

**HIT Policy Committee
Meaningful Use Workgroup
Subgroup #3
Transcript
June 4, 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 meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #3 Improving Care Coordination as well as the Information Exchange Workgroup is that correct Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

No, today we didn't invite them officially.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

But Larry is on from the IE Workgroup.

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

Okay. This a public call and there is time for public comment on the agenda and the call is also being recorded so please make sure you identify yourself for the audio and transcript. I'll now go through the roll call of the Subgroup members. Charlene Underwood?

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

Here.

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

Thanks, Charlene. David Bates? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Here.

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

Thanks, Leslie. 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. Any other Meaningful Use Workgroup members on the line?

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

George Hripcsak is just listening in.

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

Oh, great, thanks, George. And we have Larry Garber from the IE Workgroup on as well. Any ONC staff members on the line?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

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

Thanks, Michelle and with that I'll turn the agenda over to you Charlene.

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

Thank you very much MacKenzie. So, today if we can move to the agenda? What we worked on with pretty significant input as well as I think resolution last call was the care summary document and we introduced the concept of, you know, handling some specific use cases through that process. So, again, I think we made pretty significant progress with that one last meeting.

This meeting is an associated objective – to cover in this meeting we've got some associated objectives and what we were going to cover today as far as we can possibly get, because this is the last scheduled call, is we were going to go through care plan, reconciliation, the interdisciplinary problem, medication adherence.

We had some small follow-up on the referral loop and again the concept there was because we changed the care summary to be inclusive of the consult – we have two elements the consult note as well as the consult summary, but bear with me I might not have the appropriate names on that, might we be able to actually not include this objective and then we had a couple of small follow-ups on notifications, but pretty much leaving that intact. So, that was what we were going to cover.

So, the first objective was the care plan. All right, so what I thought I would do, I was kind of thinking this one through, it's just – I think – again, I think we need to level set a little bit with this one. I'm going to take the time at the high level to review some of the specific feedback because I know that there was a lot of energy put forth by the public relative to providing input to the care plan, everyone understands it's clearly a stake in our future and getting that right is what's important.

So, with that being said, again, we had a pretty substantive debate in looking through the requirements for care planning as the care plan as we moved out to the future kind of being the core grounding concept and I don't want to say document, the core grounding concept which would allow caregivers to manage and coordinate care across multiple care venues as well as multiple care providers and clearly the mechanism to be able to eventually get the patient more fully engaged in understanding what their care plan is and how they're supposed to be responding to it.

So, to that end what we finalized in our initial RFI which we proposed actually for a future state was recognizing, and again, I think we'll have to take into account that we broke down these transitions of care, but for purposes of this let's call this for transfers of care that use case, providing care plan information including the following elements as applicable.

And again, Leslie did a lot of work to try and understand the current state of that and Larry I know this is some of the work that you're doing now relative to these current definitions. But, again, the intention there was to begin the population of some of the key elements of a care plan and I'll review some of the feedback, so they're pretty much listed there.

The one that, and again, we – these were like incremental to the kind – we set a framework in the care summary to begin to start to define elements of the care plan and we took that step but these are some additional elements of the care plan and we really have to consider are these sufficient, is there a minimum set that we want to start with or is there a broader set that we want to start with?

There is one that's on here, the specific advanced care plan, physician orders for life-sustaining treatment, and again, this one linked to some of the discussion that we're having around advance directives, so again, for the purposes of this call I think we need to just – based on the hearing that we have on this we need to be open to that feedback.

Again, at this point we had a pretty generic measure that we put in place that, for those people that actually did a transfer of care 10 percent of these transitions would be – in 10 percent of the transitions this information would be available.

For a referral, and again, we've got to link this to those other cases that we decide in the care summary, we just suggested that a care plan would be made available if one existed. So, kind of back to the beginning, based on some of the work that the Interoperability Workgroup is doing, again, they're in the process of developing the standards for these and again, depending on where that work ends up would be the capability of vendors being certified to those data elements in the shared care plan or not.

One of the steps that we took in asking for some feedback, again, a lot of the pushback that we got and Paul is not on the call, but one of things, you know, he's concerned about from a policy perspective is again this is kind of new space where the solution is ahead of the practice and you can argue is this the chicken and egg scenario, but the bottom line is some of the questions that we solicited and I wanted to walk through that feedback, was, you know, trying to get an understanding of how we might advance the concept of electronic shared care planning and collaboration based on people's experience with this kind of concept because there are concepts of this starting to emerge in the industry.

We were pretty interested in if we had to begin to build what that dataset is, what it might be and we listed some possibilities and then last question we ask is are there any constraints that we need to understand as we're trying to share plans, share care plans on a – across an institution basis basically. So, those are some of the questions that we asked and I wanted to walk through that feedback. So, before I move to the next slide any comments or considerations? Okay, next slide.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Charlene, this is Leslie, and I just – the bottom paragraph of that last slide talking about role-based access I just would be hesitant to talk about that and maybe dwell instead on the HIPAA requirement that allows patients to be able to amend their record which can include both new data and corrections. So, potentially we could – we don't have to dwell on role-based access, which is very complex and difficult.

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

It is very complex. Okay and there is a comment on that later on, so, all right. So, again, I want to thank the public because we got a lot of comments on this particular space both positive and generally supportive, but again, they noted as we certainly recognized that in the – how we defined it, it was pretty broad-based and we used a broad-based approach because the concept is so broad at this point and they suggested we needed a more narrow approach and more specificity in the definitions, which, you know, I think are some of the things that Larry Garber's Workgroup is working towards.

Again, we recognized, as did they, is in the current state this is kind of an undefined concept so there are lack of standards, lack of experience and correspondingly, which I think is important, the burden on providers and we don't know what that means.

Several commenters recommended more feedback and I think that process is occurring concurrently, which I think is positive, and several commenters recommended combining 303 and 304 with some of – and I'm going to stop at the end of this one, some of the key points being that there was overall agreement that to share information about a care plan we really needed to have a core of structured data that could be used in place of free text, especially with this kind of an element, we should be working toward the definition of a minimum dataset using as much of the current standards as possible.

Again, at some point we – while we're doing that, not being overly prescriptive in that because there is potential burden to providers if we get it wrong as well as the fact that in the current standards world that these standards are emerging as we speak so there is limited real world experiment, experience in this and then lastly there is the need for these care plans to provide a roadmap for providing best possible outcomes and again re-enforcing the importance of being able to define ultimately clinical and patient goals. So, just any general comments on this feedback? Agreement, disagreement?

Okay, I'm going to keep moving and then we'll come back to – so question one, and I think this affirms – so in question one the response was how might we advance the concept of electronic shared care planning and the collaboration tools across the settings, and again, I think this – the response, which I think we got some great responses is that to date there are varying concepts of care plans, you know, so, here's our list of a couple and again I thank Michelle and their team for collecting all this.

So, again, and I think, you know, based on my experience certainly in care planning this is truly the case and as care evolves over time there is probably going to continue to be varying concepts based on what works or not. There is a suggestion for additional use cases discharge or admission to long-term care post-acute setting; I thought we had that one, that's our transfer of care, acute inpatient rehab and then the nursing facility after an acute care episode. So, Larry, unless I'm wrong, we should cover that in the transfer of care use case?

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

Yes, that's actually one of our use cases.

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

Yes, I thought you had that one. And the last one, again, I think Leslie this kind of comes to your point, the experience, which we got some experience, demonstrates population health facing tools there are just going to be challenges because, again, at the end of the day you don't necessarily know who is accountable so you've got dual documentation as well as multiple logins and workflows. So, I think we have to be, you know, sensitive to, you know, that we're moving toward a new age of, you know, electronic care and we need to create this roadmap as a pathway to get there.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

You know, this is Leslie, and your point about a roadmap or pathway there are some late breaking great work that has been completed by the National Partnership for Women and Families and this has been used or vetted across a large group they've used a lot of the work that has come out of the – care team referred to I think Larry's work and I would be happy to send a final draft but there might be some more formal publishing version coming soon, but I think this would – they've done a really good job in providing a narrative of what a care plan in process might look like with patients and their families in the future and it's just late breaking news. Can I share that with the group? And then have ONC place that on this slide? I think it's a great tool to use.

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

I think that would be helpful, because I think that's part – I mean, that kind of I think comes back to the point that we're like in May and you know, Stage 3 is a little far out but we're still in – any use case work I think would be very helpful now, so that would be great.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay, I'll forward it to ONC and Caitlin to send to the group and also to the folks participating in the other teams, thanks.

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

And this is Larry Garber I just want to add a point of clarification that it's not really just my work it's actually a large group of people through the S&I Framework, through HL7, through IHE and AHIMA and other groups that have been –

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

Larry, how do I –

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

Working.

