

**HIT Policy Committee  
Meaningful Use Workgroup  
Subgroup #3  
Transcript  
May 8, 2013**

**Presentation**

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thank you. Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a HIT Policy Committee Joint meeting of the Meaningful Use Workgroup's subgroup #3 on Improving Care Coordination as well as the Information Exchange Workgroup. I will be doing both roll calls. This is a public call and there is time for public comment built into the agenda. The call is also being recorded, so please make sure you identify yourself when speaking. I'll now go through the roll call of the Meaningful Use Workgroup subgroup #3. Charlene Underwood?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Charlene. David Bates? Leslie Kelly Hall? Marc Overhage? Paul Tang? Larry Wolf?

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Larry. Are there any other Meaningful Use Workgroup members on the line? Okay, so now I'll move to the Information Exchange Workgroup. Micky Tripathi? Hunt Blair? Peter DeVault? Jeff Donnell? Jonah Frolich? Larry Garber?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Great. Thanks Larry. Dave Goetz? James Golden? Charles Kennedy? Ted Kramer? Arien Malec?

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Arien. Deven McGraw? Stephanie Reel? Cris Ross? Steven Stack? Chris Tashjian? Jon Teichrow? Amy Zimmerman? Tim Cromwell? Jessica Kahn? And any ONC staff members on the line, if you could please identify yourself?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Michelle Consolazio Nelson.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator**

Elizabeth Palena-Hall.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Okay Michelle Nelson, thanks. And Liz Palena Hall. Okay, with that, I'll turn the agenda back to you Charlene.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Thank you very much. So to move to the schedule for today, I just wanted to kind of give you an update on the process and I do want to extend my thanks for the other workgroups joining us today. When we developed the original requirements for care coordination, I know there was a lot of cross-workgroup dialogue and it's actually my belief that that will help us end up with a better product at the end of the day. So, next slide. So to that end, we had our kickoff meeting about two weeks ago, where we started the reconciliation process around care coordination in Stage 3, and we're kind of – and we're reviewing our comments, and you'll see all the comments that were provided in the materials that were sent out. And we've actually started going through some of those elements of those comments.

And so the intention today was to – we had a couple of open items on the referral loop, as well as notifications, which I think you can help us with. And then we wanted to start down kind of re-looking at what we put in our requirements for care summary, as well as care plan and then ask the IE Workgroup, actually – well, S&I, whichever workgroup, I apologize, to kind of present their material to give us an update with where they are around the standardization of care planning. And then we will kind of come back and we'll start to work through care summary and care planning in more detail, based on some of the comments that we received.

On May 24, we expect the discussion will probably continue for that next call and we'll cover the summary as well as the plan. And then we're going to get into the discussion around reconciliation. We had a lot of comments there. And then we have two other items that refer – are related to that, the interdisciplinary problem list, which you might be able to touch on in your conversation today, as well as med reconciliation. For the workgroup, and I kind of said this to our broader workgroup last time, again, when – we had the opportunity when we formed the workgroup to do a little bit of visioning in terms of what this should look like in the future. And we kind of identified three major functional areas.

One was communication, and again, we all know that gaps in care are created because of lack of communication of reliable, concrete information through the process. And so again, that was one of our focuses. Another focus was tracking. So things like the notification function, the referral function, are all elements that we felt were important helping to track where the care was at. And then the other aspect is reconciliation. We recognize that again, there's going to be many systems out there that have to share and integrate data, and there needs to be processes to have pretty robust reconciliation. And we recognize that again, having a reliable standard set of data is going to be key to making that robust process happen in a timely way, so that it will actually be done. So those were kind of our philosophical tenets when we approach trying to problem solve for care coordination.

And the other piece that we recognize is, in many ways, what we're talking about isn't tied to one electronic health record, it's tied to many that are linked in many different ways, and really starts to engage the patient and the family and the care teams that interact with this in some way. And we recognize those products are emerging and we don't want to necessarily create any limits to what those might look like, that's not the intent here. But, what we did want to do is to create the infrastructure to enable those type of products in Stage 3, and that's really what we're working on. So it's not to say, we recognize that Stage 3 is a building block to kind of get us to where we need to do, but that was kind of our assumptions in terms of thinking through the requirements – put on the – recognize when you put out an RFI, some of that translation does get lost. Anyway, that being said, I just wanted to open it up to those on the call to see if you wanted to add any more comments or need any more additional clarification.

Okay. So what I wanted to move to – we worked through the referral loop, and I'll kind of give you an update with where we were in that, and then we also got through notifications. And I think you can help us maybe finalize these, or at least come to some conclusions on these. So I know you put some notes – move to the next slide. So when we looked through referral loop, let me give you a little history. When we started the definition of this process, we actually were defining it to be more of the full loop, sending and receiving. However, because in the Quality Workgroup they've got the capability, send out a request, an order for a referral, what we built into this workgroup was just the ability to be able to assure that the receipt – not so much the receipt, that the EP or the specialist, primarily, that receives the request for the referral sends it back.

So it's actually the act that we were looking at. So in that light, originally, and I think this was a miss on our part, we had hospitals in there. So what we did for the purposes of this measure, because we got a lot of feedback on it, was to make it EP only. The intent is to request the referral. And the challenge that we were getting to is, how do we determine our denominator in this case, because we're not always sure that an order is sent over for the referral, so we can't use that. So that was kind of the open question, and I know that some of you have been working on standards for that closed loop referral, so I don't know if there's any input that you could give us in terms of potential candidates for what that denominator might look like.

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

Hey, this is Arien. So I can give you at least a snapshot of the work that's been done, and I think Larry has some additional work that's been done from a standards perspective, that really hasn't been the work that the IE Workgroup has looked at. I think individual members of the workgroup and the Standards Committee have looked at the applicable standards in this area. The one comment I have relative to close loop referral is – has this workgroup looked at the NCQA PCMH requirement, because they do have requirements for referral tracking as part of the definition of PCMH. And I wonder, a) if there's good work that could be done here and b) if we're thinking about how if that's the direction that meaningful use is going in, how we harmonize Meaningful Use Requirements and PCMH Requirements.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

We have people on the workgroup I think that are involved in those, as a broader workgroup, but we didn't specifically do that in our workgroup. So are there any – we could certainly look at that, but is there anything that –

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

And I don't – we didn't look specifically in the Information Exchange Workgroup, Larry, unless you remember otherwise, on the issue of close loop. We were mostly concentrating on some of the issues about uncoordinated care. That is, the need to query data on, for example, an ED visit or an unscheduled visit, and for that, I think we were looking at, I apologize, it's been a long time and we've switched over to some of the topics related to responding to the RFI on Information Exchange and Quality. We switched to looking at that as a certification only measure, as opposed to looking at that as a Meaningful Use measure, I think primarily because we did have a lot of concerns about exactly the question you're raising, about a numerator and denominator.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

All right.

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

Larry, do you remember otherwise?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Yeah, can I just add to that? Really, what we were working looking at is 303 and 305 as a pair, in the sense that 303 was sending information, well both for transitions of care but also for referrals. So the notion was that when there is some referral, you'll be – with 303 you'll be sending some information –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

All right.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

– and that with 305 there would be returning information. So –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So what is the 303 at – that doesn't get it for me all the time though, because I don't have enough in my – I don't think my thresholds are where they need to be, or maybe they are. Well, I'll keep that in mind, that maybe give us the denominator then, right?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right. And so – but the other things, in terms of standards, so, we are – we have contracted with Lantana, who is working under the S&I Framework, to – for this purpose to update the consult note that's in the Consolidated CDA to be a bit more robust –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. Perfect.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

– and then we're also, as part of the that work, they're also going to be adding a new referral note to the Consolidated CDA. And so the notion – what we could do, these are still in flux and we won't have them finalized until August 4, when the need to be submitted for the HL7 ballot. So one possibility could be that as part of the referral note, that some identif – unique referral identifier is included by the sending organization. And the expectation is that the referred to provider has to return that as part of the consult note, so that use that same identifier, where it's an order number, a referral number, whatever the originator wanted to send, but that number be sent back. And that this way, there could be – that'll form the denominator, but at the same time, it will also help close the loop for the receiving – the original ordering physician.

