



## HIT Policy Committee Interoperability & Health Information Exchange Workgroup Final Transcript April 17, 2015

### Presentation

#### **Operator**

All lines are bridged with the public.

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Interoperability and HIE Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Micky Tripathi? Chris Lehmann?

#### **Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Good afternoon, Michelle.

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Chris. Arien Malec? Barclay Butler? Beth Morrow?

#### **Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership**

Here.

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Beth. Brian Ahier? Carl Dvorak?

#### **Carl D. Dvorak – President – Epic Systems**

Present.

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Carl.

**Carl D. Dvorak – President – Epic Systems**

Hello.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

David Whitlinger? Hal Baker?

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Hal.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Troy...

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Jitin Asnaani?

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Is that Michelle?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, who is this?

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Hi, Michelle, yeah, this is Troy.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Troy, okay.

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

Hey, and it's Arien and I'm just wondering, you know, I'm 3 minutes late and I'm wondering if I'm in the right place?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

You're in the right place we're doing roll so we got Arien and Troy.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Okay, good thank you.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Perfect timing for you both. Was Jitin there?

**Jitin Asnaani, MBA – Director, Product Innovation – athenahealth**

Yes, I'm here, Michelle.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Oh, hi, Jitin.

**Jitin Asnaani, MBA – Director, Product Innovation – athenahealth**

Hello.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

John Blair? Kate Kiefert?

**Kate Kiefert – State HIE Coordinator – State of Colorado**

I'm here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Kate.

**Kate Kiefert – State HIE Coordinator – State of Colorado**

Hi there.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Kitt Winter?

**Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration**

I'm here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Kitt. Landen Bain? Larry Garber? Marc Probst? Margaret Donahue?

**Margaret Donahue, MD – Director of VLER Health (Veterans HIE), Co-Director of the Office of Interoperability – Veterans Health Administration**

I'm here, thank you.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Margaret. Melissa Goldstein?

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

I'm here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Melissa. Nancy Orvis? Shelly Spiro?

**Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative**

I'm here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Shelly. Tony Gilman? We have Troy back and Wes Rishel?

**Wes Rishel – Independent Consultant**

Wes is here with Kudos to all those who attended HIMSS and this call.

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

And survived.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Really.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, thank you all for joining I'm sure you're exhausted. And I will turn it to you Chris.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you, Michelle; I have to keep in mind to unmute myself. So, good afternoon everybody Micky is not going to join us today he had an unplanned family event that he had to attend to so I hope you will suffer through with me today. I'm at the airport so I will put myself intermittently on mute and if you hear too much noise please let me know. So, with that said I have no access to the slides on line so I am driving from my laptop. So we can go ahead and go to slide two.

Our agenda for today is the review of the objective seven and that particularly means for today that we will start reviewing "send" and "capture." Let's look at slide number three. The schedule for this Workgroup is again tight we have calls essentially every week until we'll be reporting out to the Policy Committee in May. This is the first of a series of calls to talk about this objective number seven.

Slide number four, please. So, our meetings until May are divided into...we have three meetings. The first one today is to talk about "send" and "capture." We don't anticipate that we'll be able to get all your comments and thoughts in today's meeting so we have time allotted at the second meeting and also discuss governance questions at that time and in meeting three we will hopefully finish the governance and review the reconciled comments.

So, we will again solicit comments from all the Workgroup members in writing on the reconciliation measure and any questions that they might have. So, I'm going to pause here for a moment and see are there any questions about our timeline or the way we are planning to divvy up the work?

Okay, silence means I guess there are no questions or I'm cut off from the phone line one or the other. All right, let's go to slide number five. We are tasked to look at objective number seven health information exchange and the overall outline of objective number seven is that the eligible provider or hospital or the critical access hospital shall provide a summary of care record when transitioning or referring the patient to another setting of care, retrieve a summary of care record upon the first patient encounter with a new patient and incorporating the summary of care information from other providers into their EHRs using a function of certified EHR technology.

From the attestation point-of-view providers will only have to attest for two of the three measures but report on all three of them. Okay, then let's go to slide number six and dive into the "send" functionality.

So, the first measure that came with our piece is a focus on sending information about patients and the measure as it is formulated right now proposed is that for more than 50% of transitions of care and referrals the eligible providers, eligible hospital, critical access hospital that transitions or refers the patient to another setting of care or provider of care create a summary of care record using certified electronic health record technology, that is number one, and number two electronically exchange the summary of care record.