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

Yeah, how do I – it's broader than – yeah, you're exactly right I'm not sure what framework –

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

I thought for the public I wanted to make sure everyone was clear this isn't just me.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Thanks, Larry –

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

No, I was stumbling a little bit Larry because I wasn't sure how to frame the, you know, the contribution. So, thank you for clarifying. All right, question two, then we asked about if there was some – most essential data elements for ensuring transitions and ongoing care management and again, re-enforcement of the need for structured data instead of free text because we listed free text and that tends to be our, at least in the early states, we will say just put free text in place of a standard if a standard doesn't exist. Part of the issue, especially as I think we move to care plans, is there can be a lot of information and to make these really effectual I think there is going to be a tradeoff between having structured information and free text as we move toward more use of that data to coordinate care. So, I think there is a tradeoff there.

They listed medications, specifying name, dose, route of administration and frequency, and treatment and orders; again, I think these are some of the data elements that we're working to standardize now. And there are recommendations for including problems, goals, treatment modality, the provider frequency, target completion dates and the actual completion dates as they are instrumental in term of ensuring what's next, you know, in terms of what multiple care providers are included in that. So, I don't think we would necessarily change these recommendations but it's just a means of how we start to share that information, you know, in the care planning process and where they are in terms of standards development.

All right and question three then we asked, this was the relationship to the requirements for patients and their identified team to participate in a shared care plan and again, I think Leslie this could kind of come back to your question relative to we need some support for role-based access, but again, there needs to be a framework around this, if you will, that supports the administration of, you know, HIPAA protected information under the HIPAA Act, so again, that governance framework has to be in place to be able to share information in this continuum, so, I think that could be a little bit of what we're trying to do.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

This is Leslie, Joy Pritts and Deven McGraw, and Mary Jo and others we were on a call yesterday about patients contributing or correcting their records which would be foundational in this obviously it doesn't answer all the questions, but Joy had volunteered a document that she had written and I believe it talks about what the HIPAA rules are and laws are with regard to patients correction and addendum, and I think that would be worthwhile to send to the group as well. MacKenzie, I think Joy sent that to Mary Jo yesterday.

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

Okay, I can ask her for it.

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

Yeah, I mean, and again I think this particular space in terms of the need for an organization to have a governance structure around ensuring compliance is going to be critical. Next slide, please. So, this is the feedback from the Standards Committee and Michelle took – you know, there's a lot of feedback that they gave and so, you know, the bottom line is, you know, if you look at the elements that today – if we want structured data elements those elements that are in place today problems, medications, allergies and current labs are where we have codified standards defined and the feedback from them was the other items are yet immature.

And there was an intent to include those into Stage 3, but, you know, as we know these elements are required in Stage 3 care summaries. So, we've got those covered. There was a comment about the goals for the clinical documents should be more specifically defined, additional data elements by caregivers should be justified and existing data reused to the extent possible.

I think that the framework – I think there is both those – I think there is a sensitivity to that, I think we need to be sensitive to that. Also, the framework that we shared last week which looked at the CDA architecture and looked at how the different data elements are collected once but used for multiple purposes should align with that unless I'm misinterpreting that, but I think again that's the intent. I don't see us not trying to accomplish that.

This one was, again, I think we're sensitive to this like what are the essential functions that an EHR should accomplish and that should occur within clinical practice using the EHR to support this roadmap to more robust care planning. So, again, this was just, you know, relative to starting to convey some data elements of the care plan. So, I thought this was pretty powerful, so this – and again there can be feedback that exists, but again, we're starting to get patient goals defined, some expected outcomes and then the advanced order piece I'm going to leave open, but again, the advanced order piece was an element. So, it's starting to carve out a few of those real key elements that are necessary for a care plan.

The other piece of interest here I noted was, I know one of the recommendations made by the Interoperability Workgroup was that we start to align with some of the newer terminology, so this starts to move us in that direction. So, I thought that was certainly something that if we could start to think about it in this framework it moves us in a data-driven path toward the care planning process, so, that's a comment there just trying to simplify it.

They encouraged the team-based care by developing shared tools or shared documents, you know, each EP should document key care team members and I think that we took a step in that in the care summary. It should not be unreasonable, at this time, to expect outpatient facilities to achieve this level of coordination but there should be action toward that aim and I think we accomplished some of that, again, not with necessarily all the data elements, but we certainly took a step toward that under the care summary.

The next one, recommending including transfer to or from among the priority use cases I think we covered that one in our last – under the care summary. Need for validated terms, again, what those terms, again, and I think I've heard personal feedback relative to try and keeping the concept of patient preferences, the goals, you know, at a higher level. Then there was a comment on parsimony and then the S&I Framework recommended the need for functional status, skin care issues with key determination of safe and efficient care.

So, again, I think, you know, stepping back and reflecting, you know, I would take away that again there is certainly a call for standardization of some of the key data elements potentially at a minimum starting to link and starting to put standards around some of those key data elements and they correlate with the terminology that was identified by the work done on standards and I think this is one that, you know, there is certainly a feeling that we've got to get some experience with this concept before we kind of roll it out on a broad scale perspective.

But, anyway, I open it up for the Workgroup to comment, to make recommendations on. Again, we're in the timeframe of Stage 3, right now we're on the current schedule we're going to depend on what happens in Stage 2 but we're trying to, again, I think setting a roadmap for Stage 3. So, our key question is, a couple of our key questions we're still recommending it as a Stage 4 placeholder, if so do we want to modify it and if so how do we want to modify it and/or are there elements of it that we want to include its aspects of Stage 3? So, a lot of questions.

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

Charlene, this is George, hi, I'm sorry I'm kind of in and out a little bit on the call I thought Paul was here today, so actually you mainly answered it, so we're still considering this going on for the next stage and because on the one hand we want it to be fully coded and very useful, on the other hand we don't have any of that yet and so it makes sense, unless we're just going to have a field that says care plan, which we already have in the summary I guess.

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

Yes.

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

This is going beyond that, so we don't need this objective unless we're going to actually go beyond, so that makes sense. So, I mean, I would recommend we do as little – I mean, I don't know, but I recommend we don't spend a lot of time fixing something that is for Stage 4 unless there are things here that sound contradictory or something that we should – that actually has errors we should fix it but otherwise we don't want to plan too much for the next stage.

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

Right.

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

Because we're going to learn a lot over the next two years.

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

I think, George, my take would be the only thing that we might want – again, I think we've got that it's certainly to move this objective forward I think we've got to come back strongly with, again the need for – because I think that's the feedback putting some structure around some of these data elements and to – like we don't know what a health concern is and what the mapping of a patient goals are or problems, you know, there are a lot of pieces, we don't know how the current state of the care summary fits into the care plan, but I think that will be understood more through some of the work that is happening. So, I think that's going to be critical for us to understand, you know, the trajectory of these data elements.

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

So the next –

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

So that would be –

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

Go ahead.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I have a question, this is Leslie again, and so is this – I think in earlier versions we had family history under this as an opportunity for patient participation in taking care of their health data but also just as part of the care summary. So, I don't want to lose that as we go forward with structure or defining structure for interoperability.

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

Is family history in the clinical summary or the care plan? I thought it was in the clinical summary not the care plan.

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

Me too. Michelle, do you have – like that was moving around on us a little so we lose track of that.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And so I guess –

Michelle Consolazio Nelson – Office of the National Coordinator

So it was recommended as a – not something that is required but something that could be included as part of the care summary and as part of VDT, but not required.

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

For the care summary but this is the care plan objective, right?

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

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

So, we have elements – so, we made I think – I mean, my take was we made significant progress in refining the care summary and, you know, nailed it down a lot in our last call so we included, you know, it seemed like that a huge step we started to make in that particular objective.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I'm sorry the slide I have up said care summary, I'm sorry.

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

Okay and it's –

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

Because that's the – is care plan, right?

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

Right it sets us up nicely for moving to care plan is what I thought we did.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is Larry Wolf; I wanted to jump in on one piece that mentioned – the last slide.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And maybe expand on that.

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

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think while all this discussion about the structure, the care plan is really important and I would actually like Larry Garber to comment on what is in the HL7 ballot that is going out –

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

To see if that addresses any of this. I also don't want to lose site of the fact that knowing the care team members, and I'm not thinking so much the individuals providing care within a setting, but the settings where the care is provided, the physician practices, you know, the major care settings where someone has been for care, that the extent to which those become machinable entities that are tied to provider directories, that they're actionable for sending and receiving information that becomes a really big step forward for actually coordinating care if there is a useful patient specific directory within their record that says here are the folks that this provider knows are part of my care, that becomes very powerful as a patient and it becomes very, I think, helpful to providers who are saying "well who was their PCP again" you know as simple as that sounds it's not something that we do a good job of tracking today –

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

So, Larry, we have that as one of those data elements – we left it as free text but it is one of those key elements that we have in the care summary so maybe we want to, you know –

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

Could we pull that up? Do you have what the final wording was for the care summary?