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

And I think we also, this is Arien again. I think we also, and again I'm trying to rack my brain for what we talked about –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I know we're trying to –

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

– a number of months ago. I think we also took the position that the transitions of care Meaningful Use measure was the core measure that you're – we should be looking to optimize around, as opposed to adding additional measures, because the intent of transition of care was precisely for these kinds of activities. Now it doesn't get you at the issue of closing the loop, but –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So the numbers are, like a quarter of the referrals aren't done, so I mean, that's a number we're dealing with in terms of –

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

Yeah, no. I understand.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. Just so you know, there is a reason I'm doing this, or we're doing this –

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

No. I do understand and that's again why I was looking at, is there any way that we can harmonize this work with the work of –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

(Indiscernible)

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

– yeah, exactly.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So what I would take from this conversation is, I think that – again, there is a lot of good work that's happening here relative to, Larry what you talked about in terms of the consult note. I'm looking to actually being able like to identify a referral potentially, but if we cannot get to a denominator, at a minimum what we'd like to see this is in the certification requirement, right. Because the other option that we have is, there is – we need to look at harmonizing it, as well as – which I'm totally in favor of, as well as there is a measure, a CQM measure, that's in this space, which may be the more appropriate way to do this, right, once we get to the denominator. So I think the requirement is, there needs to be a mechanism to establish the knowledge that there's a referral somehow in the system.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

And to be able to return a unique identifier that had been sent as part of that referral.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah. So do I need – do we need to write that in our requirements here?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Well, you've got reference to the S&I – well, I guess it's the document you have under S&I Framework –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

And what I'll do is I'll make sure that we include, as part of that, an identifier being sent and received, as part of those documents.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. Any – so I've got a little bit – I need to do a little bit more homework on this one and we'll need – because we'll have to come back and update Paul on all this anyway. So, Michelle, I mean I would kind of just leave the slide like you've got it, because I think it's really powerful. And maybe just add the comment relative to potentially a certification requirement only because of the difficulty in establishing the denominator until the standards are in place to identify a denominator and track it – identify a referral and track it. Are we there?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information**

**Technology**

Okay.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay, got it?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information**

**Technology**

Yup.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

One of the other things that I – in some of the comments I was looking at, there was some question as to whether this was for say a referral to a specialist and the specialist sending information back to the primary care physician versus say a testing process, where I'm ordering a lab test and the results are coming back. And I know that – so I'm not sure that it's explicitly written in here, a vision, at least my vision as I was looking at this is that this was more of the sending the patient for a consultation, as opposed to necessarily having a test done, I don't know –

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

Yeah, and I'd remind, yeah, so we do actually – there is actually a Meaningful Use Measure related to electronic transmission of orders that's an EH measure, and it's explicitly keyed to the receipt of an electronic order.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

I didn't know if you needed any more clarification in here as to what you were talking about.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, that's a great get, yup, that's a great get. We'll add that in and I think – unless anyone disagrees that exact – that was the intent, was for – well, it could be you send them – I mean, we were strug – here's where we were struggling. In terms of trying to track this too, which made it hard. So like your primary care and someone's got a heart problem, you send them for six appointments, right, you send them – you need to go for a course of treatment. Well then, what's my denominator, right? So it got really mucky when we started to think it through. So it could be for procedural, right, or you need to go and have some sort of an exam done by a specialist or it could be – but there all a consult, right? So we don't want to exclude that. And then we got to multiple visits under the referral, right. So we got a little bit stuck there in terms of then how do you count it? So –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

I guess the way I would be sort of thinking about this is you're right. That is, first of all, it's an eligible professional that we're dealing with, so someone's getting an audiogram, that's done by an audiologist and they're not eligible professionals, so they wouldn't count. Someone's getting a cholesterol test done, well that doesn't count.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Right.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

But that does get to the gray area of – and colonoscopies maybe would count, but then the gray area then is, what about radiology, imaging studies. Because in a way, those are consultations with physicians –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yup.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

– I mean it's important to close that loop, but again, is it covered elsewhere that you wouldn't need to put it in here. So I think you are going to need to do some clarification on this.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Right. Okay. That's a good get. We'll have to like go back up to the quality piece, to make sure that I don't overlap that, but really, you definitely want to make sure those – where else would I catch like an imaging study was done? I mean –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Yeah, I'm not sure –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– because I don't really have any other place on catching it, right, today. I mean, it's like we have request for orders going out, but I don't have any other place that I'm closing that loop coming back. So I would want to encompass those. So I will –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right, because I know that is a problem area for us. I mean we order sometimes outside PET scans and we're going through a lot of effort to try to close the loop to make sure we get them back. So there certainly is value in that.

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

I would – I'm sorry this is Arien. I apologize. I would just suggest that in those – in our experience, we do a lot of orders and results work, in our experience, those processes look more like the lab processes than they do look like the referral processes. And I'd suggest that if that's the direction that we want to go in, that we align those with the existing language for – incumbent on EHs for labs. And then I'd also note that just like with lab results, you've got issues in meaningful use related to where you put your hooks, because a lot of – anything done in a hospital maybe you could put your hooks into, but anything that's

done in a community imaging center and the like, you can't.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Well, the only place – how do I – how do we like, I know there's a lot of work go – but don't I need it – like from this perspective, don't I need it also – how do I hook it into the lab work, I need that too, in this case. If you refer – if you had to go out and had your tests done by LabCorp or whatever, we need to know that's done, right.

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

I agree with that that you've got issues of those labs are ineligible providers, CLIA would be the appropriate mechanism if there was a federal mechanism – there might be some other federal mechanisms there, but would be the appropriate mechanism for making sure that there's again close loop there. But labs are – labs actually are already, by CLIA, required to respond to orders –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

– and so there's a pretty good regulatory scheme there.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

All right. And imaging centers, in many cases, have EPs that are – so I think we want to keep it – my intention would be to keep it broad and then we can only really link it EPs at this point, right, but it should cover those range of procedures that EPs do, as well as consults, would be my intent. But does that make sense?

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Charlene, this is Larry Wolf. The slides that we got from Evelyn –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yup.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

– embed some of the work that Larry Garber's been doing with IMPACT and he defines five different kinds of, I'll call them transitions; maybe we should call them interactions.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Maybe it would be useful to review those five and talk about, are we trying to facilitate all of them or just a few of them.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Why don't we shift – let me walk through one more, and then do that review. Because I think – because I want to kind of walk through where we were with the notification piece, but I think you're going to hit that in your presentation and answer my question. So this one, because of some of that challenge in determining our denominator, for all the reasons that we talked about, could potentially be a certification requirement, but the other open item is to expand the definition of those cases we want to cover under referral. All right, as our open item? Okay. Why don't you go to not – two slides down. One more. Okay, so again, in terms of – this was the notification piece. The main feedback we got, but Larry I think you might have in this, was to clarify the four events, so I think you may have that in your materials.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Well actually the four events were listed right here. What we were thinking, and you're right, there probably has to be some clarification, but what we were thinking was that this is really the ADT events that are in the registration system. And so when someone is registered in the emergency department, the ADT marks that registration, and that's what would be triggering the notification, or when they go from an ED to an inpatient or electively to an inpatient admission, that would be ADT registration.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

And we actually had changed it I think to say 4 hours. We were...got some feedback on that. But the other question that I have here then, as we thought this through, because we kind of walked it through from that perspective, too, was, do we have any – what are the ramifications of certifications around registration systems at this point, because we haven't certified registration systems before. Does that mean that we have to certify them?

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

I think the – I mean just in this area – this is Arien, I think the work that was done around electronic lab established the precedence that the certification in effect covers the hospitals deployment of health information technology. Because typically lab systems aren't a part of the – we haven't really taken the principle in aggregate that we're only certifying the – what's traditionally the core EHR, so at least there are some relative – there's precedence here. I'd also note that core EHRs do send out registration events or have the ability to often send out some level of notification. So, as Larry notes, the typical way this is done is by listening in to the registration system's ADT stream and responding or sending a notification. That tends to be the easiest way to deploy these capabilities, but it's not the only one and it's not a crazy thing to think about triggering this through the core EHR system as well.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Agreed.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I just – the nightmare of certifying all these registration systems keeps me up. So, I just – I think we need to be cautious of this one – I mean, I don't disagree with the measure, but I'm –

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

This would be an example of where we might have a modular certification criteria specifically around ADT stuff, is that what you're thinking?

