get that finite in this stage and we just simply say, we want receipt of information to be acknowledged and use to be measured.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

On this, can I just ask one question, this is Paul Tang. I joined a little bit late, but is the slide on the screen what you're talking about because I hear discussion about referral and the roundtrip and that's not what the slide on the screen says. So, I just want to make sure we're talking about the same thing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we are making the assumption Paul, we're trying to do close the loop and create a tracking function, okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But is that...

Eva Powell – National Partnership for Women and Families

So, we're on 305.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

305...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, could someone move the slide...?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We're on a different slide. We're on objective 305, right. There we go.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

All right. And I wanted to make, you know, like... here was where... it seems like reconciliation gives the use of the data. The piece that I was trying to set up here was kind of if you have to at least track that you got a transition and/or you got the referral result, systems then will... when the order goes out, will have the provisioning to know the order went out, it should be for 90 days and that we actually got it. So, I was really intending with this one, more so than going after use, was to really just make sure that that tracking and status mechanisms were starting to be set up in systems, so that when they went out... because then you can start to build-in did you get a transition of care and that kind of thing. So, it starts to build that infrastructure in...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, if that's based on an order, that infrastructure exists today. There is an order and an order acknowledgment. There is a results and a result acknowledgment. So, that's there today, that says the system has received it. And even if an order is placed and you use that mechanism, which is the easiest way to do it, to acknowledge that something has been ordered and the receiving system where the order is sent, receives it and acknowledges it. When an action is taken where there's some sort of order result that takes place, then that is sent back to the system. So, that mechanism is in place, if we say the referral is based upon an order, and that's easily tracked and probably would get very little objection.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, let me jump in with, there are HL7 version 2 messages that do that, but my experience is, they only get implemented for high volume things like labs, and that for lower volume things, they're often not implemented, especially when they're crossing provider organizations.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And I'll just add...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

...you're right Larry, so I think if we say that you have to use the infrastructure, there's not a lot of programming or pushback we'll get.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Oh, there's a huge amount of programming and pushback. Getting the workflow transactions to work right is a huge, labor-intensive effort.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, I would say Leslie there are no acknowledgments back to the humans, there may be, as Larry mentioned, an HL7 acknowledgment, so let's not confuse... I think what you're asking in this measure is a human acknowledgment.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so that does not exist at all today.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

The only...

Eva Powell – National Partnership for Women and Families

So, this is Eva. I just had a quick question. So, if the human's not getting the acknowledgment, who is? I mean, if there's a...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Nobody.

Eva Powell – National Partnership for Women and Families

...an acknowledgment of the result, then who's getting it?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Nobody.

Eva Powell – National Partnership for Women and Families

So where does it exist?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We got into testimony that the infrastructure to be able... like Paul said, these are sent out, and Larry said, and what we wanted to do was get the infrastructure to send out and use the standard to do referrals as well as to get the information back, and to set the mech... and I agree that many systems have that tracking piece in place. But, it is not routinely used and you need that infrastructure to be able to... you need to be able to track. It's an important piece of it from an individual system, did I get a transition of care summary, did I get the results back for a referral and manage from that perspective. And that's what I think is really the point.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, I think then there's two...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

But my sense is that we're shifting our technology base here...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

...we're using the technology base of PDA...of clinical document architecture of moving documents that are a higher level summary that have less rigid workflow around them. And we're looking to put in play some kind of minimal workflow that won't bring with it a huge amount of implementation overhead, so that you could send a consult request that was not as, I don't know, not as, I don't know, not as in the workflow details as most of the HL7 version 2 messaging is; and then allow a response to come back as a document at some point down the road.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So Larry, would a good way to restate it, build the infrastructure to manage the technical piece like the orders, but then also saying that there's an expectation when this order or a consult for referral takes place, that the sending individual gets back a copy of that consult report.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, that would be a way to measure both receipt and use by a human. When a referral takes place, upon completion of the referral event, a consult report... a report is sent back to the originating physician.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. So while we're on this thought, so yes, I agree, it should be the consultant who's now on the hook to generate the response, and is that the piece we want to measure, does the consultant generate a response.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think that's wonderful.

George Hripcsak – Columbia University

So, this is George. I think the important thing right now is to be very clear what this thing says, what we mean by it, and then it's up to the larger group to decide whether it's feasible, a) to have the providers intervene and whether the technology's feasible. But right now, our main thing is just to be clear so everyone when they read this says, okay, I understand, what I need is, I need HL7 to go between two different vendor products, I'm going to need a human being to say "yes, I got this referral," for every referral that comes in. If they understand that, then they can make a judgment and prioritize it and say this is Stage 2, 3, 4 or low priority or high priority.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, this is Charlene. I hear, there are two proposals kind of on the table. Again, so the provider acknowledges receipt of the referral results and summary, and again, it could be in the work list and it could acknowledge it. Or, the objective is, provider, upon receiving a referral request, provides the result back and receives acknowledgment of that for a percentage of patients. So, it's reversing the measure to make the person who's receiving the request accountable.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Ah, okay, so I'm hearing now, both sender and receiver are being measured here, is that correct?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right. So the sender is measured by when the referral was sent and the receiver is measured by their response and action upon referral includes reports back to the originating physician. Then we get everything everybody's asked for.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, to reiterate that, we're asking that when you get a referral request, that when you do the... when you write your consult report, that you're on the hook to send that back to the person who asked for it.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And they're on the hook...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, electronically, yeah electronically in that space, right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

...to do something with that when they get it.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right. I think that that gets to both so it's... and you could easily... so then that way you can measure that yes, a system got it from the originating person, there's been an acknowledge of receipt. And then... but what we really want to measure is that once someone's gotten it, they've acted on it and they have a burden of the report back. I think it's a both/and.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So why... let's try to make sure we're focused on a problem, one, to solve and not overburdening something that the individual already wanted to have happen that isn't happening today. So, the closed... so the two pieces when it comes to referrals, one is the specialist is expecting to get information needed to make their consult valuable, what's the prob... what are you asking me and what information do I need to help me provide you that answer, that's the efferent arm, the outbound arm. On the referee's arm, they want to get back in a timely way, the referral results. So, I think this objective, 305, should be measuring the specialist's reply to... response back to a referral request, which is referral results. So, the specialist is the one that should be accountable for returning results to a referral request. I don't know that you need to burden the referring provider saying, "oh, and you must say you got it," that's a feckless measure; they want to get this, we don't need to measure or force them to want this to happen. Do you see what I'm saying?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, and I think to follow on with Paul, what he's saying is I think then reconciliation should give us that other lever to make sure that its looked at.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yup...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't think you have... looked at by which party?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The receiving, they're concern... the concern Paul is that what's sent in won't get acted on, that's...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