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

Michelle do you have that?

Michelle Consolazio Nelson – Office of the National Coordinator

It's in the back of the deck; it's on slide 26 and 27. Twenty-seven indicates the data elements for the care summary and slide 26 is the objective and measure.

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

So, we had care team members including primary care provider and caregiver name, role and contact information. So, we didn't call for standardization of that, actually we left it free text, I think we left it in that case – actually, here's how we left it, there was – using the DECAF standard and we left this concept to the Standards Workgroup if they wanted to further define that. We didn't want to call for one standard or another. But, I think it's important that we've got it in this so it will be in Stage 3.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I guess my thought on bringing it up in the context of care plan is knowing who the participants are is a huge piece to coordinating the care.

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And speaking about that in the context of the care plan –

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Maybe moves that forward in a way of thinking of it in the context that a care summary doesn't, so that the care summary is in many ways backward looking and the care plan is forward looking and anyway I don't need to go any further with this.

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

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

But I think it would be great if this notion of getting the team members in the record in a way that serves as an actionable thing not just a text it can be really powerful.

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

So, what we did put in this one was we wanted to inform the provider directories. So, I get what you want Larry it just all has to – I think we're trying to get that infrastructure – we're trying to push the infrastructure, right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

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

So, I think we've got those it's not in the context of – but we're trying –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And the timing may very well be that it's ahead of where we're likely to be Stage 3 but we should be clear that we really want to see that infrastructure in place to ensure and see it integrated into the record and that it starts showing up in the not too distant future as part of the actual infrastructure that is being used.

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

Yes, so maybe Michelle what we want to do, because this is an important one, is again, we want to, you know, use – just – it's care team members but again if we can say it will be important to start to have those people defined in the directory and, you know, just talk about, you know, it's a placeholder then for advancing care through care planning or some words like that. So, it's a little more – a little more holistically looked at.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

I think that's the intent of what we're trying to do.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I guess if you'll embellish me for just another couple of seconds, you know, the consolidated CDA is made up of sections and so a section on care team that started to have some structure that maybe was something S&I Framework pushed to a very focused thing to move forward on.

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

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Might be the kind of action that would actually get this in place for a future stage.

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

Okay and that could be one where we could maybe get – Larry, I don't know is there work going on that in the framework do you know?

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

Yes, the care team is part of the datasets that we're working on. I do have some general thoughts. I mean, George's point was correct that, you know, we don't want to work too hard on something that's going to be part of Stage 4 and if the focus is just on a care plan during times of transition, which I think is a reasonable first step if you're trying to do that for Stage 3, you know, then we should make sure that everything is appropriately folded into 303, but, you know, if all the care plan elements are in 303. So, I'm okay with, you know, with that idea of making sure that 303 transfer summaries – make sure that they include all of the care plan.

But, then going back to, you know, sort of see again, you know, what we have in 303, you know, there are still some things that are not clean. So, for instance we still have setting specific goals in there and I think we had talked about that at the end of the last meeting that that's sort of a confusing term that I'm not sure if anyone actually knows what that really means and that, you know, in goals we generally categorize them in just sort of two types.

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

Oh –

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

In fact, you know, there are the patient's overarching goals, you know, about what they want to do with their life and then there are more concerned specific goals, you know, that are in theory negotiated between the doctor and the patient although, you know, or the providers and the patient although there are some times when those differ. But, you know, so setting specific goals I don't think helps advance this any and probably should break out the fact that there should be, you know, overarching patient goals and concern specific goals.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, this is Leslie, I would agree with that too and setting specific is not really a relevant term it doesn't mean anything I agree with you on that and I think the overarching and the concern specific or the specific concerns are really good ones.

One question has come up on the care team itself do we want to also identify or even if it's just in certification the care team members to include both the provider-based and the family-based care team members that's where we're headed in the patient generated health data team we've used the CDISC standards to identify all of the care team members that could be associated and defined by the patient. So, I would encourage us to, when we define care team, to advance the agenda perhaps we're starting with, as I think Larry said "well who is the PCP again" but we allow for the data structure to accommodate the broader care team.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle; can I go back to Larry's point about setting specific goals? That was just my miss on the slide; I believe that we agreed to high-level patient goals on the last call.

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

Yes, we did.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

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

We did, Larry, you got us, thank you for correcting that one.

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

But I think it's also important that, you know, a lot of people are not recording even, you know, problem specific goals, you know, I think they're both important to be listed here, you know, in order to advance things forward for care planning. You know, the fact is what is the target LDL and I'm not sure that, you know, or A1c, or anything else and I'm not sure that we've got that covered elsewhere.

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

So, there are two concepts again, we kind of wrote this, you know, it's the broader context of the patient goals, right? And then there are problem specific goals or objectives or whatever. It seemed like the one we were trying to get was, again, so which is the –

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

I think they're both important. I mean, I think they're both important I don't think you should pick one or the other.

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

So, it would be patient goals and problem goals and then just leave it as free text or – I mean, this is the space I think if we started to get some standardization in this space this would go a lot – like patient goals we don't have those standards around yet, so that would go a long way in moving this if we start to work on that.

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

Okay, again, even the problem specific goals are hopefully the patient's goals, in other words, to get their LDL under control. So, again, it's there is the patient overarching goals and then there are the problem specific goals, and you know both of those for now, you know, can be free text I think that's, you know, I think for this stage I think that's the best that we can expect.

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

So, should I list them as two data elements? Two different types then? Two different lines?

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

That would be fine with me or list them both under one line but at least list them both.

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

Okay. So, Michelle do you have that patient and you wanted overarching goals? What word is the appropriate word there?

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

I mean, that's the term that we've been using patient overarching goals and then problem specific goals.

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

And then we'll just leave them as free text, right? And they can't – I think it's a huge step, right? And then if we can start to get something filled in we're making progress.

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

Now how does this list on this slide relate to the details on the subsequent slide?

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

Next slide, Michelle.

Michelle Consolazio Nelson – Office of the National Coordinator

So, it's – sorry, let me get on-line.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Twenty-seven, 27.

Michelle Consolazio Nelson – Office of the National Coordinator

This just pulls them out to say you can see exactly what in Stage 2 and what we're adding for Stage 3.

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

So, it would say rather than setting specific goals it would be patient overarching goals and/or problem specific goals.

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

I would do "and."

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

And?

Michelle Consolazio Nelson – Office of the National Coordinator

And.

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

Okay, we'll take – okay, we'll see.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And then can we get the care team, at least for certification, ideas to be broader than the provider-based team?

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

I'm not comfortable with that. The standards aren't out there yet. I'm not comfortable with that.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, that's what we're working on right now and so I mean that's what is part of this ongoing work in HL7 and so –

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

And also, we hope to have it part of the consolidated CDA.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It will be by January it's up for ballot, so, I don't think standards should be the excuse and if it this is a certification requirement only and it's a consolidated CDA and we're simply adding a new header grouping of actors this is not a complex addition. So, I would not like to – I would really strongly encourage us if we can get goals of care and care team members defined in a standard and certification by the time we come to Meaningful Use 4 we can start looking at utilization beyond just or usage beyond just the provider-based care team.

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

Agreed.

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

So, this would be simply – this is not a use requirement though.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Correct the goals are but the team requirement beyond the provider team would be certification requirement, but to Larry's point "who's your PCP again" is a big deal.

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

Yeah, for the use requirement I think we've got the use requirement as the PCP, but for the family team care members I'm very uncomfortable putting in family team members and then – again, whether –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right, but I'm not suggesting it as a use requirement I'm suggesting it as part of a certification requirement which will already – if you're compatible with the consolidated CDA by January next year and with a successful ballot that will include the care team members. So, we're not asking above and beyond.

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

Right, because being a primary care physician I really do need to know who the caregiver is at home.

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

Okay. All right, so we'll put them as – again –

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, this is Michelle, can you just explicitly say what you're trying to ask for and maybe we can bring it to the Meaningful Use Workgroup for a larger discussion?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay, I'll try and then Larry can pipe in. What we're asking for is that the care team is identified more broadly than just the provider-based care team and we had defined it in care coordination early on to include the family and their caregivers. Now, today that's being described, those team members, in the standards work under the consolidated CDA using CDISC as the framework to define those and we hope to have that balloted in January.

So, what I'm asking for is that care team, for certification purposes, include all care team members as defined in the consolidated CDA and that usage include those necessary for transitions of care, which could be argued as the provider plus the home care team member that Larry just mentioned.