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

Yeah, I mean I think you could certify kind of – well, we haven't even talked about clearly, in the Standards Committee we haven't talked about the applicable standards here. But, I would guess, and I'm thinking out loud, I would guess that we wouldn't even get to the notion of certifying ADT stream, but really just certify the capability of sending out, for example, via direct or otherwise, a notification on event, and really leave it flexible in terms of the how.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

I agree because –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

This is Amy – if we could get that clarif – it would like make me feel a lot better.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Well the fact is – I mean I think Arien's correct though in that while EHRs, some of them have the ADT sending capabilities inherent in them, so they've got the registration built in, all of them have the ability to listen for ADTs. So, however they manage that, it may be that when they receive an admission ADT event, the echo out a direct message, so, I don't think we need to go into the registration system, but –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

(Indiscernible, cutting in and out) This is Amy –

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Right, I think we do need – this is Larry Wolf. I think we do need to ask standards for guidance on what message that notification is, I guess I'm familiar with today, that a lot of us are using the HL7 admit discharge messages, and I'm sorry I can't give you the A0 whatever they are numbers, but – so that's a method to do it. But in our CDA world, should we be looking to actually have the opportunity to send people some other kind of payload on admission, certainly on discharge.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Yeah I think sending –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

This is – Charlene –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, Amy, I know, we've got Amy on the line.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Now this is Amy and I just joined. I just want to add into the conversation, the whole notification on alerting arou – particularly around hospital events and discharge, this has become very big in the HIE and I mean HIE more the noun world. And so as I'm – and I know I haven't been on the last couple of calls, but, if we're thinking about modular components, I mean I don't know whether then an HIE would have to get certified, but a lot of – this is how a lot of them are driving value. And for those that are, unlike ours where consent is not an issue, I mean, they're pushing these out. And so my question is on sort of what's a the significant event here. Are we only taking about hospitalizations, discharge, ED visits or broader? I just – I think we have to think about where this capability's already being bent – built, and then think about how it relates to what we want to do from the HIE noun perspective, because this is getting to be, and being pushed by ONC as critical for all sorts of important reasons. So I'm trying to figure out how this interfaces with that.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah so, Amy, even as I started to listen to the conversa – this is Charlene, we've got to say our names, because, back to our protocol – when we were starting to think about, even like if you think about the public health notification of surveillance, often those come from ED systems, too. And it's the submission of the test, so I think Arien was saying it's more of the message that would drive us to count it as opposed to necessarily certifying the system. But that still correlates, I think Amy, to what you're saying, right, it's just another – is that how those are being managed too, as types of notifications?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Wee those types of notifications, a lot of them are from the ADT feed, so the ADT will notify, I mean, the HIE will notify, based on receiving an ADT feed.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

I mean that's certainly how it works in Rhode Island, and actually providers now can subscribe to get notified on certain patients they want to watch, but again, it's for certain events that – but I think there are a number of places now that are doing this and this is getting traction and I think a lot of it is based on ADT feeds, them being reported to like an HIE, then being sent out to the primary care provider or other providers of record or providers that have subscribed to get notified.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So what we're trying to, and I'll open it back up again, what we were trying to do here is just put the mechanism in place such that, well, I guess it could – well, again it's modular then. Whether the system sends the ADT in, we were trying to create the infrastructure to capture these kind of events and get those communicated, whether the hospital did it or the HIE did it, so I think we need to make sure we're clear on that.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Charlene just telling you, this is George, I just joined. Sorry for the delay.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So, is there like some words that we should put on here to make sure that we keep it – we recognize this is potentially a modular certification and could be handled in multiple spots or –

**M**

– requirement. Is it actually in place now or are you thinking about –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– or is it best to have, I think, Larry, Larry Wolf, maybe we're back to asking guidance in terms of how to best implement this, is that what we want –

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Yeah.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

I think that makes – and this is Larry Garber, the other Larry. One thing I think we should do, because I realized that it wasn't clear, is we talk about a significant event and then we list the four events, but it should be clear that those are the only four events that we were talking about for this measure –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yes.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

– because otherwise –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Yeah, that I think is important. I'm sorry, that was Amy.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, we want to just create a floor here and these were the four events.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Exactly.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

This is Larry Wolf. I want to sensitize us to the multiple implementation models and the fact that this is something that is getting traction out there in the world. And it may be a specific thing that we should be looking to learn from, there should be some specific outreach or listening opportunity we create so that the people who are doing this today can speak about how they're doing it –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

– and we can craft something that doesn't force a lot of rework of existing methods, but helps move forward the – standards around this.

**Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing**

This is Arien and I just want to underscore Amy's comment and note that often times when we put things into Meaningful Use measures and associated certification criteria, because many EHR vendors wish to get certified as a complete EHR, what you end up doing is forcing vertical integration. And so also being sensitive to emerging different models of how to get this done, this might be one that you think about doing purely as modular certification.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So this would be a – so back to Larry, Larry Wolf's point. Is there like – are there any candidates in terms of like – again, we've got some time to listen, so are there candidates that we should be listening to? I don't know that answer.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

So, I'm thinking, we already had some discussion about the HIEs, HIE organizations, the noun are doing this, as far as a –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Yup.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

– value proposition.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Exactly.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

I know that every partner that Kindred talks to about some kind of better-coordinated care relationship is looking for ADT notification as part of that relationship –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

– so, I think it's pretty out there, I think anyone who's doing anything that's ACO-like, is having to address this.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Which is what this document is about, I guess, the one –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

All right.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So Charlene, this is Amy. Were you looking for categories of kinds of folks to talk with us or specifics?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Actually, what we were trying to just do was – I think the recommendation is we should consider this requirement, at least under the – bucket as a modular only certification requirement such that – and it's just to keep – there's a tendency in the market to want to certify the whole, maybe that'll change.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Right.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

But again, just to ensure that the provision of this capability can take place outside of an HIE very holistically, right, that's really what we're trying to – and the four events are the four events that we looked at and if those notifications are sent from an HIE. Then it's attributable – which – back to the hospital that would be fine, if there's an ADT feed. And the other thing that's powerful there is the other piece of this that we've got a lot of feedback on is that it gives providers the capability to subscribe or not, right, which we don't have in our capability, but we know is important. We just didn't know how to put that in, right.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Right. Right.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So that's very powerful. So I don't know if we want – if there's someone that would want to talk to us about how they're doing it today that would inform us.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Well, that's what I was asking, were you looking for suggestions, because I mean at least from the HIE model, I know the Rhode Island Quality Institute here in Rhode Island is doing it, I think Maryland is pretty big in this. And I'm sure we can talk to – I mean, I'm sure some folks at ONC know from an HIE – from the HIE program, who is well engaged in doing this work. I just saw an email come through with somebody else speaking on another webinar around this, it wasn't Rhode Island. So, there are folks out there if we want to get a sense of how and what is being done now in terms of what's out there and what's developing. But it is important to HIEs, as I said, and as you've heard, in terms of their value proposition right now.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

All right. Okay. So, I think we've got some requirements around that one. We'll add that to our notes, the input and then come back on that one. We will leave it as open – let's leave it open right now, if we want to get some more – we'll leave it open, as an open request, if we want to get some more insight into this. But clearly, I think we want to position this one as a modular certification for all the reasons that we discussed. All right, so, with that, if it's okay with the workgroup, I'd like to move to the other presentation and just – Larry, were you going to provide that or Ellen, or –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

I can –

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

Evelyn from ONC was going to be on the phone, I don't know if she was able to join yet. If she wasn't, then Larry Garber, perhaps you could help us.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Sure, I –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So, just so we – I framed this one again, we've got information relative to the use cases for the referral loop that we want to cover, as well as, as we break down into care sum – the care summary, the transitions of care as well as care plan. What we tried to do was to get some – to make sure that we started to get some momentum around care plan, knowing that the standardization of the process is evolving as we speak; we tried to put some infrastructure into the care summary to start the framework for a care plan and some standardization around it. And then we put the care plan out there as a separate requirement that we saw either in a future state. So that's kind of where we were in our thinking, so – and Larry has informed us to that point. And again, we've got some specific feedback on that to accelerate or

merge them together – we had a lot of feedback. But I think this will help inform the current state and then we can go to those conversations.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

So this is MacKenzie. Evelyn is on the line, we're just having her switched over. Evelyn, are you able to speak yet?

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator - Office of the National Coordinator for Health Information Technology**

Yes, I'm here, thank you.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Evelyn, this is Larry. I wonder if we ought to skip like the first dozen slides, which gives a lot of the background history. Because I'm not sure if it necessarily as relevant to the Policy Committee as it was to the Standards Committee about the Meaningful Use gap in standards.

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

Oh, absolutely. I was going to defer to you, because I think we can piggyback what Larry Wolf said, for us to focus on the data set. So, I'll let you – I'm here to answer any questions, but on your end, this is your fabulous work Larry, so please go ahead and start. I think probably breaking it down to the work that you're doing right now with the Lantana team.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Exactly. So, could you jump ahead to slide 14. There you go, that one. So we've done a lot of work, both up in Massachusetts as part of the ONC challenge grant, called IMPACT, as well as in the S&I Framework Longitudinal Coordination of Care Workgroup, which Evelyn so successfully runs. We've come and done a lot of survey work and realized that there are five – really five clusters of transition data sets. We looked at what the data needs were for basically every transition of care that we could think of, whether it was going for a PET scan or it was visiting the emergency room or being sent to home health or even transferring information to patients. And we looked at what the needs were for each of the different transitions and clumped them into these five that I have here on the screen.