What is returned won't get acted on?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Either the summary that...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...goes over and/or the result that comes back won't get acted on.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But the person who referred has the vested interest in getting the information back and doing something with it. I don't know that we need to be in the business of prescribing workflow.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, I think a good example of this Paul is, and I think this is the one that Larry was most concerned about is the issue of labs. That lab results for a patient who's no longer in the healthcare space, often get lost and are not acted upon and so that's one example of even though yes, there's a vested interest, just the nature of a healthcare provider setting is that life moves on when that patient is not physically in front of you. And it really... and we need a way to prompt action when there are results coming in for patients who aren't physically in front of them.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But that has... let's say, inside a system of course, people get results in their equivalent of an inbox, and it is the professional responsibility and the organizations responsibility to make sure that those results are reviewed and acted upon. That's a legal and a professional responsibility already, so meaningful use of EHR doesn't have to be also another Board of Medical Quality Assurance, do you see what I am saying? I don't think we need to try to enforce professional affairs, I think we need to make sure the EHRs provide the functionality that people can do the job they want to do.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And this is one of the ways for not... for parsimony, so we don't have to expand out to professional affairs, we just have to stay with what can we do to make sure the tools equip people to live in the new world.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So Paul, I want to support your focusing in on getting the referral response back, getting the report back, from the consultant. I think that's sort of the ninety percent value in this particular one, and I don't want to lose that in the thinking around the edges.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And that's a really good way to put that. If we get the ninety percent, that's the job we're after because that's the parsimony, we don't need to work on the 10%, in particular, we don't have to go out of scope in terms of what's meaningful use of EHR supposed to do.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. So Paul, so if we rewrite the measure, you know, providers upon receipt of a request for a referral provide an electronic referral result, and again, we've got to kind of keep that real general right now.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So what I would do is work on the outcome base. You don't need to track every step of the process, you don't have to say, "Ah, got it, now I'm going to act on it." The result is what's missing today, particularly in the paper world, and in the electronic world; that is, the person who asks for a consult gets the results back.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The provider send is all you're saying, right?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Pardon me.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, but do you want me to close up the loop at the receipt end or close the loop at the sending end?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

At the sending because it's the specialist, it is their use of the EHR that makes the result, you know, go back in an electronic and efficient way, back to the requestor.

(multiple speakers talking over each other)

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...report results, right, is that kind of what you're saying?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it was garbled.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie. If a specialist isn't today a meaningful user, then what we have to measure is that the meaningful user receives the referral results electronically.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

No, we're not...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

No, we're...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Go ahead Larry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think what we're... yes it's true that if you're referring to someone who's not using an EHR, they're not going to respond electronically. And that's really out of scope of what we're trying to measure here, right. I'm not a meaningful user, they may or may not respond, that's up to local peer pressure to make work. If they are a meaningful user though, we're saying as part of demonstrating meaningful use, you as the specialist will be measured on your ability to send back the results, and that that's the closing the loop that we're asking for here.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. And that the... now the EHR in both... on both sides, need to concern themselves with how do you do it, particularly across organizational barriers, which will happen frequently in this case.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Paul, the measure would be something like, provider sends referral results, what... EH, electronically for 10% of the patients referred during the reporting period or something like that?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Ah, I think I heard you right, yes. So, you make sure that... that's correct. So, you're measured...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I left the generic referral results electronically, because I'm not saying how...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...and for 10%? We kept it low because we wanted to get it started.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Now, okay, so let's say it's going back to... so you're saying 10%, did you mention electronically, so let's say it's going back to a non-EHR user then, of course, it's going to go back on paper some way.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

A smart way for the EHR, the specialist EHR vendors to do this, and I think many of them do, is to essentially transmit that to a fax number, and so you actually can track that yes, this went out and it went out by fax. But the main thing is, you can track that that went out. It has to either go electronically, go by fax or by printing; so one of those three things needs to have occurred, and that indicates just basically of sending something back.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And I guess Paul, by describing it that way, it no longer is a question for the specialists to figure out how to send it, they just write their thing, say I'm done, please send it and figures out the method.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So, right. So the smart way to do that is to have a list of all your referring providers in your EHR and it goes the preferred mechanism of getting it back, and the system will say, opp, got one for Dr. Smith, and it goes bang, which one.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So do I... okay Paul, that's a jump, by preferred communication...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, so I think that's a nuance. I think what we can... that's how the provider would use it sufficiently.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I know I totally am with you. So, again...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I don't think we need to address that, that's the how, we don't need to address that.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the how, we don't have to do that, but...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so how do you want me to... because we're time crunched, how do you want me to, I going to be real concrete, how do you want me to write this measure. So... I drop the acknowledge one for the purposes of this discussion, right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And I just have a very simple one, which is provider sends referral results. Again, I took the workflow out, electronically and you mentioned those other nuances...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well no, so I wouldn't say electronically, is returns, returns the referral result to the requestor. And you can say (e.g. electronically, via fax, via printout. I mean, that gives people the understanding that yes, I mean, if you cause this to be printed and mailed, that that's fine, if that's the way they either want it or the only way they can accept it; but you're getting credit, so the calculation would be performed when one of those three things happens.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I would add direct or add secure email to that as well, if we're giving examples.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well, I'm keeping it just... okay, well direct implies, I don't think we should say direct...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, we said electronically.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

...but... so I think it's fine to have that in a list of examples, but I don't think we should have it in the measure itself.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct, correct. We're just telling people so they... so we're basically pre-empting question, well what if the sender doesn't have an EHR, we're explaining that paper is okay for this time of the world.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so, what I have is, EH... whatever it is, the provider returns... we can change that, provider returns the referral results to the requestor, i.e. electronically, fax and/or paper for 10% of patients referred during the reporting period.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Eva Powell – National Partnership for Women and Families

This is Eva. I think we should designate something about the results, I mean, it kind of goes without saying, but not really, that the referral results on the specialist's end need to be generated by the EHR. I mean, I'm real uncomfortable with being okay with all paper in an EHR incentive measure.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...pre-space for verification requirements if the system could do it, you know.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So, that's where I think, so in the paper world, it would be printed, because then it obviously has to be... I mean yes, you could say they could go put it in a word document, but that's sort of a silly...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well, so, but the not silly is that specialists might very well dictate their consult reports, right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

...and then that printed...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

The presumption is that that's being picked up and incorporated into their EHR.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, right. So then, so, Eva's... I think we're just adding a phrase then Eva, right? So, 10% from the EH...yeah...

Eva Powell – National Partnership for Women and Families

The way I wrote it down on my paper was, for 10% of referrals results generated from the EHR...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

...EHR, right

Eva Powell – National Partnership for Women and Families

...sent to the referring provider, and then you can add whatever... in whatever format...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so you got it, like because we're... Eva so, read it from the top then, so we're all on the same page, so that...

Eva Powell – National Partnership for Women and Families

Okay, I put, for 10% of referrals, results generated from the EHR are sent to the referring provider, and then we can have as clarification in the format preferred by the referring provider.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But we don't have to do that part because...

Eva Powell – National Partnership for Women and Families

Well, just have that in the notes or something, or leave it out entirely.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, because we gave the e.g., right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I had... yeah, I had e.g., I was trying to...

Eva Powell – National Partnership for Women and Families

Yeah, yeah, I think that's fine.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, Emma, do you have that?

Emma Potter – Office of the National Coordinator

Um, I have a question. Are we doing 10% of referrals for patients... I think I am a little confused as to...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Eva, start from the... I have 10% of patients referred, but let's get it and nail it. So...

Eva Powell – National Partnership for Women and Families

Well, what I have written is, and if we need more specificity then we can figure it out, is for 10% of, maybe we should put all referrals, results are generated from the EHR and sent to the referring provider.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And I just left it 10% of patients, because this is the current measure, referred during the reporting period.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So, for 10% of patients referred or transitioned...referred, what's or transitioned...

