

**HIT Standards Committee
Clinical Operations Workgroup
Transcript
June 6, 2013**

Presentation

Farrah Darbouze, MPH – Office of the National Coordinator

Hello and welcome to the Health Information Technology Standard's Clinical Operations Workgroup meeting. This is Farrah Darbouze, I'm ONC staff. This is the, like I said before, the Clinical Operations Workgroup meeting. This is a public call and public comment will be built into the agenda. Remember everybody that this call is also being recorded, so please try to identify yourselves when you begin speaking. I'm just going to start with roll call. Jamie Ferguson?

James Ferguson – Kaiser Permanente/Institute for Health Policy

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

John Halamka?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Donald Bechtel? Chris Chute? Jeremy Delinsky?

Jeremy Delinsky, MBA - Senior Vice President, Chief Technical Officer – athenahealth, Inc.

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Martin Harris? Stanley Huff?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Kevin Hutchinson? Elizabeth Johnson? John Klimek?

John Klimek, RPh – Senior Vice President, Industry Information Technology - National Council for Prescription Drug Programs

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Rebecca Kush? Kim Nolen?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Marjorie Rallins?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics, Performance Improvement Division – American Medical Association

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Wes Rishel? Christopher Ross? Joyce Sensmeier?

Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN - Vice President, Informatics - Healthcare Information Management Systems Society (HIMSS)

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Dan Vreeman? And for the federal ex-officios, Jay Crowley? Marjorie Greenberg? Clem McDonald? Nancy Orvis? Terrie Reed?

Terrie Reed – Food & Drug Administration

Here.

Farrah Darbouze, MPH – Office of the National Coordinator

Karen Trudel? I'm just going to also ask for any ONC staff members that are on the line to please introduce themselves. And we also have a guest that will be presenting today, John Feikema.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Here. Thank you Farrah.

Farrah Darbouze, MPH – Office of the National Coordinator

Okay, great. So, let's turn it over to Jamie Ferguson, who will go over the – actually, I'll go over the agenda, then I'll turn it over to Jamie Ferguson.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Thank you.

Farrah Darbouze, MPH – Office of the National Coordinator

Today's agenda will have a presentation on lab orders by John Feikema. They'll be discussion on HL7 version 2 lab orders, a recap of the proposed guidance on Formulary & Benefits by John Klimek and Kim Nolen and standards, a discussion on standards to record advance directives and care preferences. And discussion on improvements to the standards to facilitate unambiguous parsing, longitudinal record sharing and bulk record sharing. There will also be time for public comment towards the end of the call. Now I'll just turn it over to you Jamie.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay, great. Thanks very much Farrah. So, as you've heard, we have a very full agenda for this call and I don't think we're going to be able to get to everything that's on the printed agenda frankly. I would like us to start off hearing about the S&I Lab Orders Initiative and the electronic directory of services to go along with that. And then we want to make sure that we go through the recap on the Guidance for Formulary & Benefits, because I believe that will be part of our presentation to the Standards Committee in the next upcoming meeting. Then I think we'll have an opportunity after those two items to probably pick one other thing from this agenda that we would like to discuss. And so I think we'll kind of be lucky if we have time for that.

I would like to note at the outset that we're planning our next meeting to be on the subject of image sharing and so I welcome comments and input from everyone on any particular perspectives that need to be represented there. We plan to invite representatives from entities that pursue image sharing today, including RSNA and IHE and the vendors of some innovative solutions that are not standards-based. So we'd like to make sure we have an understanding of the broad array of use cases for image sharing for that upcoming meeting, and so I'd like to get comments by email on that one, so I wanted to make sure I mentioned that at the outset. Are there any – is there anything else for this agenda or is that agenda acceptable for this meeting?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So Jamie, this is John. As you looked at our work plan for 2013, of course these were the items that appeared as high-priority, but also reasonably doable. And so I think all of us want to have that lab interface that is done cheaply with compendia that are listed off the shelf rather than invented de novo. And certainly, we also believe that streamlining formulary downloads so they're not multi-gigabyte files with every NDC code possible, would be a good thing. And standards for care coordination around end-of-life planning preferences, I certainly in the death of my father two months ago, would have welcomed such standards. So, I certainly applaud the agenda.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Thanks John. Any other comments on the agenda? And if not, then let's turn it over to John Feikema to go through the Lab Orders Initiative, which I see is now being displayed on the web. So thank you. John, it's all yours.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Great, thanks Jamie. Thanks very much. Why don't we go ahead to the next slide and I'll give just a little bit of overview on a couple of these and leave some time for questions of the committee. The primary focus of LOI as we tend to call it, the laboratory orders interface, is in many respects to pick up where we left off, or perhaps even where we could have started with the laboratory results interface, to try to make a round-trip of the transactions required around labs. So, everybody I know is well familiar with the fact that laboratory results are a part of MU2. Our goal was to add to that and to create an Initiative starting from the work that CHCF did around e-links, to align that to the already completed LRI work that has been submitted as a DSTU to HL7. Received about 400 comments as of last Tuesday, 390 of those 400 comments have been resolved as a part of the process, and we're currently looking at resubmitting very shortly here, back to HL7. So what we've come up with is a very solid implementation guide that we believe, when adopted by both the lab side and the EHR side should really obviate an awful lot of the heavy lifting that's required to create not only – to create a round-trip, knowing that folks will have already implemented the results side and now adding the order side to it. So, next slide.