The first two are pairs for when you're sending someone for testing, outpatient testing. So that's the colonoscopy, that's the imaging study, and you're really just sending enough information that they need to be able to safely take care of the patient for that testing, know what to do if they run into some trouble, and then the other part of the pair is the note that comes back. So that's that first two, and actually, those two are not on track to become part of the Consolidated CDA. We, as Arien pointed out, this really has a lot to do with this is sort of the lab result, lab order/lab result, radiology order/radiology result, and we felt that there was a lot of work that's already out there, defined by CLIA and others, that covers a lot of this. So we actually haven't paid much attention to that first pair. Whereas 3, 4 and 5 are the ones where we've been focusing.

So the third and the fourth are the consultation request, when you're sending someone for a consultation, or for that matter, sending someone to the emergency room, which is a consultation for someone who's just sicker, and then the note that comes back. It's called the consult note in the Consolidated CDA, we've been calling it the shared care encounter summary, but it's the same idea. It's you've been sharing the care on this patient, this is what the consultant found and recommends for treatment. And then the fifth one, which is the largest data set, is the transfer of care, and that's the one where someone's being transferred from one care setting and one care team to a whole other one. That's the one that would go from discharge from the hospital over to a skilled nursing facility or to a home health agency, or when someone goes from one PCP to another primary care physician. And so the third, fourth and fifth are the ones that we've been putting all our energy on. I think we can skip the next slide.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Hey Larry, this is Charlene. Just a clarification question then –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Yes.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So, when you're like discharged from the hospital to home or which category does – I mean, we recognize five, which category does that fall into – what's the current – like an office visit's the current transition of care, so how do we overlap the current use cases under meaningful use with these categories I guess is what my question is?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

So when someone's discharged from the hospital and you're sending information back to the primary care physician –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

It would actually be a transfer of care summary, which is larger than the discharge summary.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So is that 3?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

So that's 5. They're from the hospital back to the primary care physician would be 5.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. All right. Okay.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

The patient is no longer being cared for by the hospital team, and there's a care plan that was set up in the hospital that needs to be followed, and so it's much more sophisticated than just a simple consult summary.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. But my question is, if the patient is not going to home health or to a different agency, and they're just discharged, does this data set – I mean, there's more data here I think – would they need all this data is my question? I know that there's a lot of –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right. In the age of the hospitalist, it actually is better to do the larger data set, because right now, we know that – there's a study they did up in Boston where the estimate that there at 1.5 million preventable adverse events at the time of discharge, because they're fumbles. They are hand-offs where a plan of care is not being followed after discharge and that more comprehensive plan of care is built in the transfer of care summary.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So – all right, keep going – okay, I was just –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So Charlene, this is Amy. If I'm hearing your question correctly, you're trying to say, based on the terminology in Stage 2, how does it map to these, like what's a care summary, what's a – which one is a dis – I mean discharge summary I think falls under 5, but is that what you're asking, like mapping this to language in meaningful use to be clear?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Trying to be clear, because we're trying to map from Stage 2, so I just wanted to – I mean, what I heard Larry say was that there was to be expansion of the content of the current care summary to – 5, is what I heard you say. Is that what you said?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Well that's what I'm – I'm trying – so a care summary in meaningful use, here it's broken down to sort of a transfer of care or some people call it continuity of care form, states have their own languages for it, but a care summary maybe, depending on where you're being sent from, like from an o – is either 3 or 5.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Right.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right, so –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So Larry, I think what we're asking is, can you map this to the language that's in Meaningful Use today? Which ones would fall under which here?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

So, this is Larry Wolf, can I jump in for a second. I think we need to distinguish the use case from the documents we're using to support the use case. So, Larry's work lays out 5 use cases –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

– and I think there's value in our understanding the use case, Charlene's questions about so when someone leaves the hospital, clarifying that we're seeing that as that's actually a major transition in care, and one of the problems today is, half the people who are readmitted never saw a doc while they were out in the world, on their own. And so we want to address that gap.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Right and I was just trying –

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

That's a use case thing and what information is needed to address that gap could be a care summary, it could be care plans, could be a lot of the document types that are in Consolidated CDA. But I think until we get clear with what is the use case that we want to support, that we need to be aware when we're talking about the documents versus talking about the use cases.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

And I agree that there's mapping we need to do from what's in Stage 2 to what we're now talking about.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yes. Okay.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

But I can say that – so in 303, you talk about, it says the summary of care record for each transition of care or referral. The thinking was that for the transition of care as a #5 and for a referral, it's a consult request, #4. And so that was how we were mapping that back, in our mind, to what was written there. So all of these you can consider them as summary of care records, but you use different ones for different use cases.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Number 4 is the request though it's the sum –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Correct.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– and it includes content – .

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Oh, I'm sorry, I meant number – yes, so actually for 303, you talk – in 303 it talks about transition of care of referral, so a consultation request would be the referral to the consultant.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

And then 305 would be the #3, the shared care encounter summary or consult note.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I mean, what I like about this is it actually becomes the act of doing it itself that ultimately is counted and we don't have a step between, so, yeah, that's – all right. All right.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

So we can move forward, actually, that may be the only slide – well actually, no, keep going. Can I have the – skip through the next slide. This just shows how they build on each other, and – go back one, sorry.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, I think another thing –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

And they –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– importance is, go through this one.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right. So you can see, so the 3, 4, and 5, those are the larger data sets that we felt were part of 303 and 305. But we also recognize that the care plan is a subset of these and that – so that to some extent, there are care plans in all of them, the complete care plan is consumed within the transfer of care summary. We also recognize that there's a specific use case of the home health plan of care which is when – that's the old CMS 45 or, for those of us who are really old, the HCFA 45. And that's the one that's sent from the home health agencies to the certifying physician so that they can sign off on that as the plan of care for the home health agency. And so these are the data sets that we've been focusing on and we've contracted with Lantana, the folks from New York State, NIFE, CCITI and Healthix have funded Lantana to work under the S&I Framework to build implementation guides for 3, 4 and 5 there.

And that work is already under way, we've had our kickoff meeting and let's see, tomorrow actually, I'm here at HL7, we'll be starting the project scope statement, so that we can get this through for balloting in September at HL7. Later this month, we'll be kicking off the care plan and home health plan of care that will be funded by ASPE under Health and Human Services and through the CDC. That process is still under the contracting process, so – and will follow a similar course with balloting this September. So, the work is under way for these, to make these standards available and they would be published come December, is typically when the publication would follow the balloting and reconciliation.

So we anticipate by the end of this calendar year, that these will be standard and we anticipate they'll be part of the Consolidated CDA as well at that point. There's a small chance that they may not – there may be a separate implementation guide – CDA implementation guide, in which case the following HL7 ballot cycle they'd be put into the Consolidated CDA. But, that's some of what we're working on this week at HL7. But the plan is to put it in the Consolidated CDA, as new document type – the two of these would be new document types, so 3 and 5 would be – I'm sorry, 4 and 5 would be new document types. Three would be just an update to the consult note that's currently in the Consolidated CDA and then the home health plan of care and care plan would be new document types.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
New document types, okay.

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

And this is Evelyn, I just tend to direct perhaps, also to visualize it, you can move forward to slide 23, because I think it's also – we need to be clear that these proposed revisions to the Consolidated CDA will be balloted one package, by Lantana, and so this is a break-up that Larry just talked about, how they'll be an update to the consult note, but then there will be new templates or documents created for the referral note and the transfer summary and the care plan.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Okay.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

And this work is being coordinated with other HL7 groups who are – the patient care group and the care coordination services group, so there's a lot of coordination. Actually, we've been coordinating with IHE and HIMSS and a whole bunch of other people.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

All right. So, one of the feedbacks again is the need for the standardization of the data elements that are contained in these respective documents. Is that process happening? For instance, patient goals, because again, as you look across nursing and the different communities, there's a lot of different standards – the good news is, we need to go to a standard, and the bad news is, there's a lot of different standards out there. Are those conversations happening in terms of standardization of the content? Is that what the huge leap that we took in – for instance in Stage 2 on some of the data element pieces?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

So the answer is yes, we're talking not just about the buckets, but also the vocabularies within each of those buckets. It's not entirely known at this time how far we'll get at the time of ballot. It may be that we have a bucket that says you can use SNOMED terms or other controlled vocabularies, and so, it's not clear how far we'll specifically get in constraining that. I think to some degree that's the responsibility of the Standards Committee to define what vocabularies we want, that are required to be used for these. Whereas a lot of what we're doing with these CDA templates is making sure that we've got the right – focusing more on the right buckets, at least for this ballot cycle.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So, I just want to make a statement. I think the degree to which – because of the need for in our vision reconciliation and making that robust, the degree to which we can move towards choosing one, if you will, and I know that's hard, in terms of some of the – patient goals, if we could just get patient goals as some of these data elements, standardized, that will help us get to our vision. It'll be – the degree to which we do that will enable our vision to happen because again, at the point of care, as you start to reconcile some of this stuff and embed them into different systems, there's a lot of points that these elements are coming into and the more we can ensure the reliability of that, I think it's a critical task for us.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Sure. We clearly have recognized, and specified the difference between sort of what we call overarching patient goals versus problem-specific goals. So that distinction has clearly been broken out as being different, they're treated differently, they fit differently into the care planning process.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So, I don't know –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

We –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– okay, because I think that's going to be a constraint to the extent to which how far we can go with Stage 3 and Stage 4.