Eva Powell – National Partnership for Women and Families

Yeah, that's better, to be consistent with what we've said before.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

For 10% of patients referred during the reporting period, referral results are returned to the requestor, (e.g., electronic...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...electronically, faxed and/or paper was what I wrote.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Or printout, we can be specific, so it's just in scope.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

However, we've got to keep in the scope which is that the referral is done electronically from the EHR, a referral from an EHR.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Because we don't want to measure faxing, it goes back and forth.

Emma Potter – Office of the National Coordinator

So I have, for 10% of patients referred during the reporting period, results generated from the EHR are returned to the requestor, i.e. fax, scan, printout.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Instead of i.e., it's e.g.

Emma Potter – Office of the National Coordinator

Oh, e.g., sorry.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Now that sounds about right, right?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. So, we're good to go for right... we know we're going to refine upon this, but, we closed the loop. Okay, Paul, I know we'll be back to this because there's actually some good input from other groups, but, we'll keep moving. I wanted to move on to...are we good with this?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yup.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yup.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. The next one we wanted to move on to was, this is...

Emma Potter – Office of the National Coordinator

Oh, this is Emma, quick question. For 305, for the objective, are we including refer orders and consult reports and just lab results and not summary of care, or all three of those bullets?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Where are we?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

At the 305.

Emma Potter – Office of the National Coordinator

At the 305 objective, I'm sorry.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We were actually tracking, if a transition of care, we can leave that second one out Paul?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I don't think your bullets are matching the measure any more, we should fix the objective to fit the measure.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, so just drop the second bullet for purposes of now, okay.

Emma Potter – Office of the National Coordinator

Okay, so just referral and consult reports.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We're just going to close the loop on a referral right now, we're keeping it simple and then...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...I think we'll get feedback that will expand it back, but let's for purposes of this, close the...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But this is one of our top requests...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is a tough one, right?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

...and you can measure it fairly simply, so, that's a good thing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup.

Emma Potter – Office of the National Coordinator

Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, just one little objective and one little measure now.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah for simplification.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right, parsimony.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, yeah.

Emma Potter – Office of the National Coordinator

Okay, thanks.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Now, this next one is 302 and this is the one, again our intent here, Paul, is to try and create a fairly robust, recognizing that once this care record summary comes in, we're going to want to reconcile more content with it. And we today have a recon... and we're making the assumption, that by Stage 3, they'll be more of medication lists coming in from these care record summaries. So, the medication reconciliation process still is in place, but again, it's going to become more electronic by Stage 3, so we wanted to expand this out to also include... we started to have a discussion around contraindications and medication allergies, to pinpoint intolerances. And then we wanted to start to begin the reconciliation for problems from the problem list. And we decided to keep, for purposes of this, we're not sure where med reconciliations going to end up in Stage 2, so we left it at 50%, because we know it's still a pretty hard process. And then, asked for 10% for the other types of clinical reconciliation. So, that's what the intent of what we're trying to do here, and we felt it was important to start to reconcile problems, because they're really important for establishing a care plan.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, and I think this is an intent we've had for quite a long time...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

...and I think you're trans... 10% threshold is a reasonable thing to start with. I think we'll get a lot of pushback on contraindications, one because it's not well defined and two, it just doesn't exist in any record. So, this might be something you want to put on for Stage 4.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, and I would agree with you that, I've already got... the reason I get its pushback, well sometimes contraindications are problems, you know, and sometimes they're derived from intolerances and then you find out what it is, so...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, there's two things it's actually saying. It is one of a placeholder for when we... well, actually, contraindications may be too strong... but we currently still don't even have med intolerance versus allergy.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And that might be something you want to separate out still for Stage 4, so that vendors start working on this. But that is something everybody is using med allergies just to stick something so the computer will remind us of something, and that's not appropriate.

George Hripcsak – Columbia University

So, I would say I agree to separate it, but for those medications, we're already doing, so that's that Charlene.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Columbia University

Number two is allergies, because that's already in meaningful use, it's just a matter of the next step being reconciliation at 10%.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Columbia University

So that's kind of a no-brainer for the next, as far as I'm concerned. Then you could put problems next, although I think they'll be a lot of pushback on problems because it's a lot harder than it sounds, because it's more complicated because different people use problems in different ways, in a way that's not true of allergies. So, that has to be separate, and I think it's okay to put it forward now, but we may get pushback. And then as Paul said, the next one, the fourth one, I don't know if you want to put contraindications and intolerances at Stage 4, just because no one's ever collected it before. They're kind of two different things, you know, is it a problem with the word allergies for medication and intolerances and expansion of that or intolerance is a new thing, I don't know.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. The testament we received was that the intolerances were often around a patient intolerance, right; food intolerance, procedure intolerance and so starting to collect that data was very important.

George Hripcsak – Columbia University

Okay, so next then would be contraindications.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And I think... what I don't see which I thought we had in here, which I don't see anywhere, is the patient generated data side of this that a patient... that we wanted to start setting a stage for the patient to be able to be part of the care team and entering and providing that information, and somehow that's gone. So the first point is, I think intolerances should stay, because it's a concept of patient intolerance and we start to gather things like nutrition and dietary and procedural, but then the other question in general is I don't see where the patient generated data is anymore.

George Hripcsak – Columbia University

So there's gathering and reconciling, I'm worried that we can't reconcile what we've never gathered in a single step. So that's why maybe what we need to do is start gathering... we need to define and gather contraindications and intolerances, which are a new concept or two new concepts. And then patient generated data, is there another place in patient engagement. Are they doing any of this in patient engagement, just double checking?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes they are. So...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

We are.

Eva Powell – National Partnership for Women and Families

This is Eva, I think the care coordination piece of that, that definitely is a great opportunity for patient generated data, which really should be a crosscutting across all policy priorities, is the notion of correcting errors. And that is the first case that we talked about doing, because basically to George's point, if they're correcting mistakes in their record, then obviously it's collected and it's just providing some way for them to electronically note that there's an error in that documentation.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

In fact in the testimony remember we heard, I think it was Dartmouth that talked about the patient just being able to correct the meds that they were on was a really important part of the data they entered.

Eva Powell – National Partnership for Women and Families

Right, yeah, and that actually, I mean, how can you do... how can you really do med rec without input from the patient. So, there's two opportunities here. One would be to keep meds as we've said, but to infuse input from the patient in that and then the reconciliation of the correctness of the medical record by allowing the patient to correct mistakes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I think that having it in the category 2 is a good place, instead of putting it into two places. And the way that would happen is, you would take... any one organization would take patient input and correct their med list. Then it gets reconciled with other organizations in this process we're looking in front of us. But, the patient's input isn't coming at this reconciliation phase, it's coming at a reconciliation with an individual's perspective, one entity, one organization, one person. Do you see what I'm saying, I think we already have it in patient engagement...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

...and that's a good place to put it, and it'll then work its way through this process separately.

George Hripcsak – Columbia University

So, I guess I have this image occurring that instead of showing up at the doctor office and being handed a clipboard with a blank form, I get handed a tablet that has the last things the doc office knew about me. And I can go through and I can do equivalent of reconciliation; I can say, "Oh, I stopped taking these three meds, there's another med I'm taking that some other doc prescribed, I added a supplement for this stuff." So, I could do a reconciliation process as a patient.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct, and...