Here just acknowledges that there isn't anything in the 2014 edition specifically for this, but we're certainly hoping that this will all be ready in plenty of time for us to be able to make it as a part of the 2016 edition. And it will refer back to the compendium or back to the LOI as part of the process when it's cited.

On the next slide, I'm really trying to lay out here that creating a round-trip while the orders side and the results side are necessary pieces; we also recognize that a very important part of that overall round-trip workflow will be the directory of service. Having compendia of those orders, as John said very well, pre-codified so that they don't have to be made up de novo every time a lab and EHR interface or every time a physician and lab relationship is established, we want to have those fall in place. We picked an existing guide that was built up by ACLA a while back that was a normative spec out of HL7. We've been aligning that to the e-Links HL7 work around the LRI and LOI, so that all three of them are aligning around vocabulary and the important pieces, so we will have a cohesive standard that represents all of them.

On the next slide, we – our intent is to make sure that we get all of these in place. We're well into the process of syncing all three of these together. We believe that we'll be at a point where they should be normative in mid-2014 with pilots that have supported that; however, we'll be well into that process here in 2013. Then we'll go back to resubmission to HL7 this – hopefully this month, yet it was originally intended to be mid this month, it might be late this month, but they'll all go back into the effort and we'll be taking time to make sure after that and after the pilots that we take some time to completely sync those together. On the next slide, you'll see where we are with the LRI Guide already published. This one lists the fact that the target to re-ballot the LOI will be in June and then the target to pilot the eDOS component of that should be coincident with LRI.

On the next slide I've got – the last slide – I think the other thing I wanted to make clear to this group is that we've learned a lot from the LRI process, working closely with NIST. NIST has already been codifying the components of LOI and eDOS into their test framework. They should have a trial test framework ready to go inside of 30 days, so that people could actually – pilots, for example, could start testing this with the framework that will be used down the road. So when we actually republish as final the guides for LOI and eDOS, the test framework from NIST will be ready, coincident with that. So, we're really trying to do this all at the same time rather than after the fact. That will require that one of the things we add to this process is going to end up being a behaviors guide. Something that we ended up creating on the fly with NIST for LRI after they were in the midst of the testing work and here we're fortunately able to do that up front as a part of the process.

And finally, the last thing I'll mention that I don't have a slide on is that we're also working close with CLIA, Desc and others on tightening some of the LRI guidelines such that when a lab and an EHR that's certified use these tightened guidelines as a part of an interface. They should, if not completely at least very largely, mitigate the need for the visual verification step that laboratories are required to do today in order to get CLIA compliance, so that perhaps would be the fourth leg of the stool to make it as close as turnkey as possible to creating a round-trip laboratory EHR workflow. So that's the – I open it up to questions if there are any.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Thank you very much, really appreciate that. So, questions or comments?

Jeremy Delinsky, MBA – Senior Vice President, Chief Technical Officer – athenahealth, Inc.

This is Jeremy Delinsky. So the standards work here sounds very sound to me and I think that the goal of an out of the box round-trip transaction makes a ton of sense. Because where I site, we do tons of customizations on these orders interfaces and I think addressing the CLIA requirements is really important as well, to make this happen quickly. I'd say, and I feel compelled to say it, and it's probably not the right forum, but the performance standard that gets tied to physicians associated with outbound orders will be very important to think through how we do that the right way. Because I'm thinking primarily about the community physicians who really don't have a lot of power in that conversation with their laboratory about getting in the interface queue. And that is – it's going to be, I don't know whether this is thought of as a menu measure or a standard measure and I don't know what performance standard, but I just hope that a fair amount of conversation happens around how does the community physician in a one-doc group interact with a community lab to get in queue to be able to transact. It's very much out of their control in many ways and the laboratories can still reject results to interface requests today with impunity and so, again, I don't want to get into too much of that here, but I felt compelled, because the standard is clear, but I worry about the expectation of provider performance.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yup, understood.

James Ferguson – Kaiser Permanente/Institute for Health Policy

So this is Jamie, I have a question and I'm going to put my ignorance on full display. But, I'm wondering about the eligibility for reimbursement on a test and whether that's part of the – whether understanding that is part of the order process. Because, for example, Medicare fee schedules certainly under DRGs or physician reimbursement, would reimburse for the vast majority of test orders. But does the ordering clinician or the patient have any way of knowing whether at the point of the order, whether this is a test being ordered that's not on the fee schedule for Medicare or another payer that would have to be paid out of pocket by the patient?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah Jamie, I'll answer that as best I can. My understanding is that this is a largely, if not completely a clinical workflow and not an administrative one. I don't believe that there's anything in here, and I haven't looked closely enough at the compendia, but I don't believe that that covers the administrative side of that transaction either. I believe this has to do almost exclusively with the clinical components of it, in part because the rules can be different payer to payer, obviously, but also, I mean I think there are other nuances of the transaction that are affected by that. This would include, for example, does include for example client-bill transactions. So, this isn't just a list of those transactions, which are covered, this would accommodate – this workflow would accommodate other ones as well.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Right. And so I'm asking that because of course the other big topic for this particular call is on Formulary & Benefits for medication orders where obviously the eligibility for coverage is a critical part of that section of meaningful use. And so, if we're moving forward also on this section of procedures, then I wonder if there isn't sort of an analogous interest in ensuring understanding of the payment flows.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Jamie, this is Clem. The way that is handled in some systems, and I don't know if it's universal, but for the Medicare rules they're kind of fixed, or they were kind of fixed when I last looked at them. You have to have a given diagnoses, you can't do certain tests more than a certain frequency, and so those can be kind of pre-programmed and I think that the problem was the insurance companies, is no one's done their homework that's happened in the pharmacy industry to have dealt with these things at the backend as well as they have with pharmacy. But I think you're absolutely right, it's a parallel issue and is equally important.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