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

Yeah, so it's that element is for certification not for use. So, that's the –

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

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

So, it's under the certification requirement.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And our narrative says that right now right? It says –

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

Yes – our narrative says that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Care team members through the PCP and caregiver name, role and contact information.

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Free text is permissible.

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

Narrative, the referral form, yes. Okay, I think we're back to – are there any further comments or discussion around – and again, I think it's around the care plan objective 304.

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

Yeah, actually, this is Larry Garber; I just have one more piece, which actually I guess it goes back to 303. So, if we're using the – if we're moving the transition components of the care plan from 304 and moving it into 303 it's not – so let's see you do have advance directives in there, but I don't clearly see that you're referring to the consolidated CDA for the certification criteria.

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

I think the decision we made on that one was again not to necessarily delete it but based on – we didn't want to put it in there as black and white. So, I don't know what words we used but there has to be some adoption of that as a standard to get at certification criteria. So, there are other words we can – around –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But remember the consolidated CDA requirement is already in MU2 and so by naming a standard like that every time that standard evolves it evolved in the rule. So, we want to make sure that – and we've been asking it be harmonious to have parsimony, so I think it's worthwhile to mention it.

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

I would – and I'd more comfortable like mentioning – again, this is where policy and standards start to overlap, again, based on the – I would be more comfortable with again the presentation of the standards by our Standards Committee in support of this. So, you know, because there is a lot of data and datasets, there is going to be a lot of discovery that happens. So, to put that in there as the criteria, the flow blown criteria I think is a big stretch for Stage 3.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, it's –

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

Well, I think it's fair to say as a minimum to have the consolidated CDA. I mean, I think that, as you said it was part of Stage 2 we certainly would want to continue that into Stage 3. If there are other standards certainly that can be added to this, but I would think – you know wouldn't want to drop it.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right, you don't want to drop what we've already brought in place that's the minimum requirement.

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

I have no problem with that at all.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay.

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

It's just I feel like it's the – yeah, I have – okay, so Michelle we'll just have – what I thought our plan was is you would come back and give us an update relative to the progress on that in about 6 weeks or so? Larry, this was to Larry and that group?

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

That's right.

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

Okay. So, I was just kind of holding – so we just – maybe we just rather than specifying it's all the datasets the inclusion of advancements to the CDA as defined by, you know, the Standards Workgroup. Is that okay to just at least leave it there and then that will fall out of the process? So, we'll definitely include the definition of a consolidated CDA as a certification requirement and its advancements.

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

Okay, thank you.

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

As defined by the – you know, because they'll go through whole debate in the Standards Workgroup. So, Michelle do you have that one?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes, thank you.

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

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And then are we meeting again after we hear the patient preference testimony or have that session or is this wrapping up now?

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

Michelle, that's probably one that you ask in terms of the timeline?

Michelle Consolazio Nelson – Office of the National Coordinator

So, right now we're working on scheduling another Subgroup meeting because we most likely will need another one after today. But, the plan currently is that recommendations will be to the Meaningful Use Workgroup so they can bring them forth in August to the Policy Committee and then in September final recommendations will be brought to the Policy Committee. So, if it fits within that timeline then we'll certainly try and integrate it.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay, we hope to have it fit in that timeline I know.

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

Okay.

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

And this is Larry Garber again, for one last piece.

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

Yes?

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

So, the one piece I think that was in 304 that is softened up when it goes to 303 is the advance directives.

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

Yeah.

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

So, right now on that last slide it says indication of advance directive so that suggests that one is in place and, you know, that's a very early start, you know, whereas 304 was a bit more ambitious suggesting, you know, being able to talk about MOLST Forms or POLST Forms and, you know, I do know that as part of what we're putting through as the standard is the ability to at least specify some of what the advance plans are, you know, what the advance orders are or expectations are and I wonder if, to the extent that they're available in the consolidated CDA, they should be encouraged for population.

Michelle Consolazio Nelson – Office of the National Coordinator

Larry, this is Michelle, so there has been work for quite some time of working towards a listening session on advance directives and the Workgroup that was going to take that on has been discussed. I believe, the Certification and Adoption Workgroup is going to now lead that session, but MacKenzie could probably correct me if I'm wrong, but I think based upon the feedback of that session the Meaningful Use Workgroup would then update their recommendations.

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

Right.

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

Okay, if someone from S&I or longitudinal coordination of care could be included in that that would be great.

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

Right, I don't think there is any – we just don't know how they want us to say it because it's been a continuous discussion point across all of the Workgroups.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right now it looks like it's going to come to the two Consumer Groups, right, both the Policy and the Standards Groups to hear this, about patient preferences and direction in general and how that is included that would incorporate both the advance directives and other items of patient preference that we would hear information about for instance patient's dietary preferences, patient's allergies and so forth. So, our hope is Michelle and I think – I don't think Mary Jo is on the call, but I think our hope is to try and have this done before the end of September.

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

So, this I MacKenzie, I'll take the conversation off-line internally as well just to make sure we're all on the same page because I know there is a lot of discussion of where it's actually going to be. I know that Certification and Adoption was discussed during our Chairs call, so I'll just follow-up Leslie with you and Mary Jo separately.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Thank you.

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

All right, so it's definitely on our radar screen but I think once they define at a higher level how they want to approach it then we'll – and Larry your point definitely needs to be included in some way and then the more structured we can have it the better off we're going to be.

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

Right even if they're free text buckets. I mean, because Terry O'Malley, Dr. O'Malley did do a lot work looking around the country at the MOLST and POLST Forms that are being used in different states and did bring them all together into the care plan and transfer summaries that we're building for the consolidated CDA.

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

Okay, great. I think that's been – the diversity of the standards around this particular concept has been one of our challenges. Okay, anything else on 303 and 304? Again, I think we'll see a refinement of 304 based on the work that is currently going on. So, all right, next slide, please. We're on eight. So, 27, I have reconciliation 302. Okay, thank you.

So, okay, so here's – the concept of this objective was again in the context of managing care transitions we support a robust reconciliation function and so in Stage 2 again the focus was on advancing medication reconciliation and actually increasing that to 50 percent of the transitions of care. From a certification perspective the vendors were held accountable for being able to do clinical reconciliation which was inclusive of medications, medication allergies and problems.

So, again, you know, letting the work on standards help – because there are still quite a few concepts that have to be supported for that in terms of doing those kinds of reconciliation of allergies as well as problems. So, the concept was with the work that, you know, the vendor community was doing relative to sorting out how to be able to support these kinds of reconciliations we would make as use objectives in stage – through the reconciliation for medications, medication allergies as well as problems.

And again, what we did was we varied it we said okay for medications we left it at 50 percent and then we lowered the threshold for medication allergies and problems to 10 percent in terms of – and these are both EP and EH objectives. And again, there are some requests for additional types of reconciliation and we kind asked standards to advance, you know, reconciling other types of, you know, other types of concepts such as contraindications, which again is a pretty complex concept. So, that was kind of where we were with the recommendations.

Let's go to the comments. So, again, the comments were pretty interesting, again, there was certainly the recognition of the importance of doing it in terms of increasing the percentages and again there were some that for patient safety reasons wanted to bring it up to 80 percent, 100 percent and there were others that said keep it still at 50 percent because of the complexity really of doing this process.

Medication allergy recommendations, again, there was support for that objective too including all kinds of allergies expanding it and again, we're trying to set some baseline capability and they felt that, you know, the bar was too low for 10 percent. And the same comments in terms of problem was to increase the threshold again, because this is important information to get reconciled and that's all understandable. Next slide.

I'm going to go through these three comments because I think we've got to talk about them in context, because again there was request for additional elements of reconciliation and kind of in my view as those data elements become standardized and they certainly become much better candidates for reconciliation it's really hard to reconcile free text. So, again, I would hope that what gets defined in the consolidated CDA would start to give us the provisions to be able to put that in place for certification.

Again, the tradeoff in terms of the process itself of, you know, the vendors doing that reconciliation in an effective, you know, a few clicks kind of an approach and then they felt that the draft certification criteria should be removed until the future – it's developed and again, I think we can say the same thing that we said under, you know, the care summary is that we're going to support, you know, the data elements that become standardized as part of the standards process and are contained within the CDA.

There was a response – there was a concept it should only be an EP concept not a hospital concept. Decisions relating should be left to the care provider, again, the tradeoff on the other side in terms of what should be reconciled, so there shouldn't be as much of a use case focus, the importance of recognizing the pharmacist has some input to this process as well as, you know, we should address whether providers other than physicians should be performed to be – should be eligible, should be candidates for doing the reconciliation of medications, allergies and problem lists. So, again, you know, it's really requiring the EP to do this reconciliation, but should there be other candidates for that, should that be kind of open?