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

Charlene, this is Evelyn. Perhaps if you move to slide 24, I think – we've spent significant time within the workgroup coming up with definitions for what a care plan is or what the components, as Larry alluded to, what the buckets are and what's common across a care plan and a plan of care. And you saw this from the LCC Workgroup submission in response to the Request for Comments for Stage 3. So, there's been a lot of work on coming up with a set of definitions and saying, at a minimum, for these care plans to be interoperable across multiple systems, we should come to an agreement on what these definitions are and what the components. So, when we talk about a care plan, or a plan of care, again focusing on the similarities between the two, not the differences, what is the information needed?

And so, when we're working through in our data set and our care plan use case that we're in the process of completing with the community, it's looking at the data elements within each of these buckets. So I know there's been a lot of discussion about how – can we come to an agreement of what's the minimum information that needs to be exchanged so that you do have a longitudinal care plan. And so it's broken up by, as listed here, the health concern, the goals, the instructions, interventions, outcomes and team members. So the workgroup spent a lot of time coming up with these and would hope that these definitions would be part of what you include in Stage 3.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So, just for instance, one of the elements – one of the proposals again that we've been trying to reconcile a problem list, and it's been a little bit more from a medical perspective. But again, when you think of care planning, it's got to be an interdisciplinary – whatever word we want to use, there's always a new word for that one – so where would that concept fit in here, for example, because –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

The health concerns?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

The problem list.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

So the problem list is a subset of health concerns. So health concerns is made up of the traditional problem list, it's made up of barriers to goals and interventions, it's made up of risks for – disease risks, patient safety risks; so all of those are lumped under health concerns.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. Because where I was going is, we've got two different data elements, again reconciling problems, medications and allergies as part of our current reconciliation definition, and then we have a candidate requirement for an interdisciplinary problem list. And again, it would seem like we want to harmonize these concepts to get to what – if we need to capture some specific elements to enable those, that's one approach we can take. Or we use the broader definitions that you have in place. So, do you have any recommendations or thoughts on trying to reconcile those two perspectives?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

I think it's fair to say that the problem list is a subset of the "interdisciplinary problem list," which is probably a subset of health concerns. And – because there are a lot of things that we think about, but we never actually write down. I mean, we think about the person who's age 50 and the fact that they need a colonoscopy because they're at increased – that they're at risk for colon cancer and so those are sort of

unwritten health concerns. And so that's why we use the term health concern as a broad term. So whether – and that's probably – and so whether you use the interdisciplinary problem list or health concern, it probably doesn't matter that much.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. I mean, I think one of the things that I know we're trying to just – through the use ca – I'm trying to operationalize a little bit, so, to get from your framework, which we could support. But at some point in time, what we've found in meaningful use is the more up front we can get in thinking through the required data elements that we're going to need in the policy process, it works better, which is why standards needs to work with us in this process. It works better getting us to where we need to go and then we can harmonize across other requirements that we have, too. I'm trying to wonder, or I'm wondering is, will there be a – kind of how you, Larry, you started out where you said, okay, this is a couple of presentations ago, here's the stage that's going to get us to this fully blown out care plan. Is there a mechanism that gets us from today's data that we capture to the data that we're going to need over time to support this list of – the list for the care plan? See what I'm saying?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

You need the 5 big buckets. You need the health concerns, you need the goals, both patient-centered – overarching patient goals and problem-specific goals. You need the interventions, which also include instructions. You need the care team that actualizes all of this and the care team members, and you need also the statuses, as these are assessed. There's the status of the care plan, and that's where you'd have all the functional status and wound status and cognitive status, things like that. And those are the big buckets that need to be addressed.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

All right. I'm just –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Charlene, this is Amy. I think the more – I mean, I share what I think I'm hearing your concern which is, the more we refer to these differently, the more we confuse – the more confusing it gets to figure out how, even if we understand how they're aligned, how to communicate that.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Right. I mean –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So, I share your concern and I too am trying to sit here and think about how do we try to move to some standard semantics or language, because that's in the end what trips up people. And with meaningful use, I think we've learned, people want much more clarity, especially when it comes to that – to general language, because otherwise, there's no – people are confused in terms of how to implement.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Right. So –

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

This is Larry Wolf. I guess I'd encourage us to not look for premature resolution on this discussion. We should hash through the concepts and then we should clarify our terminology.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. But you see Larry where I'm trying to go with this one in terms of – I think creating a dat – where I'm going is creating a data strategy that aligns with what we have today and fulfills what these cat – I mean, we have some of them we could just check off, right. We have team members, right. But there are other elements that we don't have, but unless we create that glide path and understand that the standards are going to – I can't push the curve if I don't have the data elements defined, right. And so, I've got some of them defined, but I don't know how they fit in yet. So –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Well the key thing is, as I have looked through the prior stuff in the MU2 language, there's sort of been a smattering of things at different levels, whereas the 5 buckets I said before are the 5 equal level buckets that make up the care plan. And within those there are things like the barriers and risks and so, because even instructions really are a type of intervention. And so the big buckets are, it's the health concerns – the care plan is made up of the health concerns, the goals, the interventions and the care team members and the status or some people call it outcomes; and it's those 5 buckets. And under those, there are more pieces to it, but if you speak in those terms, those are the pieces that make up a care plan.

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

And this is Evelyn, just to add that when we did work on this with the community, it was mapped – and this is just a snapshot we're showcasing here. The full glossary has these definitions mapped to what exists or what's proposed in Meaningful Use Stage 3 for these definitions. They weren't created in a vacuum, there was a lot of gap analysis done in looking at what already exists and how we can more clearly define these and enable interoperability.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

This is David Kendrick, can you all hear me?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yes.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Yes.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

I just want to ask you a quick question about scope. We're talking a lot about the details of the information that's needed on both ends of a transaction, but is there any – is it in scope to talk about the process of the transaction itself? Statuses, when data moves, where and how and how is that audited?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I think it will be at a point because two things. One of the things that we're doing is actually using the process of the movement as a mechanism to capture the denominator, right. And so as of – rather than requiring all of these data elements to be able – say okay, you've got to capture care team and these kind of things and they're functional requirement, we're actually making them content of documents that have to be sent instead. So I think that gets to your question, that we need to know when and how that's going to happen?

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

So – right –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Am I interpreting that right?

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

Yeah and I would say that – so I've worked to build systems that do these kinds of things over the last few years and we've been using them. And it seems like we spent – we would spend an inordinate amount of time trying to in a way boil the ocean on what data elements were needed on both ends without just recognizing we couldn't ultimately predict what both ends were going to need. But we could standardize much more easily the steps people would go through to move the information and audit that information. And since they are critical elements of the denominator, I wonder if that's not a more important starting point, to standardize the transaction process.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. Well, so given – there's a couple of different paradigms that I've got in my head here. We've got use cases and we've got – and I want to ask one more clarifying question before we move back to the care summary document, and that we may not be able – we've got to keep all this in our head as we kind of walk through that but. As I look at these elements of the care plan, and you have the other two document types out there Larry, 3 and 5 –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Yes.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– these elements would be in that red layer that's above or – and included in 3 and 5? Is that what I'm understanding?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

That's right. Components of this are in 3, 4 and 5, but 5 is the one that has all – definitely all of them.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay, so 5 has all of them, okay. And then – all right. And if I look at all of these, there are additional data elements such as labs and those kind of things that are outside the scope of what's on here, so I should of this as that red box, is that what I'm thinking of this as?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

That's exactly right.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So why don't –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Now –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– we just go back to that one slide and we'll get ourselves framed, okay? So here are the term – these are the care plan terms that we're going to try and advance.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

And I just wanted to – just wanted to address the comment about the process.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

We – to a large degree we're trying to leave some of that in the care planning process in a black box, because we know that different organizations, different settings, are going to have some slightly different processes for how they'll do care planning. But the one thing that we are doing is for the specific use case of the home health plan of care, the CMS 45. We are doing that workflow where the home health agencies EHR sends the document electronically to the certifying physician, the eligible professional's EHR, that they have the ability then to either comment on it, send a comment back to the home health agency saying stop this, add that, or to actually add a signature to that home health plan of care document and send it back. So those are things that we expect to be part of our balloting process this fall with HL7, whether that can or should be in Meaningful Use Stage 3, I'd love to see it in there as certifying functionality of an eligible professional EHR, but I don't know how you feel about that piece of scope.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

Well I was just – this is David again. It's just all of the sort of specific information needs on both ends began to work themselves out once we had established a formal set of statuses for moving and monitoring the status of the transition.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Statuses, okay.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

Yeah, I mean, the way I look at this is, when I write a prescription for a patient, that goes through a series of statuses and I can check at any moment in time, as can every other member of the – participant in the transaction, where the transaction sits, regardless of its content – the message content. And we just have not, and I've said this in several S&I meetings, but, we need to formalize – and we do the same for labs, right, we know the status of the lab at any moment in time. But we don't know that for these care transitions and I feel like that's the lowest hanging fruit out there –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So just give me a – can you expand in terms of – this is the thing that we struggle with in the workgroup, because we don't know what infrastructure we're working with. So how would we say that, do you see what I'm saying here? Like how –

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

Yeah, I mean, I'm trying to –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs  
– prescriptions you've got an infrastructure, right?