And certainly an opportunity for additional savings if it's streamlined. I just know that it's not within the scope of what's put together here.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Thank you. Other questions or comments on this?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So Jamie, this is John. I guess the question is messaging back to the Standards Committee, do we want to say something like, there are a series of efforts underway to ensure that there is going to be a directory of laboratory services, there's going to be compendia, there's going to be a standard mechanism for transmission of orders. We already have results, but all this stuff in the whole what I'll call closed-loop lab ordering process will be done, it appears, by the summer of 2014. And so, we won't have this, of course, for Meaningful Use Stage 2, as John said, but it may very well be good enough for Stage 3, and so we put trust and faith in the S&I Framework Initiative and the HL7 activity. This seems to be what we should focus on with regard to lab, there does not need to be a separate initiative or a separate workflow; we will just continue to monitor their efforts.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Well yeah, I agree with that sort of as a report summary item, if you will. But I also think that it could be very useful for the committee to propose some end-to-end testing and to, in fact, request some end-to-end testing and for results of those tests to be made public on really how this bundle of standards will work together. So that's something like a pilot that could be potentially funded by ONC or CMS or NIST, I suppose. But the idea is, frequently when you have these groups of standards that are supposed to work together, you find something in the initial piloting, and so I would hate for us to say that the standards work has been done on all these different independent standards and then therefore they should all just be adopted –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

True.

James Ferguson – Kaiser Permanente/Institute for Health Policy

– without a real world testing of the end-to-end process.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

And I should have mentioned, Jamie, sorry, I should have mentioned that we have very active industry participation on both the EHR side and the lab side in these efforts, and we have active pilots work underway, EPIC, Allscripts, Cerner have all been very active on that side of it, from the EHR side. And a number of reference labs, as well as some of the large commercial labs have also been very active at the table and we're in the process of marrying EHRs to lab vendors, so we will have demonstrable results from those well in advance of the July. In fact, we hope that the information that we gather from those pilots will inform the normative work that happens July 2014. These will all be DSTU and out in the real world in a matter of a month or two, and active in the pilot realm.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Is there any document that specifies exactly the plan of these different standards, is there something that could be distributed to the committee members?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

On the IG itself or, I'm not sure what you're asking.

James Ferguson – Kaiser Permanente/Institute for Health Policy

I think Clem is asking about the plans for that integrated end-to-end testing.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

No, no, I was actually asking for the list of the set of – what's done so far? You know, there are some specs on this one already in – written down.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Certainly, I can – we can share with you even the IG that's – that will be submitted in a matter of a couple of weeks, back to HL7.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, yeah, that would be great.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Certainly.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay so then I guess I would like to ask for perhaps something else which is something that – some document that would explain the how – sort of the entire group of lab standards, including the LRI as well as the eDOS and the new order, would be sort of tested together and sort of – just so the committee can have that kind of an overview.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Sure. And NIST is the one who's putting together the complete test framework, so are you looking for something from them, a couple of pager or an outline of how they're putting the framework together and how that would be tested, or are you looking more for how our pilot's going to execute this?

James Ferguson – Kaiser Permanente/Institute for Health Policy

I think it's more about the pilots and sort of, what's the plan for the pilots and sort of who's involved, but also I think more importantly, when should the results be reviewed and so forth.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yup. Do you need that in advance of the next Standards Committee meeting or is that something that can –

James Ferguson – Kaiser Permanente/Institute for Health Policy

I think that would be ideal, but I don't know if that's doable, isn't that next week?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

The 19th or whatever, it's the week after next.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay, okay.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

I'll see what we can – I'll see if –

James Ferguson – Kaiser Permanente/Institute for Health Policy

Just a one page diagram that kind of –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yup.

James Ferguson – Kaiser Permanente/Institute for Health Policy

– would be really nice.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yup, sure. Certainly, we can do that.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Thank you. Any other questions or comments on the Lab Initiative.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well just, I came on late so, yell at me if this is already known, but will hospital labs be easily able to do this? I don't know that they've got the same energy behind the one standard. So if a doc wants to send labs off to one of two local hospitals, will that be easy for them to do without having to get into all the other connections?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