George Hripcsak – Columbia University

...and I guess what I'm hearing Paul is rather than treating those as the same, you're suggesting that we specifically put that under the patient engagement piece.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly, and that's in fact what happens with our... for us right now. It doesn't matter whether it's in the tablet in the waiting room, you are reconciling a provider's, wherever you are, in your example it's the waiting room of that provider. You're reconciling that provider's med list and then that corrected med list works its way through this process we're looking at.

George Hripcsak – Columbia University

That's okay by me, because I think what we were doing is confusing two uses of the word reconcile.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup.

George Hripcsak – Columbia University

And so this is a formal reconciliation process between two EHRs and the other is like a correction kind of reconcile.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

George Hripcsak – Columbia University

And that's listed above in group two.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, and again, as this functionality is built, I think what Paul said is just kind of a natural outcome.

Eva Powell – National Partnership for Women and Families

Yeah, this is Eva. I think I can be okay with that, I'm just wondering though if it's stated that explicitly in the patient engagement objectives and measures. I haven't looked at the most recent...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, I think we can reconcile that later, but also, back to Larry's point, I think it was, separating out making sure we still capture intolerances so there's a collection phase and measure that, and then there's the other reconciliation phase, somehow in here.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, my...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Where in general though are we putting the patient as a care member, have we done anything or are we counting that all in patient engagement team.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think it might actually be interesting, maybe in a comment here, to talk about one of the sources of the information being reconciled could be patients.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But that's what we're saying already happens with any one entity, this is a multi-entity reconciliation process. See what I'm saying?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right, then which entity right? So if we...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Wherever you are.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

You've logged in somewhere, or in Larry's example, you're in somebody's waiting room, and you're trying to fix that person's records and then it percolates through, this is a multi-organizational reconciliation.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right, but it's passed forward to the future, the patient is one of those reconciliation points, even if they're at home. So, I think that it's just adding in that field, as Larry suggested, that the patient could be part of that helps to set the stage for the future.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

You're just at the wrong point in time in the workflow, so the...

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Whose workflow? If the patient is an equal care team member and the patient now is taking a new over the counter drug that has some relevance to the care, they're an equal member, so it's...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Leslie, it's coming at the patient engagement stage, so their input, there's a diet... there's only... there's a person doing a reconciliation. The patient can be one of those people; we've captured that in category 2...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

(indiscernible)

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

...we're now...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Fine.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So we'll make sure that we do have that wording right, but that has been already suggested for category 2.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

All right. So where I'd like to leave this, and this is just for purposes of putting...getting something on the piece of paper, recognizing we'll have to continue. I would like to change this to medication allergies and the drop contraindications and intolerances because there is a requirement under quality to capture contraindications. I don't know if it has intolerances, but it has the same feedback, but I know that David Bates captured that as one of his data elements. Would that work so that we've got it provisioned for Stage 4, in terms of reconciling it? So the data capture piece, and again, they'll have to figure out how they're going to capture it, would happen in Stage 3, but the reconciliation process then would happen in Stage 4? That work? So, it would read, medication, medication allergies and problems for Stage 3. That's a big jump.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a big jump, and it's a good thing, but we'll get pushback, like you said, with problems.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we will get pushback.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We'll see what happens with problems. We're just putting it forward and then we'll get feedback.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. And we were going to... and it has been referred, contraindications, to David Bates and he does have that in his matrix, and he got the same standards feedback that we got back, which was, there's no standard for this. So...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And that's why we pushed it into Stage 4, is we have to start working on both the standards and the function.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And I assume the standard here is the data standard, we're not looking to standardize the reconciliation process.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It's the data standard, yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Good, okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Just checking.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I actually...with that, Emma do you have that one?

Emma Potter – Office of the National Coordinator

Yes, I have that one.

George Hripcsak – Columbia University

So, Charlene. Charlene, before you...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We have to correct the measure to reflect that.

Emma Potter – Office of the National Coordinator

Okay.

George Hripcsak – Columbia University

Charlene, before we go on, can we go back to 303 for one second, I have a question about it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, 303.

George Hripcsak – Columbia University

The first one in this group.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, I was going to go on...

George Hripcsak – Columbia University

The...you were what?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup, 303.

George Hripcsak – Columbia University

What was the... I kind of got lost there, we went through. What's the measure for the second bullet, provide updates with supplemental information?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That's a great... I didn't know how to do that George.

George Hripcsak – Columbia University

I'm not sure how we can do a denominator, like, how are we going to measure every update to every type of information and how will we know when it's an update sufficiently imports that it has to go, or are there ever any updates that don't need to go...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I...

George Hripcsak – Columbia University

...entire record, so I'm just not sure how I would measure this.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Paul, the intent was to provide the inform... it's the request... the change we're making is we want the information on the care record summary as soon as it's available and if there's an update, and specifically like to a lab test, we want the update. That's really what we're trying to accomplish.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So in a sense you're subscribing to update, that's a big... there needs to be some way for us to start introducing that concept into... is there a standard way of doing this Leslie? Is this already something that you can keep... you know, how would people keep track of one update and to who... and two, to whom those went?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Well right now, if you just take like a path report and a lab, right, I might do a lab order that includes both a lab result that's just a simple blood test with a... but included in that order is a path report, so something has to grow for two or three weeks.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And so what happens today is the order that's generated then generates subordinate orders that are linked back within that... the top system and as updates come back, they go back to the originating order and they refer all the children orders or the subordinate orders back up. So, routinely you'll get a result back into an order, and it will reference it all the way back up to that parent.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So that...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

That is just today, and so, it... I think building upon that is what we're trying to say; is look, we acknowledge that not everything is ready immediately, but systems in place show that as a new result happens on that originating order, that result can go back to the original.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, but that's easy to implement because you hang on to that order ID from the requestor. We have a completely new and much more challenging situation of we now don't... the folks who we may be sending information to, like the summary of care document, don't have a numbering system for us even to understand how to tell you, "hey, I've got an update to order X," and those folks are not hanging on to this order, because that's defined at the local level, right. I think while the concept is good, we need to find a way of signaling it without making it part of Stage 3.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Can't you build upon the same order model? If you refer... today, when you do a referral, to do an order for that referral, and it acknowledges that there is a result expected and that result would come at a later date. It would build upon that same infrastructure. Because that's how it's handled internally now, right, if I do a referral internally, that's what I got. If I have a discharge order and an admit order from an internal hospital to my long term care facility inside my hospital on the third floor, I have an order processed that handles that referral and that referral management.