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

But you've – well, with prescriptions you've got an infrastructure, but before you had an infrastructure, you had a standard. I mean, they sat down and decided what were the important steps to a prescription, I mean, it's got to be draft and signed and transmitted and received and so on. And it's all of that – those statuses that I think are important to track here and so we have – I think we tracked something like 25 states that a care transition can be in, and do so intentionally and making improvements we've made would not be possible without those statuses. It's very little about the message content, frankly.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

The use case – as part of the S&I Framework work, we do have use cases that do describe also all those steps for both the transition of care documents, the 3, 4 and 5, and we're just finishing up the ones for the care plans and plan of care right now. So that work has been done, in terms of describing the steps.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

And that's really where I was hoping to get to is to describe. I mean it strikes me that if S&I were able to put on the table, here are the statuses that any – generically any care transition should go through and the things that are important to measure, then you're going to get an environment where every vendor is going to build to that.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

And that's ultimately, I think, what we want.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

I think, this is Amy and I – what I'm hearing right now and what I'm sort of wrestling with in my mind is, the status of the transfer or the process is sort of where in the process, and obviously you've said that's very different from the content or what. And the question I'm asking is, in Meaningful Use, what do we – sometimes we talk about the functions of what and how something has to happen and sometimes we talk about, and it has to have this content. And I think we're sort of going back and forth – I mean I think we've been focusing on, this is what it has to have in terms of content minimally, which we've done sometimes in Meaningful Use, and then the new question on the table is, and where is that process and status and checkpoint along the way. But they are clearly, in my mind, two distinct different – they go together to make a complete – both process and content, but I think – I'm not – now I'm confused in terms of what our goal is here and what we're trying to accomplish.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

I apologize for that. I'll withdraw the question other than to say, I feel like the process winds up informing the content more than the other way around in this.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Well I wasn't suggesting you to withdraw your comment, it's a valuable conversation. I'm just trying to distinguish in my mind, what we're trying to do in the end, relative to those two. And if one drives the other and we haven't thought about it in that context, we should try to understand if that makes more sense. But, I'm just trying to – distinguish that there are two different things.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, and –

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

I mean I –

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

I just want to add, this is Evelyn, you have a very good point and this is a challenge within the workgroup because it continuously comes up that when we're working on the content, so exactly, this is content-focused, what is the information needed? But then you get into the process discussion, and that's where you end up going, as Larry said, it's a black hole because if you look across all settings and disciplines, there's a different process in place of how this information is exchanged, who completes the work and I agree. It is a separate use case, and that's what we've been trying to drive with the workgroup saying, at this point, where we are, if we want to get this into Meaningful Use Stage 3, if we start going down the process route, we're not going to get there.

It definitely needs to happen, I think it's a different use case, we need to spend the time there. There is conversation, which one should come first. We think, given that the process discussion is difficult, especially when you do have these different provider groups participating in these calls and they all state that they do things differently, it's hard for us to come up with a concrete set of recommendations in the limited time. So we really appreciate this discussion within this workgroup because it is a challenge that we face from a standards perspective because we're saying we're not, from an S&I perspective, we're not here to dictate what the process should be. Our use case should not be descriptive of what needs to happen within one setting and another, all we can say is, we'll have standards in place of what the actual content needs to be and how the information system needs to be updated with that content. But we can't stipulate what the process needs to be. And that's where we would look for your help.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

And I think that's where the struggle comes with measurement then, because if you don't have –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Exactly.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

– dates and times and actual steps being taken that you can measure, you have a very difficult time. I mean, just saying the document contains certain words is less valuable than knowing that it was done in a timely fashion and touched by the right people. So –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

This is Larry Garber again. So, the way I've been looking at this is that, we know that probably the largest area of concern in adverse events is during the transitions of care, and that we know that the components of a care plan need to be conveyed during those transitions of care. And that's why we've incorporated them into the transfer summary, that it has all of these care plan components in there. But in order for them to be there for the transition, they need to be there within the source EHR in the first place.

So – but how they're used and worked within the source EHR is not something that we've been addressing or think that we can address. But the key thing is that all of the 5 big components need to be part of a certified EHR system, so that they can be sent during transitions of care. And so I wouldn't be specifying that the care plan document has to be sent, I'd be saying that during transition of care, the transfer summary or the consult request, that those are the ones that should be sent, knowing that they will have these components within them, and that's what you'd measure is the actual transmission of those. The only actual care plan document that I would consider probably for Meaningful Use Stage 4 would be the – specifically the home health plan of care document, and the workflow that's involved with that, because that's very precise. But otherwise these care plan elements are part of the transfer summary document.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So why don't – so, just – as I'm listening to all this, it seems like even my – as I look at my referral loop requirement 305, it almost becomes your document – is that document 2 or 4? Document 4? Is that how I should think about this? This is Charlene.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

305 is, I'm sorry, I'm trying to pull that up –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– so, should that just be the execution – I don't know how I'm going to get a denominator yet, but –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

So that's number 3 –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yes. Or it's – okay, so does that just become number – well, I thought it – oh yeah, that's number 3 because number 4 is the requ – sending the information over when I request a referral.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Exactly.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Do I have – is 304 mapped to any other Meaningful Use requirement? I mean, is document 4 mapped to any other Meaningful Use requirement?

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

To 303.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

– 303 –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Because that's the referral –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

It is document 4. Well document 3 is also mapped to that and then – in some cases, right.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Well that's – well it's transition of care or referral, so, those are really document 4 and 5, that are part of 303.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay, let's start to look at, since we've got a little more time, 303, because as I'm thinking through, again, just back philosophically in terms of Meaningful Use Workgroup has done in these cases is, eventually what we're trying to accomplish meaningful us. So it's actually not so much tracking all the statuses, but like as we did ePrescribing, that it was actually used, it was actually done. So philosophically, I understand this whole conversation about the statuses and the ability to get to the denominator, but what our process has been has been more measuring that the payload actually went for the particular use case and I think that's perhaps the most powerful thing we could do. So if I need to restructure my objective to map to your use cases, I'm okay with that, because that's kind of what the intent of meaningful use has

always been. Does that make sense? And again, we've got to work through care summary, but it could potentially – we could break these out into, if you will, map to the document type, to some extent, because they mapped as use cases, if you will. Yes/no? Lar – George, you're on?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
I'm on but lost.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Okay. All right. I get it. All right. Let's – I wanted to – can you go back to the slide with the use cases?

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**  
It's slide 16.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
So what we've been doing in Meaningful Use is try to really start to understand the data sets that we're trying to support with the care summary and then we expanded it to the transitions – to the care planning as we defined 303 and 304. What the S&I Framework, as well as the other workgroups of S&I, the EI Workgroup, IE Workgroup have been doing is looking at it in terms of use cases. I'm fine – I'm actually okay in following that approach, because that's really what we're, I think, at the end trying to do. So, it's just to recognize that they've kind of categorized these different data sets under these different use cases. And I – earlier in the call we were trying to map these use cases to what we have today. So, I just want to frame – go back one more slide, I think it's on your previous slide – one more. It's the one that defines – there's five different use cases – Larry, you probably know which one that is –

**Michelle Consolazio Nelson – Office of the National Coordinator**  
Slide 14, please.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Thank you. Okay. So these were the – based on use cases, the three, 3, 4 and 5 are the use cases we've been focusing on and some of those encompass the current care summary as defined in Stage 2, and I think we just need to, as we walk through the care summary feedback, we should consider these different use cases. And again, use case 3 encompasses things if there's an office visit, summary of a consult, the return from the ED, so it's that kind of document. Consultation request was the request – when you request a consultation, you send a care summary over or if the patient goes back to the ED, you send the current state of the patient there. And the last one then was when a patient's discharged, there's a more complete data set that's sent. So, I'm trying to put these use cases in context to looking at care summary and the care plan. Okay?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
What's the difference between 3 and 4 again?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Um, Larry, do you want to clarify on that one? I could probably say that, but – Larry Garber? Evelyn?