This covers ambulatory workflows independent of whether the lab that provides that testing is located in a hospital or whether it's a standalone commercial. So yes, the standalone doc will be able to submit it in that workflow as well.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Okay.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Great work, I'm really appreciative of all the progress that's been made on this. I think this is really good, so very supportive of this myself. What I'd like to suggest is that we switch gears now and turn it over to John Klimek next, to take us through the Formulary & Benefit. And of course, I think most everybody on the call knows that we've had quite a few discussions on this and what we'd really like to decide here is some of guidance that we'd like to make to the Standards Committee. Go ahead John.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Thanks Jamie. What I'm going to do is sort of ask Kim to lead this because I'm dealing with a little bit of a sinus problem and I don't want to be coughing in between. So if Kim could sort of just start this off and I'll try to chime in where I can. Kim are you there?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Yes, I'm here, can you all hear me okay?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Yeah, thank you.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Yeah, great, thank you. I'm sorry, Kim, I didn't realize you were on, I thought – for some reason I thought you weren't able to join us today. I'm sorry.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

That's okay.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

That's no problem. So what I'll do is I'll go through them and I'll stop at each slide and let John add in anything that may need to be added. If we could go to the next slide please. So with Formulary & Benefit we noticed that it's becoming, in Meaningful Use, it went from a menu select item to a core measure. So with that, we have certain responsibilities to make sure what is – the information that's getting to the provider at the point of care is accurate information and is information that can be utilized for the patient in their care. Next slide please.

I did up this quick diagram, it's a little busy, but I think it's important for everybody to understand the flow of the ePrescription and all the different parties that play a part in that. Because there are some that fall, if you look in the blue section, the arrow, that those are the ones that fall under like Meaningful Use and have an influence of Meaningful Use. And then the ones that are outside of that do not, so there are standards that are not influenced by Meaningful Use. So you have the payer or PBM or even a third party publisher that has a relationship with the payer, the PBM that provides formulary information to the intermediary. And then the intermediary takes that data and pushes it to the EHR vendors and from there the vendor supplies it to the provider office, and I'll go in a slide in a little bit talking about how that is done, because that's another key point. And then the physician sends it to the pharmacy.

And if you look, we have the patient up here. So the patient is in here and whatever is given – whatever the physician sees at the point of care, the patient goes to the pharmacy and if that information is inaccurate, then that creates a hurdle for the patient. And they may not be able to get their prescription or there may be a delay in their prescription, because what the physician sees today is not the patient formulary, but a formulary that represents that patient. And then if you look here with the pharmacy, they have a different workflow that actually is the patient formulary. So I'll stop here. John, did you have any comments on that?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

No, Kim. The only thing that I'd like to add is the fact that in this whole process of ePrescribing and formulary checks, NCPDP membership has decided that there is an issue with formulary compliance, not formulary compliance but issues with prior authorization requests that were needed coming back from the pharmacy to the physician, back to the payer. So just recently our membership has approved an e-prior authorization method for that to happen in this whole sequence of events as well. So I would like for the committee to also think about that for future, as part of this whole scheme because checking for formulary is one thing. But also being able to supply information that's clean to the pharmacy, without having that stop that there's a problem with a prior authorization being needed. Or at the point of service at the physician level, for the physician to identify a prior authorization request as needed for them to be able to start that process before that ePrescription is even sent to the pharmacy. So, that's the only piece that's missing out of this, although outside of the scope, I think of our total discussion, I still think that's a big component of the formulary and ePrescription process.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

And that's a really important point because for the provider to know that there is a prior authorization, the formulary and benefit has to match with that patient benefit for them to know that. So that would actually help streamline the process, the formulary and benefit I think of as step one, and it helps a physician realize what is happening with that patient so by the time the patient gets to the pharmacy, they're not running into any barriers. Next slide.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Could you clarify on that though? This is Clem McDonald. Is that prior authorization; is there a flag to that effect in the formulary at the present time, for insurance companies?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Yes. In the formulary and benefit standard, there is the option to have a flag.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, I mean, but the current databases don't usually have that, is that what you're saying?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Well, no, they – I think most of them have it. Is that – John, do you know if that's an optional? It may be an optional element, well – the flag is in the coverage – which not everybody uses, is that correct?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Right, it's an optional field that's used. And typically what happens today is, first of all physicians are not using the formulary and benefits so they're sending an ePrescription to the pharmacy, not knowing if that prescriptions even covered. And the point of service at the pharmacy, the pharmacy gets a reject from the payer/PBM for that – saying that a prior authorization is required, so that process is backs up to the physician level –

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

No, I understand. But our prior discussion was that, at least some places are now getting the formularies downloaded to them and with the right coding systems, it might make it easier. And if that file already has that information in it, that we should at least alert practice systems to that fact, because they could easily check it, when the physician's writing the order.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Absolutely, that's the point of the formulary and benefit check. Yes.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Right. And there is one more step, one of the issues too is the information, and this is outside of the standard. These are other – some of the other players that are outside of the standards, like all of the information that is sent in the formulary and benefit file, today that is not the patient's formulary that is just a representative formulary. And especially for benefit information, it's very difficult for them to have all of that information in those files to get to the provider. So, there's kind of a gap in there of what the provider gets because ...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

But I mean to clarify, when you say it's not the patient's, you mean it's not specific to the patient's exact insurance plan, even though –

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

That's correct.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

– it might be specific to the company.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

In some cases there are layers, and I could tell you, I know firsthand from working for a small, actually a rather large payer in Chicago that had multiple plans and multiple benefit levels. And it just required just one list of drugs with some caveats to that list saying, for this particular group or this particular plan, these drugs may or may not be covered. So that's the same issue that we're running into with formulary and benefit check.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Now there is a workflow. The pharmacy does get the patient specific benefit and so that, when John and I put this together at the end, when we go through the proposed recommendations, we kind of have some stepping-stones that help bridge this process of where the physician is getting that representative information, to get something closer to what the pharmacy gets today.