Paul Tang, MD – Palo Alto medical Foundation – Internist, VP & CMIO

Right, but that's all inside of one EHR. You know how we have...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

...to do it, you do it outside... you can do it outside that, too.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

If we have unique identifiers, so just like we have a unique plan identifier, we have a unique provider identifier, we'd almost need a way of making a unique order identifier. That's possible.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right, it is, because it adds the entity name and it adds the... right, so that infrastructure is there, we just have to build upon it.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I get a unique order number when I add the ID number of the patient and I add also the entity ID...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Paul.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't know that all ques...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Paul, I think you're right. I think you're right that this will be a big stretch for the vendors to know what changed...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, huge.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...and to be able to track it and send an update, I agree with you. I think...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So every...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I think we should signal it.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But guys, it's not like we're asking something that there's nothing there that they can build upon, we're...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But Leslie, think of the... all these Quest Labs and stuff, they don't have unique identifiers do they?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah. I got a unique identifier when that comes in, and I send it back... and I send that lab result back, I do. Now, sometimes if the physician doesn't have an EHR, my result goes back to the physician, it doesn't go back to a patient identifier. And even if I have labs sent from my hospital to Quest Labs, right, when the result comes back to me, it comes back as my results, Leslie's... Dr. Hall's results coming back to me with then subordinate to that, the individual patient's name, the test and so forth. So, there are two mechanisms that happen, either it goes back to an ID to the patient, or it goes back subordinate to the physician.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, but we're in the context of... this is a care record summary, and in that, when I send a lab result, I'm not IDing that today, I'm not linking it. On the HL7 transactions, those identifiers exist. So all of a sudden I've got to keep track of the context of what I sent and measure variation to it, to be able to send this update.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That's tough. I don't care whether we necessarily do it that way or not, because there might be a better way to do it, but for the context of this... the way we've got this defined, if it's an update to the care record summary, which we agree, it'll be... you know, there's a lot the vendors are going to have to figure out to be able to do that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But they have to do that whether the summary of care record is internal or externally sent. If I have an update to a...if I'm sending my labs, I send a lab at discharge. I'm now doing a summary of care document at discharge, my lab result is not in. There still has to be a mechanism to get that additional information.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah. You're right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

It definitely exists, so, what if we...so pick a method, we want to make it a Stage 4 so that people start talking about this?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

No, because if our whole thing in Stage 3 is about care coordination, and we don't have a measure on this, what have we done that's different?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

We've got to move this stepwise Leslie, we can't do everything at once. And this is completely new and it requires an infrastructure that we're still trying to build, which is this whole HIE. So, by putting this in Stage 4, we will definitely start the discussion and we'll start finding all the things that have to be put in place standards-wise, technology-wise, infrastructure-wise. And that's sort of what... part of the purpose of the program, but it's not to force things that can't be done on a broad level.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

How about a menu item then for the... that allows optionality and with that, then that infrastructure starts to get formed as people want to have it active in that menu.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Menu is required for all the vendors, and then you have parts of your... let's say your... area has it in parts. So it's just really... a menu is, you've got to be already... a menu is almost flexibility because it may not apply to this specialty for example, but it has to already be broadly applicable, otherwise it causes a lot of burden. That's what we learned in Stage 1. So, putting it in Stage 4 is truly a signal, it's not a commitment, but it starts the discussion going. And maybe there needs to be a separate track for vendors to be having these discussions and providing their more ongoing feedback. That might be a useful add-on. And I think there's actually some of that going on for quality measures actually.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Paul in general then, are we presenting a Stage 4 vision as part of our Stage 3 recommendation, because where are we... if it's not part of the Stage 3 recommendations, where are people getting these signals?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

We've always had a column for the next stage. In fact, Stage 3 appeared on Stage 1 and Stage 2 matrices.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So we're going to have a Stage 4 matrix as one of the ways we signal, and start the discussion going.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So. I struggle with it. I hear you really well, but, think about that CMS patient with between 13 and 17 providers and how many meds and I struggle with it.

George Hripcsak – Columbia University

You know, a flow of every update from every patient on your... fifteen hundred patients on your panel won't necessarily fix that problem. It may actually cause a cacophony of information coming through.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I agree.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And plus, then if you've got to do more reconciliation.

Eva Powell – National Partnership

This is Eva. I don't know that I have tracked with this conversation very well, because it sounds like Leslie is saying there's capability to do this now, but then everyone else is saying, oh, but there's not and I don't have knowledge to argue either way. But I will ask the same question that Leslie asked in that we have summary of care record in Stage 2; so if we are not advancing toward update, how is this measure going to be different?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the other comment I would make is, you have a list under measure, must include the following. I think that's pretty...

Eva Powell – National Partnership

The content is different, okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, but also I think... I wasn't part of the discussion, but I think that that's pretty burdensome. So, it has good intent, but where you're saying must, may, might be an okay thing, because that's a signal and then in a sense, the vendors would have to program so that these things can be added when they exist. The must is where I'm having trouble, because you could send somebody to a derm appointment for a rash, they came in to see you and we don't necessarily have to have each one of these things. It just adds burden to the process. So, I guess the concern I would raise is this thing that "must have," each referral "must have," each transition "must have" these things, and that doesn't seem like...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think we had as clinically relevant in an earlier slide.

Eva Powell – National Partnership for Women and Families

Yeah.

Larry Wolf – kindred Healthcare – Senior Consulting Architect

I think it's on the next slide.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, yeah, whatever you do, I don't think it should be must.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The one, the one Paul that we wanted to be must, and I know we're close on time, that concise narrative, it says synopsis statement. That seems to be pretty consistent, that we actually wanted to put that up in, provide a summary of care inclusive of this synopsis statement, and make that kind of a must. That was the only one that we...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I think that's getting into the medical process point again. I understand where it's coming from and yes, I understand completely from a specialist's point of view, it is one of the expectations. We are providing a way to easily do that, but still we're going to get questions about, well what is concise narrative and how much do I have to say about this rash. It's pretty apparent to the dermatologist what the rash is and they can describe it better than I can. You'll get that kind of thing and do we want that kind of angst to go on when the requirement already is there and the professions really have to essentially police themselves; the specialists want this from primary care. We need to make sure the records can give you a space to do that.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That was really what we were trying to do, is get the space in this record.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Now that's...I've never seen a record...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So the...the criteria, certification criteria perhaps and...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well I haven't seen

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And hopefully market forces and feedback from peers will get people to improve what they're sending.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I actually haven't seen a record that doesn't have free text for the referral itself, because that is a requirement. So, I think it is true that this is one of the requests that specialists have of the referrer, but I don't know that we're the enforcer for that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, and I think some of the problem is that in the care summaries, in the CCDs, while there's no constraint that you can't put narrative in that doesn't have coded structure. Because there is no specific section for sort of just say what you need to say that's really important, I think there's a sense that the CCDs are becoming very heavily auto-generated and that they're becoming a "hit me hose" down with data, rather than this is really the highlights that I need to pay attention to.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's try to put... let's try to actually be explicit and say just that, because I understand that. And then we can feed that back to the HIT Standards Committee, and then that can feed into the certification requirement. Let's not... this says what the human professional has to do each and every time, that's burdensome and gets in the way of process. Why don't we just be explicit on what you just said?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We're trying to make sure we got space, right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

We want some free text because we want to be able to write that concise summary.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So what we want to say here is includes the following information, if clinically relevant and provide that concise narrative and support... and maybe...

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

No, I think what he's saying is the system, the EHR system shall support concise narrative in the summary of care document upon referral.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And you know what you might say is to support reason for referral, that people understand. It's like the chief complaint, reason for referral is the way we describe this concise summary here. Here's my problem, here's what I'd like to get out of this consult. That's what...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well, and/or transition, because again, what's the end-stage of sending the patient home...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So it's a little broader, the broader the definition and/or referral, so.