And then the last point was, and this, you know, was a pretty strong recommendation that's kind of where I wanted to end this and just get the feedback from the group, we did, actually, as part of this process get input from the Standards Committee early on in the process relative to the maturity of this as a standard and readiness to actually be used in a use case and at that point the feeling was the readiness was there, time has passed and they gave pretty definitive feedback that we need to – that this process and the standardization as well as the reconciliation around the allergy and the problems is still too immature and should be considered as a future case as well as understanding its relationship to contraindications, etcetera.

So, kind of take that whole bucket of stuff and look at it as a whole and then come back with a more robust standard for this process, you know, in a future, in a Stage 4 or beyond and hold off in terms of making it a use case requirement. So, again, it's pretty contradictory in terms of the feedback that we have on this particular objective, so, again I wanted to kind of open it up to, you know, the Workgroup for your feedback on this one.

And again, the question is, again, two elements, we retain the same threshold for medication reconciliation and do we want to do that and secondly we added two elements in, do we want to include those for use, you know, Meaningful Use objectives? And/or making part of this EP only.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I'm wondering how much we can learn – this is Larry Wolf, I'm wondering how much we can learn from Stage 2.

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

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Obviously, that's not going to inform what we say today, but it could inform what gets said starting, you know, after October as Stage 2 starts rolling, because we're going to start seeing care plans or not care plans, but care summaries getting exchanged and they will have medications, they will have problem lists and the extent to which they're coded, they will have allergies, the extent to which they're coded in a way that's actually useful will start to become evident or if there are problems, you know, if consistently things are not coded well, if consistently they're not coded at all that's the kind of feedback from real use I think would help address these concerns here.

I understand the reconciliation process itself is one that could use maturing, but I'm thinking in terms of the data that is being sent. We're right on the verge of starting to actually get some real experience with this and I wouldn't want to cut off that learning, especially if it turns out that Stage 3 is another year or 2 out.

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

Other comments on this one?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Charlene, this is Paul Tang, I joined late.

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

Thanks.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

I just joined so I'm just hearing a little bit so I'm a little bit out of context, but is – so right now we have the certification requirement and that's one of our options is to continue or potentially refine those certification requirements and now the question is whether we add any use requirements to it is that it?

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

Right, yes the question is we have the use – because we did some of the work in certification, at least on the vendor side, for the reconciliation around medication allergies and problems, so we had a use requirement for medication reconciliation at 50 percent in Stage 2. So, the question is for Stage 3 we put the use requirement for allergies and problem reconciliation at 10 percent, we just put it at 10 percent and again the feedback was too low, blah, blah, blah or don't do it all because the standards are too immature.

And then, you know, in terms of the certification requirement do we need to consider a broader context of doing this reconciliation including contraindications and all those elements that are around problems and contraindications and allergies that we've worked through.

So, we can either, you know, back off on the use requirement and leave medications and just, you know, I don't know whether we want to increase it or not I think we want to just wait until we get some more feedback.

But it's really the question is based on the feedback from the Standards Committee that it's too immature to do allergies and problems do we say don't make those use requirements?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah, I'm fine with the – I wonder if we might refine some of the certification requirements, it's interesting I think Larry just brought up an interesting point about whether – so interaction between problems, i.e., diagnoses or diseases and either medicines or lab tests that sort of is implicitly in CDS although maybe that's a refinement we could make in terms of having, one having the capability in EHRs to be able to write decision support, rules, algorithms whatever they use to show interactions between these three things problems, medications and allergies well or labs I guess and that same functionality could be used to improve the accuracy of the list. One of the challenges of – I think our original intent was to move onto use but I think –

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

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

I don't know that we have a good way other than attestation or checkbox and that's a problem. So, maybe an alternative is to beef up the capabilities in the EHRs so an organization can write certain clinical decision support interventions that would improve the accuracy.

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

So, how would we specify that then, Paul? How do we say that?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Well, because I'm only on the phone I don't have access right now – in our certification criteria for Stage 2 in reconciliation, in problem accuracy I think – is it handy for you to see what we said there?

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

So what – actually we didn't do – in this one we didn't do – it's probably someplace else. The only – the criteria we put in place for this one was standard work needs to be done to adapt and further develop existing standards to define the nature of reactions to allergies, i.e., severity and those types of things, but we didn't call for improving the accuracy of these other elements problem list and that type of thing.

And we did ask for reconciliation of contraindications, but again, remember how we were kind of down that track on contraindications, reasoning, again, we didn't know how to kind of frame, you don't want to do this kind of procedure, those kinds of things, orders that are not viable for this patient.

So, we weren't really sure how to handle that kind of information. So, we were kind of more down the line, rather than making them smart, down the line of just, you know, sharing the information as opposed to necessarily being smart about how that information is kind of presented.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

I thought, and I might be confused, but I thought we had a certification requirement proposed so that you could write decision rules that would help –

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

It might have been under quality, remember we were putting some of those under quality.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

No, I don't think so, I think this was under – I thought it was under I want to say problems. So, let me give you an example. So, if you notice that someone is on anti-diabetic medications and there is no diabetes on their problem list then you could propose to, the physician, to add that, same thing with a higher A1c things that – you can write rules that say “hey, I noticed there is a pretty good indication that this patient has diabetes, but it's not on the problem list.”

The same thing with blood pressures another good example or renal insufficiency, or renal failure those are some things that don't make it on the problem list yet we need those things to help alter drug regimens for example. Is Michelle on the line? I don't know why –

Michelle Consolazio Nelson – Office of the National Coordinator

Yes, it was part of Subgroup's ones recommendations, yes, Paul is right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, but that's for Stage 3 or Stage 2?

Michelle Consolazio Nelson – Office of the National Coordinator

Stage 3.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, so that is an advance over Stage 2 and that kind of thing would help us for either medications, allergies or problems here are lack of standards about the actual allergy itself.

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

But – and then on the medication list you can write rules, the kinds of rules you'd like to write are if, you know, an antibiotic is a non-dermatologic antibiotic is going on for a long time to remind them or someone has a certain condition like diabetes the reverse is true and they're not on any anti-diabetes medicines then at least prompt the user to see if there is something missing. Those are the kinds of rules that would help and I think if in Stage 3 we at least put that capability in the EHRs that can be used.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

This is Leslie, building on that one of the areas we talked about earlier and I'm – were on the contraindications were things that the patient contributed and said that they were – did not want a particular type of procedure or –

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

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

For instance blood products or food allergies and we've heard a lot of testimony about all of those other kinds of items that the patient wanted to be included but didn't have a vocabulary. So, I think this might refer to the idea of having a vocabulary and standards for contraindications so that in the future we can do reconciliation around things that are specific and unique that the patient wants to contribute like my food allergies, like no blood byproducts, like my religious preferences and so forth.

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

Yeah and we did, Leslie, we did have that proposed in the future stage so we didn't lose that, we just didn't know how to codify it yet, so –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So, maybe we look at certification first in 3 and then beyond that in 4, so we're still building toward that future.

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

The problem is we can't really code it if we don't have standards.

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

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

What I'm talking about is create the standards in that timeframe.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation

Well, I mean, I think we need the standards to be created – I'm not even aware of some of these activities that would create standards for some of these things.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think LOINC has a vocabulary, I think we're closer on vocabulary than we are for the actual data structure. But it would be worth looking at I think.

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

And we did signal them.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yes.

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

In terms of standard work needs to be done to support the valuing and coding of contraindications like the definition, you know, because there are correlations between – like Paul said some of the – what's medication allergies and problems, a lot of these things are together it seems in the process. So, we did call that out as a standard element for a future stage, contraindications, patient contraindications.

So, Paul would – so the recommendation – I mean, so in Stage 3 if – what we want to do in this case is link to the use of some of the CDS capability in support of this, refer to that under – I mean, I think it's powerful in terms of reconciliation linking those together, because it's the process that's killing the people, right? That makes this hard.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah, so I guess, in other words we – the first step probably is just get better problem list even in each organization and I suppose the way it spills over is we, in care coordination, would like to have that as well, but right now we don't even have it done in the original organization and so that's why it's in category one.

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

Yes. So, do we signal in certification that that work should be used in the reconciliation process, is that what you want to do?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

I think we're saying that it is being taken care of in category one, the first step, certification and that I guess we're not ready for reconciliation across organizations at this point.

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

Okay. So, we would change the objective to just keep reconciliation and medications? What Larry had said was leave this one open recognizing that, you know, problem, allergies and problems still could be too high of a step for Stage 3 but at least wait until we get a little further down Stage 2 to understand, because the vendors have done some work in this space if it's even – you know, even if we could get to 50 percent of medication reconciliation, but the provisions for the systems having them in place will be in place in Stage 2 and then hold off on – use requirement or the other approach is I could just put dependent on Stage 2 feedback or we could just make them – we could take them out as use requirements.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Are you referring to medications or allergies and problems?