James Ferguson – Kaiser Permanente/Institute for Health Policy

And this is Jamie, I just want to intervene for a sec because I know there's a lot of material here to cover, we've got about 20 minutes left. What I'd like to suggest is that we allow Kim and John to go through this sort of as quickly as possible and then have our discussion about all aspects of it. So please make note of your questions and comments and we can bring that up at the end, otherwise, I'm not sure we'll get through this.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Okay. Next slide please. So there is a standard today that currently exists through NCPDP, 4.0 is approved by the membership, 1.0 is what's being used mainly today. And I think through some of the calls I've been on, Surescripts is ready for people to adopt 3.0. Most of that is being pushed through CMS regulation, so depending on what they say in the new physician fee schedule, that's probably when we'll see that move. And again, the standard that's used here from payer to provider is different than the standard from pharmacy to provider or to payer. Next slide please.

The next three slides just are – they're straight out of the Formulary & Benefit Standard and it talks about the responsibilities of the sender, intermediary and the vendor. I won't go into a lot of details, but for the sender, they're supposed to send the information into the intermediary and either match the pa – there's a key and that key is the one which decides which formulary file is displayed at the physician, at the point of care. Next slide please. The intermediary is responsible for taking all of that information and communicating it to the EHR vendor. Next slide. And the technology vendor is responsible for accepting all of that information and then making it usable at the point of care for the provider. Next slide.

Some of the possible industry issues that John and I went through when we were going back and forth. These files are done in batch form; they're not done in real time, so that creates a couple of issues. One, the size and two, the timeframe, latency and information and one of the things that has been discussed a lot is the use of RxNorm in the Formulary & Benefit Standard instead of NDC. That could help with two issues; one it can help with accurate exchange of medication information and then two, it can also help with reducing the size of those files. And John, you know what, I'm sorry I didn't stop at those last slides if you had any comments with the sender –

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

No, no, you're fine Kim. You're fine Kim, keep going.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

I just thought about that, I was trying to get through to make sure we had time. So RxNorm is NDC and representative NDC is one issue. Group level variations in coverage are not represented, leading to the provider not seeing an accurate representation of the patient's drug specific benefit, because member specific exceptions and other variances are not accurately reflected in the Formulary & Benefit Standard today. Assumes that the patient's current drug insurance plan is identified through a successful eligibility check, and this is an issue that comes up because the match – in the EHR there's not a way to put the pharmacy benefit information in there, you just have the medical benefit information. So there's a five-point identifier for that patient when it goes to the intermediary to match, and depending on that match, depends what the provider gets back. If there's not a match, then they don't get a formulary, if there is a match then they get a representative formulary. And if you did have the PCN/BIN and issue a number, then that would help, just like the pharmacies see today, to get the – that first set and creating a flow with that, getting that actual patient information.

There are differences in coverage among different employee level groups; within individual health plans is a major source of inaccuracy with the information that's presented to the clinician. Today there is this use of symbols that's used at the point of care and how each vendor and payer defines those symbols can be different. So, every plan out there may say, let's just say the vendor uses a red, yellow, green; every payer may say well all of my reds mean this, all of my yellows mean this and all of my greens mean this, but then another payer may have different definitions. So it leaves at the point of care for the provider really not knowing what those symbols mean, and can lead to confusion because a red, they may think it has a PA, well it really doesn't have a PA and then the patient gets to the pharmacy and there was a PA and it could have been green or yellow. So, the use of symbols can be confusing at the provider point of care. And you can't detect differences between primary and secondary prescription benefit coverage. John, do you want to comment on any of those or follow up?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

No. I think the biggest issue that I have heard is that second one with the symbols and how vendors interpret some of that data coming back to their system and how they display that to the physician. I think if industry can come up with some logical way of displaying that across the board and make that standardized; I think that would benefit everyone. Here again, it's not the purview of NCPDP or our standards to tell people how to display information, it's just a way for getting information back and forth in a standardized format. So I think that's where there tends to be a little bit of an issue and I think that's something that still needs to be addressed.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Okay, next slide please. So when you look at the EHR vendor to the physician office, there are two ways that the formulary and benefit information can get to the provider. Some vendors have the automatic or push method, which automatically sends all the formulary and benefit information to the physician office and there's really no provider intervention needed. And some vendors use more of the pull or manual method where the provider office has to schedule a time to update their formulary and benefit information. And the main reason I'm pointing this out is because one of the issues outside of data quality with it being accurate is the timeliness of the information getting to the provider. John, any comments on this slide?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

No, that's exactly accurate, is getting information to the provider, which is accurate and on – that's real time more or less, is very important. Because as we all know, formularies change and again, from my previous position, I worked on a PNC committee and I know we made changes on a monthly and quarterly basis. So, if provider gets information only on a quarterly basis, they may be missing most of that information that's been changed.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Okay, next slide please. So these were the proposed recommendations. The current Standard should use a standardized vocabulary, RxNorm, to facilitate accurate exchange of data, which we talked about earlier. Certified EHRs should have the functionality to run at real-time, patient level formulary check in a timely manner. So this would be in addition to the current standard that we have, which is in batch form. Can we add a transaction into the script standard that would allow that, I don't know? That's something that we could evaluate to see if a physician, if there was a flag, they could run it just as the pharmacies do and say, okay, this does have a PA, I may want to consider something else or I want to go through the process of the prior authorization.