Eva Powell – National Partnership

Well, and this is Eva. I can see that for the concise narrative and that sounds good to me, but in terms of the goals, instructions and care team members, that I think should stay must, because otherwise they're going to be clicked through, if the information is not easily accessible and that is critical information for ensuring a safe transition. So, I think perhaps we could say, must include the following information, concise narrative and support of care transition with the clarifications you all just said, if clinically relevant or something, have some qualifier there. And then leave the others alone, because we've required them in Stage 2, at least the specific goals and instructions, we just added some clarification, which is part of what people asked for in our feedback, and then the care team members, which is just, I can't emphasize how critical that piece is. And so, I'm really uncomfortable and cannot be okay with making that optional.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I agree.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, did you say though, aren't these all still clinically relevant?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, to the patient though, these things have a... remember, we're now adding patient to the care team, they need to know, who are the care team members, what are the goals of care, what are the instructions. So, I think those are musts.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so, we're kind of back to... remember how we broke out the distinction between when a patient's referred versus when their transitioned, is this required in all cases or just in the case of a transition?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's more a trans... it's... the must is more in a transition, I think. So...

Eva Powell – National Partnership

Yeah, I think that's the... Larry's 90%, certainly is the transition. I can see a lot of times... a lot of cases where it would also apply to referrals, but, that's for us to discuss.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, since we're breaking it...

Eva Powell – National Partnership

This is a really simple thing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Although you can... ask for clarification what is a transition of care Paul, because we were arguing that. But, in the case of a referral, we want the narrative in any case, this concise narrative; but, the last three, in the case of a transition.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the interesting... we had previously defined transition as a transition of site or provider. So, transition actually... a referral actually came under transition in our... so, I don't... so that's why I don't know why the must...to get the 90%, we don't want to force all of the unnecessary and burdens... it's like false alerts, where you get alert fatigue. If you make everybody do things when it only applies 80% of the time, then you get all this disgruntlement for the 20% and it causes bad effects in the 80. So, that's why the phrase clinically relevant gives...so one, by clinically relevant it makes sure that this is capable in all of the EHRs and standards. So that's one of the effects we wanted to have. But to force people to do things in the 20% when it doesn't apply, has unintended bad consequences.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But doesn't it always apply to the patient. If we're again, if the patient is a care team member, and the transition is to home, then we are providing this information to the patient.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, but the referrals... my problem is this doesn't always apply and it becomes burdensome if you include all the referrals.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right, so...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So think back about the rash, you know, you don't need to have all these things, we don't need to have all the care team members, so on and so forth. It really applies much more to a... I guess it would be called a site transition. Hospital/home is one of your prototypes, for example, and that, I would agree. But, I don't want to burden all the other transactions where this is not necessary and have all the disgruntlement for in fact the 80% where it is for the transition.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, is it as clinically relevant and at patient request?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think those could be okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

What do you think about that Eva?

Eva Powell – National Partnership for Women and Families

I've kind of lost track of where we are. So, we're talking about care team members specifically for referrals...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Actually, it's all the... we're actually talking about all the items with asterisks.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Eva Powell – National Partnership for Women and Families

Okay, for both referrals and transitions, or are we talking about separating them?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, unfortunately, or wisely, referrals are included in transitions.

Eva Powell – National Partnership for Women and Families

I see everyone's points on the concise narrative and so I feel like that's fine to say, if clinically relevant or what have you. Goals, instructions and care team members; I think if we make it optional for... if there's not an option to separate referrals and transitions, making it optional means it likely won't be done for anything and I can't be okay with that. I think that it must be setting specific goals, instructions for care, care team members using DECAF; and I think there's a way to make that easy for times when it's not as important, say as a care transition. Like say your dermatology example, the specific goal is get rid of the rash, I mean, it doesn't have to be hard...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, but Eva, that act takes time and...

Eva Powell – National Partnership for Women and Families

Well I think my point is that oftentimes people are referred and they don't know why the hell they're there. And from the patient perspective, I think what we're doing here is bending over backwards to make things easy for providers and I'm sorry, but care coordination, the patient's the only constant and I cannot be okay with that. If this is something we have to battle in the full workgroup, then fine, let's battle it in the full workgroup. But I think we lose our 90% if we make the goals, instructions and care team members optional.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And, you wouldn't be okay with saying, must include the following information if clinically relevant for those asterisks to be strong caveat...

Eva Powell – National Partnership for Women and Families

But that still is a loophole Charlene. I mean, how... it's going to be... I understand how busy provider settings are and I fully appreciate that, but that's why we're in the position we're in and why care is never coordinated. It's not clinically relevant because it's not relevant to me, the provider; but the patient is the one we're trying to help. So, I think we need to battle this out in the full workgroup. I cannot be okay with taking these things out.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And the big issue is, now we're adding the patient in this mix and they deserve this kind of information.

Eva Powell – National Partnership

Right, and that's the other thing. I can be okay with what we decided before about the patient generated data, and keeping that confined in the context of the care summary to the professional care team; but what we've done is effectively excluded the patient from all of our care coordination objectives and that is not okay. And so, we need to put the patient somewhere in some of those objectives and this is a really good place to do it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Paul, I'm not sure I can get to resolution on this one.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we're talking in just a couple of hours, so we'll just raise this issue.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Because this under, remember what I would like to do is prioritize the "new" and this is a new requirement you're adding.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, on this slide, I think where we ended up, we're going to leave this is a new requirement...

Eva Powell – National Partnership

Wait, I'm sorry, this is not a new requirement. This is the summary of care, we've had this in Stage 2, we are just adding some information, that's the new part.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the new part.

W

No.

Eva Powell – National Partnership for Women and Families

But, this does not make this a menu, I just want to be clear about that.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

No, this is new, so emphasize the new part. I think you could summarize it as, some of us thought if you just put “comma, as clinically relevant,” and others wanted to be included in everything. Another possibility is you make it only for site transitions, and that might get at, I think people understand that better, I think the issue is most of... many of the referrals you won't... anytime you require people to do unnecessary work, it just bleeds into the other things. So, I'd just...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Paul, we actually did break that concept out. We said, provide the following information, on our care plan one, we made it for site transition, and then we said, for referrals, if it's available, send it. That's kind of how we handled it.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, where is that?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It's our next objective. That's exactly how we handled the care plan.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, okay. Well, that's one way. Is that okay with you Eva?

Eva Powell – National Partnership

Say that again.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We'll handle it...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

You have to break it out...

Eva Powell – National Partnership

If it's available, we'll send it.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

No, no. It's for site transitions; I think that's the bigger issue.

Eva Powell – National Partnership

Oh, I see. For...it says specifying for transitions in the...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Precisely.

Eva Powell – National Partnership for Women and Families

...three bullets, the second, third and fourth bullet.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, must include for the site transition, and if...