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

Allergies and problems.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah, I think, well, I mean I don't know what you're getting from a sense from the group, but I think we're saying just keep them as certification requirements.

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

Okay and they are today.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

They're not today they're proposed for Stage 3.

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

No, no, no they are certification requirements today.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Oh?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

No.

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

We have to do clinical reconciliation –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

For drugs, yes.

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

No for medications, for medication allergies and problems, we have clinical reconciliation is the vendor requirement.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

That's –

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

For Stage 2.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, Michelle is that true, so we didn't add anything Stage 3 in category one?

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, Paul, say that again for category one in Stage 3 what?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Did we not add to the certification requirements for reconciliation of let's say of problems and allergies.

Michelle Consolazio Nelson – Office of the National Coordinator

We did all three.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

But in Stage – new for Stage 3?

Michelle Consolazio Nelson – Office of the National Coordinator

For Stage 3, yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, Charlene where are we –

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

The question is just we did not – in Stage 2 we just asked for medication reconciliation. In Stage 3 we upped the bar to include allergies and problems.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Correct, okay, so that's what we're saying, so it is a new requirement for Stage 3?

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

For use, not for certification.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, so that's what I'm not clear on. So, Michelle, did you say we have a new certification requirement for Stage 3 for problems and allergies?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, so Charlene, what are you saying?

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

No – requirement was –

Michelle Consolazio Nelson – Office of the National Coordinator

Well –

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

No, no that's wrong.

Michelle Consolazio Nelson – Office of the National Coordinator

So, for Subgroup 1 for – there was a certification requirement for problems, medications and allergies. For Charlene's group there was a use requirement in Stage 2 and Stage 1 for medication reconciliation and the group wanted to add an additional use requirement in Stage 3 to add medication, allergies and problems, but the threshold would be lower in Stage 3 for problems and medication allergies because they weren't in Stage 1 or Stage 2. Does that help Paul or no?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

I think so, but it seems Charlene is saying – not saying the same thing?

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

No, I'm saying that in Stage 2 the vendors, not the providers, it's just like how the vendors are ahead – like in order to do more order types in Stage 1 until we upped to Stage 2, so this was the same case where the vendors had to be ahead of the use requirements. So, in Stage 2 we have to do a clinical reconciliation function which is those three data elements.

It doesn't matter – or not but we've got to have that capability within our system. So, there are all these conversations happening around how we reconcile allergies and all that stuff, you know, we have ingredients versus, you know, different types of allergies and that stuff. So, that's noise that happens now.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

But, that's not what you're saying, Michelle, correct?

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

Let me look up, this is George; let me look up the certification piece.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah, yes, I think it's just a matter of fact somewhere we are –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And then would you, this is Leslie, then would you include, as that's being looked up, in the certification requirement the things we've talked about that were more consumer facing that we had heard information about like my food allergies and my preferences?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, Leslie what Charlene was saying is that we had it on the list it was just for later than Stage 3 because of the immaturity of or the lack of any standards.

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, it is there. We've talked about it before and it's just not ready for Stage 3 because there is no standard.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, work on that.

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

I should have this other one at my fingertips.

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

Oh.

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

Yes.

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

You know, I'm not so familiar with this as I am with the other one.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle, so I pulled up the certification requirements for the medication reconciliation for 2014 Part 2 says enable a user to create a single reconciled list of medication, medication allergies or problems.

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

So, Charlene is correct.

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

Yeah, I'm on page like 209 it gets into the motivation behind it so that's right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, so we do already have – so we do already have the certification requirements and so our choice is either to leave them as is and not add a use requirement for –

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

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Problems and allergies or to refine the certification criteria. Now what's the exact wording of the certification requirement for 2014?

Michelle Consolazio Nelson – Office of the National Coordinator

Do you want the whole thing or just the part about reconciliation?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

–

Michelle Consolazio Nelson – Office of the National Coordinator

I'll read it to you. Enable a user to electronically reconcile the data that represents a patient's active medications, problems and medication allergy lists as follows for each type; electronically and simultaneously display, in a single view, the data from at least 2 list sources in a manner that allows a user to view the data and their attributes which must include, at a minimum, the source and last modification date.

Number two, enable a user to create a single reconciled list of medications, medication allergies or problems and number three, enable a user to review and validate the accuracy of a final set of data and upon a user's confirmation automatically update the list.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, that's a reconciliation function. Is there any accuracy; is there any maintenance certification criteria or problems and allergies? Do you see the distinction I'm making?

Michelle Consolazio Nelson – Office of the National Coordinator

So, Paul, I just want to make sure I'm interpreting right, so part of it says to indicate the source and last modification made.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

No, this is to make sure you have a, let's say a complete problem list and one way to do that is to have the CDS function that says – you can write rules that say, hey, look if there is no diabetes on the problem list and they're on anti-diabetes medicines –

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

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Suggest to the user, you know, check with the user on whether that should be on the problem list and vice versa. So, they've got diabetes but they don't have any anti-diabetes, hyperglycemic medications should there be any? That capability I don't recall whether we specified that in Stage 2.

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

I don't think so, Paul, I remember that was –

Michelle Consolazio Nelson – Office of the National Coordinator

No, because that is what was asked for in Stage 3 from Subgroup one.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Right, okay.

Michelle Consolazio Nelson – Office of the National Coordinator

The clinical decision support piece.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So that would be good and it is new and probably we can't go further than that, well, I don't know a way to go further than that in a non-burdensome measurement way.

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

So, your recommendation would be just to correlate what we asked for in the quality section with its support of the reconciliation function or just to make it the same or, you know –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah, or I guess we could reference what's being said in the –

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

Right, yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah.

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

We would just like that capability included in the reconciliation function is kind of what you said and was certified to that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Right. Now how did they – right now the medication reconciliation is basically a check off requirement, correct?

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

Again, Paul, I think different vendors do it different ways, but effectively, you know, they – you know, you bring forward those two different lists, you come up with –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Right.

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

And some systems are smarter than others so it varies I think out there you know.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah, that's true, okay.

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

So, I don't –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

But from a compliance – a compliance to the – to get to – to qualify for Meaningful Use incentive it's essentially a check off or is it more?

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

Well, once the – we would know once the function is done if the patient has been reconciled, right? So, the function is, you know, you do the process, you know what you reconcile and you've got your denominator already, right?

So, you kind of, you know, it's the process of actually doing the reconciliation. So, we don't kind of do it as a check off, you know, you bring in the two lists and if you don't have all the data you add data to it then you hopefully have some smarts to support the reconciliation process and then update the effective list.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So as long – as long as the user clicks the button of reconcile which brought up these two displays –

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

That would be – it would record a check in the numerator?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Right and update to the database, right?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Well, I mean, if they made no changes the act of just viewing the two lists qualifies for reconciliation.

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation

Okay. Okay, so I guess the same could be done in problems and allergies then.

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, that's a different – so that's a different – that's a different certification criteria. So, the first one is to be able to have rules or interventions that facilitate maintaining an accurate and up-to-date problem list that's the category one thing. In category three then you could put the same certification requirement, the whole, you know, two lists viewing at the same time kind of thing.

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

It is 2 steps; well actually you wouldn't even have to do the first. What do people think about that? Maybe that's along the path. That's right because we're not requiring a use – so the option is just to do that similar kind of certification requirement so that we can facilitate this reconciliation but not –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Right you add – yeah, that would be a step, you add the intelligence in.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
In Stage 3 and then the use requirement is for medications still.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Correct, correct. What do you think, George?

George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics
Sorry, I missed, Paul, do what?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, put a parallel certification requirement in for reconciliation of problems and allergies very similar to what you read or what Michelle read for medications, that is displaying, you know, displaying two versions and seeing if you can reconcile.

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

But that's already in, that's in Stage 2.

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

That's already there, that's what Michelle read off.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Oh, gosh, that's so confusing.

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

What the piece you were saying Paul was to – I forget what we wrote under clinical decision support, but, you know, we've done that provisioning, what you would do for Stage 3 is add the clinical decision support intelligence to help them ensure their problem list was accurate or, you know, assuming the medication list is accurate, but you detect from what's on the medication list and you look at the problem, I mean, that's a lot of work, you know, as well as –

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

Let me just clarify for Paul. So, Paul there are three things you can do you can enter the problem, you can reconcile the problem between two lists or you can use decision support, you know, rules to keep it up-to-date.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Right, right.

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

So, what's in there is entering it although I guess we now made that certification only.

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

Yes.

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

Two was reconcile, which I didn't realize until now was certification for all three in Stage 2 and only use for the first one so that's why it's staying the same in effect. And then for keeping it up-to-date we had – until I guess Stage 3 and now we ended up putting it in decision support. So, what we're really saying is –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay.