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

Hi, I'm here. Sorry. Yes, definitely. So number 5 is more a robust set. So for the first one, you would think of an office visit, from acute care setting to a PCP and so they'll be a shorter summary of information exchanged, while number 5 is looking more as the robust set that will include all of the components – the 4 above, but it would be from one facility, a hospital, or even a PCP to a different facility, so home health agency, nursing home, skilled nursing facility. So, it talks about –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
What's the difference –

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

– the transfer of care data set.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

I think the question was about 3 versus 4.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, 3 versus 4.

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

Oh, sorry. I was looking at 3 versus 5. Larry, are you back off mute? Because I think the difference is the referral piece.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

So in one case you're asking for the information, so you're sending the information that you could – you might need to do an ED assessment or to do a colonoscopy and then the other one you're getting back the assessment or getting back the plan out of the ED.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well, return from ED – so 3 is, I'm just telling you about the patient and 4 is saying, I'm telling you about the patient and here's what I want you to do.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Actually none of these are returning back, are they? I mean, it could be part of 3 and send – oh, that's the consultation summary under 3 –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I think that's part of 3. So that was why, George, where I was thinking I've got this close the loop on the referral, why isn't just getting the consultation summary what I asked for, was what I was kind of leading to.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Yeah, I mean so 4 only adds literally, here's what I want you to do for me, and otherwise, everything's – I mean I understand 5 is a little bit different. Where I want to know all the details of the admission so if an allergy pops – if there was some sensitivity to some treatment, I want that in there otherwise it might get glossed over, so that's a big thing. But between 3 and 4, I think 3 is just is, whatever it is, 303, is transfer information for any purpose from one to the other. Here's what I know about the patient, but I think a summary of the patient that I think is most relevant, which could be the consultation back or office visit to someone who asks for it or whatever. So 3 actually is a broad thing that covers a couple of different scenarios –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Exactly, so – but my –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

And then 4 just adds one more field which is, what do I want you to do.

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

Yes. This is Evelyn.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Yes, the sense of creating closed loop, 4 is the one that is the initiator saying, oh, let me introduce you to this patient, please do "X."

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So George, kind of if we look back at, I forget where this stands now, what David was doing in terms of requesting a referral or a consult, would the requirement be that they send this document, basically? I'm just trying to loop us back to that original request with what we had up in –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

I forget what we ended up with –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I don't remember either –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– with consolidation and everything, but, the idea was that was the order so we'd have the denominator so that we can measure these things. But, yeah, the idea would be writing an order for a referral, presumably that would also be accompanied by a consultation request, specific consultation. So the order was writing the order to send the referral, right.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, yeah.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Yeah. So that would be number 4 here. No, that wouldn't be 4, it would be accompanied by number 4.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Right.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

This is David. It seems like these are really should be couplets, if we're really talking about loops, then we need to have things start, go out and come back. And so 1 and 2 are – 3 has a couplet embedded in it, 4 has a couplet embedded in it and 5 should be a couplet as well –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah. Here's our problem. Our problem is, the way that our framework is organized, my couplets are in a different section. So, I'm with you, but we're trying to – that's a good point. Maybe we just need to raise that when we meet with Paul and say, we've got these couplets here, right. And should we be moving them from that other section down to this section. And I don't know where we are with consolidation, in terms of removing those couplets. But we will raise that as an issue when we meet with Paul then. The other – so, in the spirit of consolidation, and I want to then move to the summary, if I had – this is for item 305. I had the referral loop there, 305 if I just – if we encompass this under 303, basically, do I get rid of the referral loop as a separate objective is what I'm asking. So, I just will include the consultation summary as something that they have to send.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

This is Larry, I'm back, sorry, my battery died and I had to go find a landline. So that, I mean it makes sense to put the – I would be fine with putting the two together and I don't know if I missed it with 304, but bringing the components that you have in 304 about a care plan, you could actually bring that into that combined one as well.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay, 303.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

So you could merge, 303, 304 and 305.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Hold on, I've got to look at 305 –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, 305. All right. Yeah, that's kind of – now are we ready to kind of look at it? So to the workgroup, well, in the – one of the things that we've been trying to do is consolidate it, but based on looking at those 3, supporting of those 3 use cases, if we can get that defined as part of 303 and maybe 304 just stays out there as your home health care plan or we just table it for a little bit –

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

But you could – but the components of it you can incorporate into what you've got in that 303, 305, the fact that they ought to be conveying the components of a care plan, because those will be in the summary.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

In the red box is what you're saying.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right. In other words, the red box is part of what we'd be telling – asking them to send anyway, so we could spell it out.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. All right.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Charlene, are we trying to figure out how to consolidate or what is the question.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

We're going to just look at the feedback – there's been a lot – one big element of the feedback was consolidating 304 and 303 and moving care plan sooner. And in looking at the feedback from referral, where we're just trying to accomplish the consultation summary at this point, and we don't even know how to get to the denominator. It strikes me that it might be a better approach to consolidate under 303 as much of this as we can, rather than trying to break them into separate objectives, unless you think we should go that way.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well it's just that under 3 – I think it's fine to consolidate for various reasons, but what will be in 303 now will be if you are the request – if you are requesting a referral – if you are making the referral, here's what you do and if you're the person who was referred to, here's what you do. Like if 305 is the person who did the consult, 303 made the – well, 303 is a little more general purpose, but say – yeah.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So let's look at 303 but my – the open issue relative to what you just said in terms of number 4, right now that isn't – I don't know how we do that, but it's encompassed under the requesting which is in our Quality Workgroup piece. And the point that was brought to the table here is, we've really kind of got these couplets and we're struggling in our workgroup because our other piece of our couplet is in the Quality Workgroup request for the referral, because of the way our framework's structured. And so I don't know to deal with that one, but I think we should start looking at 303 and see at least if we can handle maybe 3, the use cases of 3 and – at least we can look at 3 and 5, right.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So the history of 4 was that, at first it was together, then it was felt that care plans are very important and so we wanted – we split it out for emphasis until we could do work on it and have a whole set of paragraphs and bulleted lists about it, really go into more detail. And then when it went to the committee process they said okay we're ready for 3 but 4 is way too far off for everything you've done and so then 3 got – 4 got pushed off to future stage, leaving only 3 behind, which had care plan in it in some vague sense in Stage 2. So now we have other pressures to reduce the number of objectives, so we can certainly put 304 back in and if we limit 304 to what's feasible by Stage 3, then that's fine. We just have to look and make sure we think that – although it was felt that what's currently 304 was beyond what we could do, maybe there's some shorter thing we could do and incorporate that into 303.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

And then 305 is just a matter of whether we want an if/then statement that says if you're the referrer versus if you're the consult. Although 30 – wait, 305 –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Don't we really want the ability for EHRs or – to produce this consultation summary in a standard form. I mean, it seems like that's what we're trying to – I mean it's –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

To do what in the standard form?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah and then – because EPs are measured by that anyway, at least they can send it in a standard form.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

We do, remember, so we have 50% of which 10 – 10% is electronic and then 50% is returned in some way. So I guess it goes into the EHR but it's not sent to them via direct or something.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Right.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So that's sep – but that's okay, the format of the results could still be consistent, even if you can't send it via direct.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yup.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So that's fine. I mean it seems like 305 is really just another summary going in the opposite direction.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I agree, I think that we can consolidate, because of all this numerator problem, too – I've got or my denominator problem, I –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

It'll be two different denominators now. One denominator is all patients – so 303, the one half is any patient – what you really want is number of patients who have transitions to another setting of care or who get referred to another provider. And then the 305 half of what will become the big 303 will be or patients who were – number of patients who were referred to you.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah, so I think we have some of that language in 303, but – could you bring up 303 on the monitor please, slide – care summary, 303.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

The slide number, just to let them know, the other deck, it's going to be the other deck, it's our –

**Michelle Consolazio Nelson – Office of the National Coordinator**

It's slide 9 in the other deck –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Slide 9 in the other deck.