Eva Powell – National Partnership for Women and Families

Yeah, that would be fine, I think.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

...appropriate, or if clinically relevant, for referrals.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Eva Powell – National Partnership

Yes, I think that's a good solution. And the other thing, and this is Paul where I, I mean, I understand your desire to keep things parsimonious and to kind of confine things so that they're clear. But the other way to resolve this, again, this is why I think that patient generated data has to be a crosscutting thing, or at least... perhaps not in terms of the requirement, but in terms of our narrative and explanation. Because that is one way to totally relieve provider burden here, is let patients put in their care team members, let patients put in their goals, and if the issue is provider burden, there's a really easy way to take care of that for a whole lot of information, and that's to let patients do it themselves. And where we can encourage that, we should.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, I'm sure we'll be back to this; must include the following information for site transitions and, if clinically relevant, for referrals is how I put it. And those are the asterisked ones. Okay? Are you still there or did I lose you?

Emma Potter – Office of the National Coordinator

This is Emma, I got it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

All right. I just wanted to... just to finish this one, the concise narrative in support, that one we're going to make a certification requirement, that the EHR is able to...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Larry stated it more specifically, because... I don't know of any other EHR that doesn't have this for referrals anyway, but what his point was is, in the CDA, it doesn't have...I guess it doesn't have an explicit text field for this. That's a problem.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

George Hripcsak – Columbia University

So the requirement, this is George, is concise narrative in support of care transition or referral, that's our requirement, and then as a sub-thing we want to remind the Standards Committee to make sure this gets done. And then the next three are just for transitions of care because that's what they're about. Is that where we ended up?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Um.

Eva Powell – National Partnership for Women and Families

Transition also includes going home for the patient.

George Hripcsak – Columbia University

So we have to define what we mean by transition, but we don't mean referrals. I'm a cardiologist and going to the dentist, I don't need to go through instructions for care for 48 hours.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Columbia University

And then, on the top half though, we're just including the first bullet.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct and we'll put a placeholder...to supplemental updates, we'll put a placeholder for Stage 4.

George Hripcsak – Columbia University

Right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

We've had that discussion, yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, we have like five minutes left now, so, I don't know, number one, if there's any more time that we can spend, I know we're booked for only an hour and a half, Eva or MacKenzie?

MacKenzie Robertson – Office of the National Coordinator

This is MacKenzie; we don't have any more calls after this using the webinar, so we can go over about ten minutes if you want. I just don't know about other people's schedules.

Eva Powell – National Partnership

I'm open, this is Eva.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay with me, Larry.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, all right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Me too, Leslie.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay thank you, thank you, we'll... I just... so, the other one, I'm going to actually just run by 304. But I think we made our corrections on 304, but I did want to touch on one point on that and then I wanted to move to slides 5 and 6 quickly, and then we can decide if we can discuss those later or not. So, in terms of this one, Emma, are you okay with the changes to that?

Emma Potter – Office of the National Coordinator

To 303?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

303.

Emma Potter – Office of the National Coordinator

Yeah, I believe so.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

If we want to move to, let's see, 302, 304?

Emma Potter – Office of the National Coordinator

Oh, wait, I'm sorry, I have one question. This is Emma. For the concise narrative bullet point asterisk, it's in parenthesis free text to include key points and summary of care including setting specific goals and instructions, do you want to delete that...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Emma Potter – Office of the National Coordinator

...because that's in another bullet. Okay, great.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We just wanted to keep... we want room for a free text narrative, but on the standard is what we want... is really what we want.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And it's really the language that folks will understand, this is Leslie, is reason for referral or transition.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, reason for referral or transition.

Emma Potter – Office of the National Coordinator

Okay, great.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But again, we're getting... hearing a lot of nuances on that, so it's just more important to have the field so that they can...

W

That's fine.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, slide 304. Again, what we did on this one, this is a new one and we're recommending that its core in support of care coordination, and again, I think we can debate that on the larger call, because you've heard the context of the conversation. But I think what we need to say for each site transition, because that's exactly what we're trying to accomplish here. We kind of went through the same thing, discussion Paul, that we needed this information for site transition and not necessary...and if it was available, provide it for a referral. And we had a pretty low denominator, but we wanted to make sure this kind of information started to get captured. The issue that we faced with this one, as you look at these different elements, and again, I know a lot of work is happening in standards, much of this is going to have to be free text in Stage 3, because there's not standards for many of these data elements, and that's the feedback that we got from John Halamka.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But also, part of the problem is there isn't a... it's not part of routine, the way people think about this. So relevant environmental factors impacting patient's health, yeah, that's... it's not a routine part of thinking about transition of care.

Eva Powell – National Partnership for Women and Families

Well it is for disciplines other than physicians, Paul. Like a social worker would be asking those questions and I think...and that was one of the things that we talked about, I think Michael Barr brought up the fact that even the physicians in hospitals are the only ones who actually receive the incentives. Part of what we're trying to do here is encourage team-based care and so, somewhere in our narrative or prologue or whatever, we should really hit the point home very hard that the intent of many of these objectives is to encourage other disciplines to interact with the EHR and to be part of the care team using the EHR. And so, coming at it with that perspective, then this information, at least in the hospital setting, I know is all collected. It's just maybe not collected by a physician.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The intent is not to burden necessarily the physician, but in many cases, this information is captured. Again, the challenge here is going to be the variation in the data that's really captured because of the lack of standards around this place. So, our preference is to feed this into the process, because there's a lot of work going on here, and then if we have to refine, to kind of step back later in the process.

Emma Potter – Office of the National Coordinator

This is Emma from ONC, I thought that we had added the sort of qualifiers that these elements would only be included as applicable, so while it may not be...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Add applicable, that's what I had in mine.

Emma Potter – Office of the National Coordinator

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

That's reflected on the slide, and if the elements change, there's an S&I team that's working on what is the minimum information required and this came from even a subset of that list, and getting it as applicable starts to set the stage for other care providers to participate in this. So, this wasn't a list that was made up from this group.

Eva Powell – National Partnership for Women and Families

Well, and the other really big point in all of this is to move us a step closer towards an actual care plan, with the understanding that we're not going to have the care plan in Stage 3. But to take a step that both is clearly distinguished from the summary of care and that is meaningful, that moves beyond that into the concept of more of a longitudinal set of information that is available for those who need it.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So I guess my... I actually work on these things for my day job, so I completely subscribe to the importance of these. If the scope of what this program is trying to do, and the people who are subject to these objectives, it may be true that the social work... I mean a social worker would probably be the better... in better position to do this, but how... it seems like we're going beyond the scope of this prob... we're not trying to fix all the processes and training and philosophies of all of the care team... all the people involved in health care; we have a very specific objective about people who are defined to be EPs, for example, or EHRs and their use of these certified electronic health records. It feels like we're over-reaching in terms of what we're requiring.

Eva Powell – National Partnership for Women and Families

This is Eva. I think one of the major flaws in the HITECH law is that it assumes you can coordinate care with only doctors and hospitals. And of course, that's complete fallacy and so, I see it as, we can either subscribe to that fallacy and go our merry way with blinders on, or we can actually do what needs to be done. And that is, team-based care and encouraging the adoption and development of new EHR systems that are usable and meaningful to all care team members, which is what this objective does. So, I think if we want to confine ourselves specifically to what HITECH says, and the assumptions it makes, then okay; but, I think that's complete folly.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So I...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well Eva, I don't think we're... nobody by following the law is saying that that's all that they think. But, we're also not Congress, we don't write the laws, nor do we train physicians or mentor them. I think we need to operate within the confines, which doesn't mean you only believe that. I don't know that I accept that just because we're saying X in any one of these objectives, it's saying well that's to the exclusion of all else, because none of us believe that. And that they exist is... these things are part of my day job, so, it is not a question of whether you believe it or not, it's a question of is it within the intent of the fact that we're operating under. And...