All certified EHR technology should support the automatic push functionality to update the formulary and benefit data and this would help minimize latency in information at the point of care. Certification criteria should be set to minimize variations of presentation of data at the point of care. Certified EHR technology should be able to match the patient not only to the medical benefits, but also to the pharmacy benefits utilizing the PCN/BIN and issuer number. And formulary and benefit data presented at the point of care should at minimum represent the patient's group pharmacy benefit, but a specific patient coverage for a specific drug and dose would be ideal. John, any comments?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

No, I think the only comment I could make is that that second point of a real-time formulary check, I mean that's a pie in the sky at this point. We certainly think that the Formulary & Benefit Standard as it stands today at least is a stepping-stone for physicians to get the information that they need today. The second point is just something that we at NCPDP have discussed and talked about and it's something that we'll be reviewing for the future.

James Ferguson – Kaiser Permanente/Institute for Health Policy

That is a really great presentation, thank you, I really appreciate that greatly. Let me start off, perhaps take the prerogative to ask a first question. And that is, on the prior authorization issue, if there is a flag the use of which is optional in the standard, what problems or challenges might be found for the Meaningful Use Program to specify that essentially this is sort of a required if present flag rather than strictly optional?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Well I think Jamie the issue there is that NCPDP again in developing the e-prior authorization transaction is to pretty much subsidize not only the Formulary & Benefit Standard, but also the ePrescribing standard as well, because we saw that as the missing link in all of this. Now, as Jamie has described – I'm sorry, as Kim has described earlier, there are always going to be gaps in the formulary information that's coming to the physician, and that's because of multiple reasons. So again, if a physician sends that prescription to the pharmacy, not knowing that a prior authorization is required, our e-prior authorization standard allows for that communication and that happens back to the physician for a quick response and follow through on the e-prior authorization to the PBM or payer. Again, this is just a solution – to the current problem that we see today.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

And I would just like to make a comment, too. Today they do have the optional flag, but you still run into the data quality issues of having the patient's actual benefit information. And I'm sure any health plan will tell you, they have thousands and thousands and thousands of different benefits for their formularies. And so being able to get that patient's benefit is critically important, and I realize that real-time patient level formulary check is sort of a pie in the sky. But it also is critical for that patient – the provider to be able to get that information and to have accurate information so that the patient isn't stuck at the pharmacy wondering what to do. I mean there are studies out there – there was a study that was done in 2011 that if a patient got to the pharmacy and their initial script wasn't covered, 85% of them would abandon that prescription and then if it was non-formulary, 30% of them would abandon that prescription. So we're talking about a patient safety issue here also.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Could we get back to Jamie's question though? It seems to me that you should absolutely say, you've got this slot for saying whether prior authorization required, and it should always be filled in. Now people screw up, so it won't – and not – I mean, you're describing a spectrum of things that's going to take five or ten years, some of them, but that thing could be done in short term. And then, at least on average, they'll see something that says, I'm going to have a pain with this thing and then can make their choice about it. So, I mean, you didn't really answer that question I don't think. Why can't you just say, this is not optional, now they'll still screw up, but at least we'd get a much more complete content on the drug for what the physicians do get now.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

And Clem, you're right because what we've done with our standards in certain cases where we've identified fields as being optional, we have made exceptions and that optional designation says, under these conditions, it is required. So we could make that designation for certain situations that it is required. I mean that's – again, I think when you hear the word optional, you think that it's just, people just won't use it. We do have some designation that says it is optional, but for these certain conditions it is mandatory.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well that's a key thing because that's one of the biggest barriers to the whole process, compared to the other ones, formulary/non-formulary. And the second thing is, whether if you could just implement what you had now, wouldn't that be a huge advance over –

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

It would be huge.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

– what – case now.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

If we can get the Formulary & Benefit out there and have physicians using it, it would be a huge benefit. I can see – and we talk about prior authorization and drugs that are not covered and things like that, that's – I don't know, I'm just doing a quick estimate, that's probably less than 10% of the cases. I think if you did a Formulary & Benefit, you could probably hit 90% of your – that's a drug that's covered and it goes forward and then physician, if it's not covered, can make a decision at the office as to what is covered.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah. Well that seems like a good step forward.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

That's what we think.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay, I didn't mean to sort of preempt the whole discussion period with that one question. Other questions or comments on this? So is everybody comfortable then with this set of recommendations. We might want to refine the wording a little bit, but essentially –

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I'm not clear, was that long list that was described in the last slide the set of recommendations. Because some of those are going to take a long time and I'm – what timeframe are we talking?

James Ferguson – Kaiser Permanente/Institute for Health Policy

Right. So, some of them I think, as you said Clem, are not – clearly not in the scope for the near-term of meaningful use, but I think that we can make directional recommendations as well as specific implementation recommendations such as the use of RxNorm.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I mean, the things, like if there's something they can get up in the next cycle, isn't there? As we know, because we've looked at it, that's what I thought I heard. But the additional things about doing the extra layer and doing fetching in real-time, they were described as pie in the sky here on the phone, at least the real-time, and there could be real obstacles to the delays in writing a prescription if you had to wait for that.