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

That we came up with the right thing in the first place and there is nothing to fix. I mean –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yes.

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

Not in the first place but in the last thing we did was the thing we want to end up with it seems to me.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

My apologies for getting so confused.

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

Yeah, so you'll have to –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

–

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, I'll go back to the proposal that we just leave it with the Stage 1, the category one Stage 3 certification requirement of tools to help us maintain these lists.

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

Okay. So, we'd cross reference that right?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Yeah.

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

And then we take it out of the use requirements medications, allergies and problems is that your proposal?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

And not have the use requirements? Correct.

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

So –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

I mean, what do other people think?

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

Larry was kind of let's just wait and see.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

And George?

Michelle Consolazio Nelson – Office of the National Coordinator

So, this is Michelle, so essentially it would stay the same for Stage 3 because the threshold wasn't increased for Stage 3 just the linkage to the CDS certification criteria would be the only addition, correct?

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

No, we would remove the use requirements from medications, allergies and problems is the proposal.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes, sorry, other than removing that the threshold then stays the same and then we just add the reference to the CDS certification criteria.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

What about, this is Leslie, what about inpatient food allergies?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So, let's see are we talking about the same thing which is what we've been saying we put in a future stage and we just didn't have the standards to do it in Stage 3?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well, I agree on the ambulatory and on the standards for the outpatient, but we've heard, I think at least four times, that food allergies in the inpatient setting was a big deal and there was no way to reconcile that, they weren't included today in the problem list, they weren't include and I agree there is some future stage but what we now said we've kept this pretty stagnant is there a way to advance the agenda on food earlier in the inpatient setting?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

So are you – you're on the Standards Committee right?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I am.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, so is that something you can discuss with them?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I can.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

As Charlene pointed out our signal was to put it on the matrix as a future and the reason was lack of standards so that seems like that would be one of the things that could be brought forward there?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I can do that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Okay, thank you.

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

Okay, so the proposed changes are to reference, to cross reference the quality requirements for ensuring the accuracy of problem list, the clinical decision support we put in and then to remove medication, allergies and problems as use requirements for Stage 3 and then also ensure that we're still signaling the need for – and I don't know if I have to put patient generated, but – we're trying to better understand, which I think makes some sense of doing, is reconciling – contraindications, you know, food allergies and other types of clinical information relative to, again, maintaining accuracy of problem list and that type of thing. So – and they're correlated so we need to continue to signal that that process be thought through. Okay? Going, going, gone?

All right, we have the next one was medication adherence, so this was actually, this was one that I think was – probably was – we didn't actually have this on our radar as our Workgroup but I think it was one that was recommended through another Workgroup process, so again, this was...expanding the concept and so I don't know if we include this as opposed to a separate one or under medication reconciliation, but the ability to be able to accept a data feed from a PBM, return that medication fill history for medication adherence monitoring. So, it's really, you know, monitoring the outcomes of adherence and vendors would need an approach for identifying that, you know, the important signals such as the patient is not taking the drug or there are two kinds of the same drug, blah, blah, blah.

So, again, starting to leverage the ability to capture data from the PBM and this is more on the – appears in terms of more of the compliance side. There were no use requirements for this. This was simply a certification requirement for Stage 3 where we're supporting – the vendors are supporting streamlined access to prescription drug monitoring programs and there are a couple of suggestions of how that is done.

So, again, I think many vendors today already access data but, you know, again, I don't think it's probably a consistent mechanism that's done. I also don't know if it's more pertinent to ambulatory vendors versus enterprise vendors, but again you're going to have these situations happen in the ED so maybe that's an irrelevant comment. Next slide, please.

So, in general the majority of the commenters supported the addition of this requirement. There were some caveats relative to the data must be up-to-date. We didn't have a Meaningful Use measure at all it was just a certification requirement, again, additional burdens on providers as well as added requirements that should be considered, as well as, you know, feed from other Non-PBM sources and I think the focus here was leveraging existing medication adherence sources, PDMP sources. Next page.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation & Technology Officer

Charlene, unfortunately, I have to drop off so thank you.

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

All right. So, we're going to get contradictory information on this one too. So, the majority of the commenters were supportive, they thought it was important; they wanted to actually accelerate it into Stage 3.

And again, the feedback from the Standards Committee was against standardizing against this time because their point was this information should qualify as helpful to but not be mandatory requirements. So, again, I think we've got both views in terms of this requirement, in terms of putting – the request is to put a certification requirement in to be able to provide access to medication adherence, you know, the medication adherence information. So, I'll kind of open this up to the group and get your opinions on that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is Larry wearing a provider hat for a minute.

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

Yes?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And this might be an example of an unintended cost consequence to providers.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That my understanding is historically most pharmacies don't send the fill message back to providers because of the cost of doing that. So, it goes to the PBM because they need it for billing but the loop back to the originating physician or to anybody else involved with the care sometimes has a cost component.

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

Yeah and I've heard that too from physicians in this one, why don't they just do this right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

There is also a concern about liability, if they start getting information about patients not filling prescriptions are they on the hook to do something about that. That's a general deterrent about liability in general for information.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah, this is Leslie, and where this came from was the patients and the consumer groups desire to make sure that their – originally it came out of a formulary being able to be considered from a PBM or an external source that met the payer requirement and insurance requirement so that the patient would better have the ability to have this included in payment in the ambulatory setting specifically.

So, I think that's where the original genesis came from on this was to try to make sure that we were looking at medication more broadly both what was ordered and what was actually filled and give the opportunity that in a future goal what was actually being taken.

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

So, I agree with both points. So, any other comments or proposals? So, the proposal is keep it as a certification criteria or not basically. I mean, I think we've got both votes from the feedback.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I say yes.

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

So, if we have to trade this I'm just – is this – again, this is potential to tradeoff for other requirements too, so –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, it's Larry Wolf, I think it's powerful to be able to get the information about what was dispensed, you know, the cost model is a whole separate discussion.

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

But again, I don't want to sort of create undertow costs for people, because there is huge value in sort of closing the loop on was the medication dispensed and it does head towards the "is it being taken and how is it being taken."

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's also the first opportunity where we see cross pollination of data from the payer and the provider world that is meaningful to the provider and to ultimately everybody. So the standards –

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

So, why we do this – we've got to bring it back to the larger Workgroup so my recommendation is we leave it, we might be able to put this under the medication reconciliation process or it will be separate, because I think it's important too.

So, let's leave it as a certification requirement and then bring this one back to the broader Workgroup. Is that okay as an approach? I agree with both I've heard the cost issue here in terms of making it a use requirement as well as, you know, the vendor requirement. I mean, we might get pushback on this but I would recommend we bring this back to the broader Workgroup for their input unless people object against that.

Michelle Consolazio Nelson – Office of the National Coordinator

Hey, Charlene, this is Michelle; the only question I have is this was originally proposed as a future certification requirement.

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

Oh, it's future?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, are you bringing it back to the MU Workgroup of the Stage 3 requirement?

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

No, oh, well that's a good question.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

We did not have it as a Stage 3 recommendation at least as I described it, that Workgroup is looking at it as a future requirement and we needed testimony from the PBM side of the business to understand how that might work.

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

Okay, so –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That's right, it was proposed.

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

We just leave it as proposed then. We leave it there we're not taking it away. I don't think anyone disagrees with its value when it makes the cut. Thank you, Michelle. So, we leave it for a future stage then.

Okay, we've got about 20 minutes left. Interdisciplinary problem list, so this was proposed as kind of a new objective and this was in support of versioning in support of collaborative care. Here is kind of – so, I'll walk through the comments, we're on page 16. I'll move it. Okay, so I'll continue so we can move forward.

Okay, so what was proposed for Stage 3 is the ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care and again the feedback on this one, and this is on page 17, was there were 54 comments overall support but again trying to understand what the measure meant and some felt that the measure was premature or unhelpful. Again, this came back to needing definitions around versioning and interdisciplinary and maybe replace interdisciplinary with interprofessional because they wanted to include the scope of OT, PT, social work, etcetera.

The current state of care limits the benefits of interdisciplinary problem lists when compared to the burden imposed by the requirement, potentially physicians would be overwhelmed by the information they receive and they suggest adding it to certification requirements before future stages.

And the Standards Committee was, need further definition of how this would work, expect external sources of problem list data would be incorporated into the EHR and so data integrity concerns as described in the previous requirement. So, are we moving the slides?

Caitlin Collins – Project Coordinator – Altarum Institute

What slide are we supposed to be on right now?

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

We are supposed to be on slide 17.

Caitlin Collins – Project Coordinator – Altarum Institute

All right, thanks.