Eva Powell – National Partnership for Women and Families

Well, and I guess I don't understand why you think this is reaching then. If our stated policy priority is to coordinate care, and physicians and hospitals are going to be the ones rewarded for that, then should they not have a role in engaging other team members?

(multiple speakers)

George Hripcsak – Columbia University

We're running out of time, so what is it we're deciding right now?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Paul, we would like to bring this one forward as a core objective. We carved out care plan separately because we felt that it's going to be very significant in driving. Now our customers say, "Just tell me what the standards are and I'll... it. Now there's a question on whether these are the right standards or not, but, both Leslie and Eva drilled down to get that minimum set of content. We would like to at least put this on the table.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

George Hripcsak – Columbia University

I'm still not... this is 304 right?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

304.

George Hripcsak – Columbia University

What's the controversy? I mean, we're saying fill in those fields as applicable...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And it's for sites of care transition, not for referrals.

George Hripcsak – Columbia University

So... (indiscernible) essentially saying is to the Standards Committee, these seem to be the fields we care about, and then the providers will fill in the ones they think are appropriate, so it doesn't seem like we're overstepping anything. And for the referral, we're not mandating creation of a care plan, it's... I think of transition of care asking for there to be some kind of care plan, but we're not even saying what the fields are; I think we're okay with that, no?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

We are saying... that's the concern is we are saying what the fields are...

George Hripcsak – Columbia University

Yeah, but we're saying what the fields are, but not that they have to be filled in.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, then so who's going to decide where applicable?

George Hripcsak – Columbia University

That's up to the provider; that was the intent of putting it as applicable. It's... in other words, we have to have a care plan, maybe there should be one mandatory field, but we didn't even do that, we just said, whichever these... someone has to sit down and decide what... I think the set of fields will evolve...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, I agree.

George Hripcsak – Columbia University

...from the Standards Committee or from the transitions of care workgroup or whatever it is group; so that will evolve the set of fields, but we're not even saying you have to fill in any of these fields really, although I guess you have to have at least one field, theoretically, to create a care plan. I don't know what it would mean to fill in zero fields. But, I don't want to get into that level of detail here, but the intent was that the doctor... not the doctor... the eligible professional decides which ones to fill in, and that's why we were okay with it.

Eva Powell – National Partnership for Women and Families

Right. And one of the things that we've learned from people who are actually really working to figure out how to do care plans is that over-specifying is the first big mistake that a lot of people make. And so we didn't want to do that, and I think what this will do is provide the electronic capacity for those who are honestly working on this. Since it's core, it forces everyone to at least start figuring this out for themselves and then, as George said, the fields and what's necessary and all that other stuff will evolve through the use of this.

George Hripcsak – Columbia University

So, we're just mandating some kind of care plan for every actual transition of care as opposed to referral.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

George Hripcsak – Columbia University

And that actually matches what we did in the previous objective anyway. So, I don't think it's a burden beyond the previous objective.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So we defined the previous objective and then this one aligns exactly, we cite transitions of care. We went through that same conversation.

George Hripcsak – Columbia University

Guys, I'm going to have to go off very soon.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

All right. So the one last item, and there's a couple of open items that we're not going to get to on slides 5 and 6, but we're going to have to come back to those. But I just wanted to go through the exercise that Paul had asked us to do, relative...and I think it's going to be tough, to prioritizing these objectives. So Paul, we kind of had gotten down to four, we really worked hard to make it... to narrow them, and I think we really scoped them back in this conversation today. So, in terms of prioritizing, what is... can you give us a little... I sent the team your guidance you gave us, but can you give the team like how we might think about it in, like three minutes?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So you're saying you're down to four.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Four objectives.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. No, I think we've had some of the discussion actually as we covered in, beginning with I think 305, where we cut back and said, okay, it's not just checking very step, that's the kind of thing I was talking about. If you can narrow it down to where one, it's as automated as possible, it's got adopted and standards in use and has broad applicability, so the referral, getting it, that fact it's coming back; that's a really good example of... that catches the problem, it's broadly applicable, you know urban and rural and any specialty. That's exactly the kind of thing we're doing, and I think, I don't have the whole thing in front of me, I think you've gone a long way towards that.

George Hripcsak – Columbia University

So, I think it would be fair to say during this whole noon call, that we've gone through the process of scoping back and so these are the four high priority ones, and we've actually already eliminated the lower priority ones in effect. For the most part, there may be further objections, but that's kind of where we're coming from, we've already done most of the scoping.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

There's a couple of other ones listed, like the interactive problem list or something from collaborative care...

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

George Hripcsak – Columbia University

So I think we're pretty good, right, because it's the interactive problems so in the first set, there's going to be the problem list reconciliation, which is still in there.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

George Hripcsak – Columbia University

We already have that one. Patient information reconciliation we talked about and moved that to group two. And PBM, that would be a Stage 4 anyway, I would think.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie, I agree. I think this is our minimal set, I mean we really struggled and tried to push and I think this is really minimal and all high priority. I would make one caveat. I want to make sure that the team is allowed to continue after the Meaningful Use 2 finals are brought out, and that it is not then all assumed at that higher level. Because we will be informed by that and I'm not sure of the process, maybe MacKenzie can tell us, but making sure that we have that loop back is important.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I thought that was our intent Paul, that we would do the reconciliation with these.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, I think that seems reasonable. So, you're saying, look at the final rule for Stage 2 under category 3 and try to reconcile that...

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

...and then... yes, that makes sense.

Eva Powell – National Partnership for Women and Families

Yeah, and this is Eva. Also kind of reconciling across the policy priorities and the work that all of these subgroups have done. I know that that will be part of what the larger group does, but I think things will become clearer and there will probably be opportunities for further parsimony once we really talk about this as a whole. And I also just want to remind folks that part... I feel like we have done an incredible job of being parsimonious and only having four objectives and they are four really important objectives. And the particular importance for this is that care coordination really has been behind and if you look at some of the other policy priorities, we've made really good progress and there's good reason for care coordination to be behind, primarily in the state of HIE. But nonetheless, it needs to move forward and it needs to be moved forward in a more robust way, and I think what we've done is accomplish that in something that's doable, yet very challenging and very parsimonious. So, if we end up with some more bulk perhaps than other groups, I think that's actually appropriate.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think a lot of good work's been done, and we've continued that on this call, trying to get to the really the meat of it, and so I think that's been very useful.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. So, I think that brings us to a close. Emma, you'll have to... if you need to run anything by me, you'll call me, because I've got the next time window free, so you...

Emma Potter – Office of the National Coordinator

Okay, yeah, if I have some last minute questions, I'll give you a call.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Any comments or questions from the workgroup?

W

Do we need public comment?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, get public comment.

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the lines for public comment?

Public Comment

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, thank you everyone.

M

Take care everyone and thanks Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Thank you, talk to you at noon.

MacKenzie Robertson – Office of the National Coordinator

Talk to you in a few hours.

M

Yup, bye.

W

Bye.