James Ferguson – Kaiser Permanente/Institute for Health Policy

So let's actually, that's a great comment. Let's go back to that list of proposed recommendations for just a sec and look at – so I think probably the first one – well, is there any disagreement that the first bullet recommendation is something that we want to recommend to the committee?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Not here.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

What was that, was that the RxNorm?

James Ferguson – Kaiser Permanente/Institute for Health Policy

That's RxNorm.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Standardized vocabulary.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Standardized on RxNorm. Okay, but the second one is on real-time patient formulary checks in a timely manner that seems to me to be more of a directional, long-term desire, rather than a near-term requirement.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well that, yeah, depends I think on whether they're talking back to the benefits or they're talking to the internal medical record system which has it pre-downloaded, and that is already in the spec I think in the current rules, isn't it, that the system should support that? Or should support some formulary?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

It's not patient level.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And after you download it, it's not real-time right.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

No, it's not, it's batch.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Right, so that's what I'm saying. So this, so real-time patient level checks would be more of a directional statement for future development.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Yeah, I agree with that.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay. Any disagreement with that?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

So it'll be listed, but more as a long-term objective or –

James Ferguson – Kaiser Permanente/Institute for Health Policy

Yeah, I think what we're doing is we're kind of just trying to separate out the list into sort of near-term concrete recommendations versus long-term directions. The third one then on the automated functionality to update formulary and benefits data, that it seems to me could be a near-term implementation recommendation, any disagreement with that one?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So Jamie, are you saying that it's in use today in the field?

James Ferguson – Kaiser Permanente/Institute for Health Policy

That's what this would recommend.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, right, but do we know, is it in use, I may not be asking the question very well. Is it in use today, does that capability that functionality exist today?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

The formulary and benefit functionality or the automatic push –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, the automatic push and pull or automatic push, I guess.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Automatic or push functionality, I'd have to check with our Surescripts folks to see where that's at. What – I would think that there's probably a mixture of the two, but I think there's prob – again, I wouldn't be able to answer that without checking with them first.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So Jamie what I'm thinking is, it is a correct – it's something we absolutely should be shooting for, I was just trying to think about it in our terms of the way that we look at level of maturity –

James Ferguson – Kaiser Permanente/Institute for Health Policy

Um hmm.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

– and where we put it in the timeframe as far as when we expect it to be in real use.

James Ferguson – Kaiser Permanente/Institute for Health Policy

So, yeah. I mean, I think that this is not universal, but my understanding was that it is implemented in part.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

It is, yes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And is it in part in hos – is it EH or EP, is it hospitals or doctors?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

My guess it's both.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay. Jamie, I'll check on our side.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Yeah, we'll have to – and Kim, can you check on that as well please?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Yes.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay, great. So at least tentatively, subject to verification, then that third bullet for the automatic or push functionality for updates would be a near-term implementation recommendation. Now the fourth one, certification criteria being set to minimize variations of presentation of data. That seems to me that it goes into the EHR usage bucket and is more of an advisory recommendation to the EHR usability work stream. Is that fair?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

That's true.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

This is Stan. I worry about this kind of thing. I think I understand the intent, but one of the things that we're seeing is that there tend to be unintended consequences of a lot of the recommendations and you get in situations where you can't do improvements because the recommendations are starting to encroach on the capabilities that you can put into your user interface. And so I'd like to understand that one better I think, before I could just blanket endorse.

James Ferguson – Kaiser Permanente/Institute for Health Policy

So perhaps we can hold this one off then for further analysis, is that okay with everybody?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

That's good.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Agreed.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay, thank you Stan. Okay, next to last one, certified EHR technology should be able to match the patient not only to the medical benefits, but to their pharmacy benefits using specific data items. I don't know enough about the detail of that to know whether that is a desired long-term direction or a real-term – is this something that is done today somewhere?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Well in the pharmacy benefits arena, that's how the pharmacy submits claims, using specific information on the patient ID, the PCN, the BIN, which identifies that patient specifically. There could be group numbers involved with that, which then gets down to the level of exactness of what that patient is – that they are covered and what medications are covered. And I think what – I'm sorry, go ahead.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I got kicked off, some operator – so I just got back on. But I think the challenge really is that there are three numbers to put in the office practice system and it'll take a while to set that all up. But the bigger problem is they won't have internally that detail anyway, so that is tied very tightly to the real-time connection, which I think is a more challenging activity. So I think it needs more – I think it's a future planning thing.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay. Any disagreement with this matching recommendation being put into the longer-term directional bucket?

M

No, I think it's long term.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

I just have one comment about that, it is a stepping stone to the real-time but then it also today there is an issue with patients being matched because of the 5-point identifier, and this would accurately match them to receive to formulary and benefit batch information. Because there is an issue with the matching today in that, so this would help improve that.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Is that being downloaded in the current formularies, it could achieve that goal to the office, to the physician's systems?

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

That's part of the Formulary & Benefit Standard, yes.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Okay, so that you could pull it out of the ones that are being downloaded regularly with that additional information?