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

Slide, go back to slide 16, one more. So, comments and feedback on the concept of interdisciplinary problem list? So, the recommendation would leave the concept for proposed to a future stage to continue to work on, you know, the definition of it and I think that follows with some of the work that is going on in care planning. Are people okay with that? I don't know where – it's just proposed for a future stage. So, are we okay with that?

To some extent it feels like it should be incorporated to me under care plan. I don't know if any of the work looks at – again, as you start to define the data elements in support of care plan, patient goals if we should be redefining the problem list as an interdisciplinary problem list under care plans if it is smarter to do that rather than leave it as a specific objective, that would be another question I might ask.

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

It sounds logical.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, Charlene this is Michelle, I was going to suggest the same thing.

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

Okay, so can I – can we just – I would like to carry this forward and put this under, again the care summary or the care plan objective so that there is some – so they look at that concept there. Does that work?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

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

Okay, all right, next slide. This is – we're almost done, back to the referral loop 305. So, my question on referral loop is again the intent of this referral loop and how we narrowed it for Stage 3, this is objective 305, one more slide, 19, slide 19, thank you. Okay, was that – again, we really narrowed and simplified this, but what we were going to do was just to close the loop relative to completing a referral. So, how it would be measured is on the burden of sending back, oh and do I have that, what we called under the care summary the consult note or whatever we called it.

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

Yes, that's correct.

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

So, it strikes me that the need to maintain this as a separate objective now because we've got it captured under the use cases of the care summary that we don't need to even keep this as an objective anymore. Does that seem to make sense? Because, I think the intent is the same way unless there is another measure we should put in place under the care summary, but I think we had that.

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

I think, this is Larry Garber, you know, I think that made sense, you know, you had moved this into 303 so that you've got, you know, the three different kinds of transitions, you've got the consult request, you've got the consult note coming back.

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

Yes.

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

And then you've got the transfer of care all listed under 303. So, I agree that you probably don't need this as a separate measure.

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

Yes, I agree and it keeps it more organized. All right, so we're going to drop 305. I mean, when we present it we'll tell them this but we're going to say we – like the interdisciplinary problem list we transitioned to be part of the care plan, this one we transitioned to be part of 305. Okay? All right, next one.

And this one, we're just repeating again – this is actually one – we made some changes to this one, this is slide 22. So, here were some – we didn't really make any changes necessarily to the recommendations it's a new requirement notification, we left it intact. We again, clarified which were defined already the significant events. Often this is managed by a registration system, so the one thing we wanted to try and make sure of was that, you know, that we don't have to have all these registration systems certified, so we were a little concerned of that. We did change the time from 2 hours to 4 hours in terms of when an event occurred, we recommended that.

We wanted to make sure that this one, and we don't know how to say that, is that in many cases health exchanges are doing these functions today, so do we want to consider making it a modular certification requirement only as opposed to one that's part of the total EHR because there is a tendency to want to certify your total EHR, but maybe by Stage 3 that becomes less of an issue because there will be more modular pieces of the EHR by that point. So, again, it was pretty much leaving it intact and not changing it except for the change to four hours of when the event occurred.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, this is a really interesting sort of topic here, this whole notification piece.

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

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It's something that the HIEs are trying to do as a value add; it's something that people are working on as part of ACO efforts.

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Sort of this whole real-time “have you let somebody know that something has happened?”

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And I guess in this case I worry less about EHRs ability to send the event and more about their ability to make sense of it as incoming information.

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

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

The most – the standards that we have in place today though the most advanced are admit, discharge, transfer and movement, and every registration system alerts or interacts with every other feeder or downstream system. So, there is – it's just now extending that to say, we want to take that notification and allow that to be an out and out notification to the provider of record.

And I think Rhode Island is doing this already and I think this is an area where there could be huge benefit because, especially in the new models of care like ACOs what you don't know is what hurts you and so being able to be aware that that occurs I think is important and ADT is very strong and we've been using them for 30 years.

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

This is Larry G, I mean, I agree that's absolutely important, but I do agree with Larry W's point which is that just because it gets sent doesn't mean anyone can actually receive it.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yes.

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

So, for instance, you know, in my EHR, you know, we do actually receive all of those things, you know, the arrival to the ED, the admission to the hospital, the discharge, we take all those ADTs from a hospital which is, you know, on some other system and we do successfully load those into our EHR.

I don't know if for certain – and it creates hospital or emergency room encounters, I don't know for certain that all EHRs can support that and so I do wonder if there is some need to specify that as a certification criteria that they can handle these incoming events.

In terms of death, you know, we actually also get that from the ADTs and there was some concern about automatically marking someone as dead in our system based on what some other system was doing. So, we actually – you know, we do take note of that but we don't automatically make the patient dead in our system.

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

Okay, so the certification would be kind of the receipt of that piece we would recommend then?

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

I think that makes sense.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I agree.

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

Okay, I mean, we're not going to make a use requirement around it, we'll just, you know – or should there be a use requirement –

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

I think just the fact that the EHR can receive it I think is sufficient.

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

Okay, all right. So, Michelle we'll have to get – we'll put that as a certification requirement then in the language, you'll have to look up and make sure we have the right language on that.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

Okay? Okay, so, with that I think we're done. The next step is – I think, again, great work in terms of I think advancing the care summary, a lot of good discussion, you know, I think we made great progress it's a hard space but I think we consolidated to some powerful objectives. So, I want to thank everyone. Are there any other comments or additions? And then we'll take this back and George maybe you know when we review it with the full Workgroup?

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle, so, I think we might have time on June 12th because Subgroup 4 should be fairly quick because they don't have many changes. So, Charlene if you're ready we can do you on June 12th.

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

That's fine.

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

Okay. And thank you, Charlene, for all your hard work this was hard, so thank you.

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

Well its – because we know it's a very needed powerful space but creating the trajectory is hard. So, again, I thank the other participants of the other Workgroups too.

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

Very good, thank you Charlene, too.

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

All right, open for public comment.

Public Comment

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

Sure, operator can you please open the lines for public comment?

Caitlin Collins – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do have a public comment.

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

Hi, can you please state your name and I will be limiting you to 3 minutes.

Terry O'Malley, MD – Medical Director - Partners Healthcare System

Hi, this is Terry O'Malley, I just wanted to chime in with Larry, this is spectacular work you guys are doing and much appreciated, and really trailblazing. So, please keep at it.

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

All right.

Terry O'Malley, MD – Medical Director - Partners Healthcare System

My other comment was in terms of the care plan and the exchange of a care plan it probably is only going to be necessary for a relatively small percentage of individuals with very complex people getting care at multiple sites with multiple providers and most of that care gets done in long-term post-acute care sites, post-acute care sites anyway. So, I was wondering whether there is a way to include these sites really early on in this process rather than waiting for them to become eligible providers, that's my comment/question. Thank you very much.

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

Thank you; are there any more public comments?

Caitlin Collins – Project Coordinator – Altarum Institute

We have no more comment at this time.

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

Okay, well thanks to the Workgroup and we'll report back after June 12th.

Michelle Consolazio Nelson – Office of the National Coordinator

Thanks.

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.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Thanks, bye.

Public Comment Received During the Meeting

1. A relatively small percentage of patients will require a complex, multi-site, multi-provider care plan. Of those who will require such a plan they are disproportionately cared for in post acute care setting. So, wouldn't it be helpful to include the post acute care sites right up front even though they are not EPs.

2. FYI, there is already are two current "places" in C-CDA for Care Team members, but it's not a specific "section." Rather, it's part of the "CDA Header" -- specifically, the "Performers" within the "service event" which is a general purpose part of any CDA document where a variety of health providers can be documented, and also the "participants" in the header, which includes relatives, guardian, guarantors, caregivers. However, it's possible that they don't have all the data elements that are desired for care team members and roles.
3. (4) Clinical information reconciliation. Enable a user to electronically reconcile the data that represent a patient's active medication, problem, and medication allergy list as follows. For each list type:(i) Electronically and simultaneously display (i.e., in a single view) the data from at least two list sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date.(ii) Enable a user to create a single reconciled list of medications, medication allergies, or problems.(iii) Enable a user to review and validate the accuracy of a final set of data and, upon a user's confirmation, automatically update the list. This is certification criteria for Stage 2
4. It is true (as Charlene said) that Clinical Reconciliation (including meds, allergies AND problems) is a CERTIFICATION requirement, but not a USE requirement, in MU2. However, there is not a STANDARD specified for the certification of reconciliation. It's just a functional requirement (user can compare two lists and enable user to create a single list).
5. FYI, FOOD allergies already have a vocabulary standard specified in C-CDA. It is UNII (unique ingredient identifiers).
6. I suggest that more time be allowed before saying "there are no public comments." I waited on hold, for a while, then when I was trying to tell the operator my name, the call ended.