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

– is where it starts.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I think we should just – I know it's hard to read, and I've got the small print out, so I'm not any better here either. So when we did this, we definitely...we thought through the two use cases of, and again, I think you went a little deeper, the use cases of who transition their patients to another setting, so the more, your use case number 5, right. Or refer the patient to another provider for a referral or we can call it a consultation. So when we thought about it, and I'm not going to go through how we measure it, let's come back to how we measure it at this point in time. And then from – and then for Stage, so that was kind of for Stage 2. Then for Stage 3 then, what we did was used that same paradigm, provide a summary of care for each site transition or referral when the transition occurs with the available information. And then for the – we broke out the transition for the site of care and then what we asked for in all cases, and again this gets complex, with – it says with the first referral, concise narrative in support of care transition. And again, we've got a lot of feedback just for what the intent of that transition was, so that's necessary for referrals and then setting specific goals, instructions, care team members were our mandatory elements, in terms of the care summary.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right. And that's where – this is Larry – that's where you were sort of spottily touching the 5 pieces of a care plan, whereas you could just list the 5 pieces of the care plan.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yes because we have – I mean we would leave number 1 in place, but we've got kind of those same health – you would say health con – well, no, you've got patient goals, we've got instructions, we've got – we've got like 3 of the elements, right, in that summary.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right. I mean, are you allowed to call them health concerns and explain what that means?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

The –

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Yeah, so we're introducing some new concepts here, we're broadening what people have been thinking about as problem lists.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right. But if you also – if you'd call it interdisciplinary problem lists –

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Yeah, but you want to encompass in here things that have been tagged as allergies, right and will include all of the do not give this, the patient goes into – has all kinds of problems, it might not be allergies, if you do this procedure, right.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Right.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

So, I think what we're struggling with all through this call today has been that as people dive in to what does it take to provide really good transitions, that some of the concepts that have been put forward over the last decade and are embedded in the various CDA documents, need to move forward themselves. And so we've been struggling with that as we're looking – we're hearing new terminology from Larry Garber, it seems like it's useful to try to incorporate it, but we're going to be creating chasms of understanding as we try to move people from what they've been thinking about for Stage 2 to what we're now discussing. I think they're valuable things to be doing, but we need to recognize that we're creating some conceptual discontinuities, even if we're not actually creating any data discontinuities.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

This is David. I would agree, it almost feels like we need a definition page.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

Which we do have that we could give you. That would be great.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

This is Amy. Evelyn, before, did you say that when we were looking at those definitions, you said there was a more complete mapping to Meaningful Use Stage 2?

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

Yes.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

I'm wondering if that document would be helpful to try to –

**Evelyn Gallego-Haag, MBA, CPHIMS – S&I Initiative Coordinator at the Office of the National Coordinator for Health Information Technology**

Absolutely. Yes, we can – I can share it with Michelle or MacKenzie to forward to all of you, or Larry can forward it. But we definitely have that all on our – with the – on the S&I CC Wiki site, all those documents, and the initial analysis done for the care plan glossary.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I think that would be really helpful.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Yeah, I agree.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Larry Wolf hit the nail on the head, what happens now is, again, there's language that they're very familiar with and will become increasingly familiar with Stage 2. And as soon as you switch your paradigms, they're really – look at the comments, they're even struggling because of the lack of standardization around this, to even give us input for Stage 3. My – I'd like to take a crack at – I think when – and Larry Garber, I think you see this, we've I think encompassed your use cases in our thinking here to some extent and I don't know if I need – should reword this a little bit in terms of – I'm not sure I can jump to those new terms. But at least proposing getting – because we've got a consultation request in here, we've got a transfer of care, right, those pieces are in here so I think they're being framed in this scenario. The piece that – and your recommendation is we just expand those elements and say those things, which are available, should be populated, right, in a particular use case. But it should probably be clearer here, as opposed to – I should break the use cases out just a little bit more, it would seem to make some sense.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

That's right.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

And then I should potentially look at including sending back the referral request as part of this particular requirement, that's the other thing I would try and feed in here.

**Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics**

The only advantage of that is that it eliminates some of the redundant text that you were going to have to put in otherwise.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yeah. Yeah. Yeah. All right. Since we have about like – let's just look – overview some of the feedback that we got and just – I think it would make sense just to ground a little bit in that and then I'll try and get us a little better organized for our next call, which is on May 24. And my first focus of that call will kind of just summarize and bring Paul up to date with where we are, what some of our issues are, because he's got transparency and will be able to offer some guidance there. But why don't you move to the next slide.

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

Charlene, this is Michelle.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Yes.

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

I just want to point out a mistake that I made, or a miss. On the list of items that are included in the care summary, in the consolidation process, we consolidated the CPOE for referrals piece and we added it as an additional element in the consolidation, asking for the status of the pending referral. So, I just want to mention that.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So – where did you put that?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

So in the items that are included in the care summary itself, one of the ones that we added was on the status of the pending referral.

**David Kendrick, MD, MPH – Chief Executive Officer – MyHealth Access Network**

Ah, now we're to statuses, so were there – was there a list of options for that status, what it could be or was it just a generic "X" the status?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

What did I put in there? What do they want me to put in there?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

I don't know.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Hi, this is Larry Wolf. I'm going to have to get off early, I apologize. It's been a great conversation today. Thanks everybody.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay, thank you for your help on this one. So, you would add that, so the status of the – so we have reason for referral, right, and then you would have status of the referral?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Charlene, I think Michelle's already added it. If you go to the very bottom of the chart, there are some additional items added here, under certification criteria number 3, then there's 1 and a 2 sub-bullet if we're looking at the same table.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I'm looking at slide – well the care summary 3.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So I'm looking at the table that starts – I think I have it up on – more on the PowerPoint because it's easier to read, it's larger.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

What page?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

I'm trying to see here – page 4 of the document I'm looking at. It's under – I think it's under 303 under the Stage 3 recommendations, it's like the next to – the third to last bullet, is that what you're talking about Michelle?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

So I remembered to include it in the word document, but it's not included in the PowerPoint document.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay.

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

**Technology**

It is included – it just says – it's included on slide 10, it just says, CPOE for referrals in the consolidation, but it was added as an additional item as well.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

So is the request for the referral under CPOE –

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

**Technology**

Yeah.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Did it go away, is that what happened?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

**Technology**

I just didn't – yeah, we got rid of the objective or consolidated the objective, I should say, here.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Well, that might get this group to tracking statuses then, which if we understand how it could be used, that would help. So, just as overview of where we're at. This is the current content of the care summary items, so to the request that Amy made, if we could understand what we're currently asking for – well, that's Stage 2. Do you have a Stage 3 view, because we added more? Is this Stage 2 or Stage 3?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

**Technology**

So, for Stage 2, what's there and then for the consolidation, you can see the two items. So it just says CPOE for referrals, but you really want the status, is what we decided in the workgroup, or what the workgroup decided.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. So my question, are these only Stage 2 or are there additional data elements that we asked for for Stage 3?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

**Technology**

Well I think that's part of this conversation.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. All right. Okay. So, I'm going to do some – between now and our next call, I'm going to – if you could – we'll just get clear in terms of Stage 2, requested once for Stage 3 and then the other column will be the potential mapping to the proposed new terminology, but know that's going to be a big leap, okay. But I think we should at least put that on the table, so there might be 3 columns of this information then, if we can get it to look like that, for the next call. So we look at the proposed, based on the care plan paradigm, we look at what the intention was for Stage 3 and then we look at what's currently in Stage 2. Does that make sense, so we can kind of get grounded in terms of our data elements. Yes, no?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Yup.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. All right. So for the next call then I will summarize the feedback, to bring Paul up to date, and we'll kind of use this group again to have that conversation, look at the – where this tending to go is actually notifications I think we got through, well, we didn't get through, but we kind of came up with a recommendation. Referrals is potentially to look at potentially make a – including under 303. And then if we make – the decision we'll have to make is do we consolidate 304 or do we keep that as a stand-alone item, but that might be based on looking at the data. Is that where we're at? Yes?

**Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology**

Sounds good Charlene.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

I know it's – we're – thanks for staying with me on the call and clarifying and adding your input to the process.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

And Charlene, this is Amy, I just want to say thanks for taking this on. I know I've missed a few calls but this is complicated, it's hard coming back in, but your effort and energy in trying to keep this going is greatly appreciated.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Thank you. I'm feeling like I get a brain freeze occasionally, so –

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Well I think we all do.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. I think we can open for public comment. And again, thanks for all of you participating on the call.

## **Public Comment**

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

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

**Rebecca Armendariz – Project Coordinator, Altarum Institute**

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

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. And again –

**Operator**

We do have a comment, I'm sorry, that came from David Tao. Please proceed with your comment.

**David Tao – Technical Advisor - ICSA Labs**

Hi, this is David Tao. Hi Charlene.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Hey David.

**David Tao – Technical Advisor - ICSA Labs**

Hi, good meeting. I agree totally about the mapping of terms so that people can see how they're partially there, as opposed to not there at all today, with Meaningful Use 2, and have that passed forward. I think one thing that needs to be clarified is transition of care versus transfer of care, sometimes they've seemed to be used interchangeably. Although I don't think they are meant quite – I think transition of care as used so far has been more broad, including the referral, which is not really a transit – a transfer and then there's the transfer. So, I just urge that there be some clarity regarding those terms if they're different or if they're the same, that they both be defined real crisply. Thank you.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Okay. That's a great get, because – and I think we're aligning on transitions of care, but we'll take that into consideration as we work through the use cases. Okay.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Are there any more public comments?

**Rebecca Armendariz – Project Coordinator, Altarum Institute**

No further comment at this time.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Okay, thank you.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**

Thank you.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks everybody.