M

I thought I heard that it would require the real-time connection back to the benefit manager.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

And again, I think what Kim is saying is that when we say real-time, that's exactly what it is because it processes a transaction very similar to the way pharmacy processes a transaction, it hits up against those data elements to identify that patient in real-time. And again today, because the Formulary & Benefit Standard is in batch, that's not really being utilized.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

But it could help with just the basic level of patient matching.

James Ferguson – Kaiser Permanente/Institute for Health Policy

So it seems to me this is not something that is really ready for sort of a near-term implementation recommendation, although obviously long-term doesn't mean we put it off, it just means that it's not really fully mature for immediate implementation. Is that an acceptable categorization of this one?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

That's the way I hear it.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, that's what I hear as well Jamie.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay. Now the last bullet on the recommendations really I think is two things. One is a minimum for representing the patient's group pharmacy benefit in formulary and benefits data and then I think there's also an ideal or a long-term what I would categorize as a long-term designer to get specific patients coverage for a specific drug and dose. So my recommendation would be to split this out between a minimum for data presentation at the point of care would be the group pharmacy benefit and then put it into the long-term directional bucket to get an understanding of drug and dose coverage.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

That sounds reasonable to me.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, it's Liz again. I agree.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay, so Stan, this touches on your point of sort of standardizing what's presented at the point of care, so this is saying that there would be a minimum level of formulary and benefits available that would be the group pharmacy benefit. Does that seem reasonable to you too?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Yeah, I mean I'm not – I'm just worried, excuse me, worried most about things that – I'm not worried that you say the information needs to be displayed, I'm worried when we start saying how it has to be displayed and people start certifying against a particular screen representation as opposed to saying whether information is present. We're bumping up against things where I think things were well intended, but they say, well – well, I won't go into the details. But, we're starting to micromanage – the recommendations are starting to essentially micromanage screen layout, which I'm not sure is a good thing.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Yeah.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

And that's exactly my point earlier Stan is, that's not part of what NCPDP would even think about recommending, but here again, it's just what we hear in the industry as some of the issues that physicians run into, not understanding what some of the symbols and what not mean. Now maybe it's just an educational piece –

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I think some of the symbols they get from the formularies, not from their display system, don't they? So it's a problem for the formularies not using the same symbols, in some respect. The triple dollar signs and those kinds of things that we're talking about.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

I think it could be both.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

But it think there's a – go ahead.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

I'm sorry, this is Kim. I just wanted to clarify that bullet about the certification criteria. It's not to say how it should be displayed, but the way the information is provided to the intermediaries and what it means can be different amongst payers. So it just needs to have a better understanding around that so that the standard can do its job when it does get to the point of care and then the vendor is still allowed the ability to display it and do their screen however they choose. Does that make sense?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, but –

Farrah Darbouze, MPH – Office of the National Coordinator

Hello. Hi, this is Farrah. I'm sorry to have to do this, but, we're about 9 minutes over and we still haven't had an opportunity for public comment and there is another meeting scheduled at 1 and so we want to make sure that the support folks have an opportunity to have a bio-break in between.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay, thank you for that intervention. So, I think then Kim, let me just take a minute to wrap this up, if I may. I think Kim your point on that is that the minimizing variations of presentation isn't meant to describe screen layout, but actually the data representation for the features of the formulary. So it seems to me that that one can be re-worded. One thing I wanted to ask both John and Kim is, if you could both be available for the Standards Committee meeting in two weeks to present these recommendations, and I think we'll have a round of refinement of the actual presentation of them by email in the meantime, but is that okay with both of you.

John Klimek, RPh – Senior Vice President, Industry Information Technology – National Council for Prescription Drug Programs

Yeah, I'll be there so –

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

I'll be there virtually and I'll be able to be on the phone until about noon, and then I have to go to another meeting.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay. So I'm assuming that we can handle that schedule-wise to get this on the agenda before noon. So I want to thank everybody for their participation in this vigorous and rich discussion. I think we made a lot of progress on both the lab and the pharmacy formulary issues today. So I really appreciate that. I'd like to say though that what we didn't get to on our agenda for today is patient preferences for care and related documentation such as advanced directives. And so I think we're going to have to have that as the subject of another meeting. Our next meeting will be covering image exchange, so I think the meeting after – we have a series of meetings scheduled, so I think the meeting after the image exchange one will really want to focus on advanced directives and patient preferences and the use case of end-of-life care.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And Jamie, to that point, I did send some reading that the group might find interesting, describing IHI activities around this topic and some early pilots we've done at Beth Israel Deaconess.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Great. Thank you very much John. Okay, if there's nothing else from the group, then I think we're ready for public comment. Are there any final comments from the workgroup? Okay then Farrah, back to you for the public comment period, thank you.

Farrah Darbouze, MPH – Office of the National Coordinator

Okay, operator, please let me know if there is anyone that would like public comment.

Public Comment

Rebecca Armendariz – Altarum Institute

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

Farrah Darbouze, MPH – Office of the National Coordinator

Okay. All right, well thank you very much and we'll be – the Standards Committee will be meeting on June 20, so if you would like – it's a virtual meeting so if you'd like to attend, the information is available on the website. Thank you very much.

James Ferguson – Kaiser Permanente/Institute for Health Policy

Okay great, thanks very much. Thanks everybody.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you Jamie.