So, at this point I'm going to start...I would like to start a discussion about this measure but I want to kind of...I want to lay out a little bit the rules of the comments and the discussion if possible. So, for each of the measures that we'll discuss we want to focus on some key issues.

So, first of all is the measure meaningful and that means, is this a measure that will drive clinical improvement, quality safety of care and is it meaningful from a business perspective. Those two are critical questions to ask and I'm soliciting the Workgroup's input on that.

Then the second question that I would like to answer, have answered and I have some thoughts on that is, is the measure precise enough, is it disambiguated enough, are there any issues that are unclear or potentially gameable or could be misinterpreted?

Another item that I think we should focus on are these thresholds that are proposed here, are they the right ones, are they too aspirational, are they too low, are they stretch goals or are they achievable?

And then the execution is this measure can it be calculated with enough accuracy and precision so that we can integrate it in our clinical administrative workflows?

So, those are the high-level issues that I think we should focus on. And with that I would like for us to...we can dive and I'm going to see what the thoughts are, we can dive directly into the denominator or numerator or we can start a discussion on the overall goal of this measure one first. What does the group think?

**Carl D. Dvorak – President – Epic Systems**

Chris, this is Carl.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Hi, Carl.

**Carl D. Dvorak – President – Epic Systems**

Good overview. One question I had is just in watching ONC move from the 5% down to 1 patient in a year, I'm wondering when we speak of a goal like 50%, you know, we're in an odd zone here where many of the users of certified technology have taken the hardship exception and therefore probably not done the upgrades or setup, or whatever it takes to securely get the certificates connect to the network be ready to exchange.

And I'm wondering if in this 50% if it could somehow be modified to say 50% of the referrals that went to another organization that had Meaningful Use technology. I feel like we're again in a strange zone where might punish the people who are ready to transmit because their community may not be ready to receive. And I don't know how to articulate that...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

This is Brian, I just missed the beginning when you said the flexibility rule proposed last week, they're taking it down from 5% to 1 patient. I was under the impression that this was for the patient engagement measures.

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

That's correct, this is Arien.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

The patient engaging objective...

**Carl D. Dvorak – President – Epic Systems**

It is correct.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Not for the transitions of care.

**Carl D. Dvorak – President – Epic Systems**

Yeah, I guess I left a point off the table that I was working towards and that is, if things seem impossible we might find more people just abandon the program or politically oppose it with more vigor than if things seem practical and if practical would ultimately lead to success I'd rather pick practical that could lead to success than audacious that will lead to abandonment.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Okay, so, yeah, so you were using that as an analogy analogous to this situation.

**Carl D. Dvorak – President – Epic Systems**

Yes.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

I agree, okay.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

So, this is Kory, just one thing I want to jump in with here, because I want to make sure it's clear to everybody, a couple of things that are proposed to change with this measure versus the measure from Stage 2, just so everybody remembers the threshold for Stage 2 was 10%.

The other key thing I would just point out here is the second point around electronically exchange the summary of care record that's really opening it to different transport options at this point, it's not requiring that you send via certified electronic, you know, via CEHRT, you have to create the summary of care record using CEHRT but you don't necessarily have to send it using CEHRT. So, just something to keep in mind in these discussions.

**Carl D. Dvorak – President – Epic Systems**

Okay.

**Wes Rishel – Independent Consultant**

This is Wes, could you...that seems to be inconsistent with what we just heard and what we're looking at on the screen. It seems to me that it says, for more than 50% must electronically exchange the summary of care record, can you help me reconcile what I think I'm seeing versus what I think I'm hearing?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Well, I'm not sure where you heard a disconnect there, because I wasn't trying to say you have to do it electronically but again you have to...

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

You don't have to sustain it...right so you could...my understanding on just connecting those two dots for Wes is that electronically exchange is open to directly sending it for example via Direct, it is also open to the receiver querying it on when the patient shows up in that care setting so it provides additional flexibility in the means by which the exchange occurs.

**Wes Rishel – Independent Consultant**

Okay, so...

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

Do I have that right?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yes.

**Wes Rishel – Independent Consultant**

So, just trying to reformulate what Carl said in light of this, it would say that in order for a well-advanced and modern system to achieve conformance with this criterion they would have to have a recipient in their community that was capable of receiving those records by at least one of the methods thereon for 50% of their patients. Is that correct?

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yeah, that's how...

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

Fifty percent of the care transitions, yeah.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

That's a very important and very interesting point that Carl raised, yeah, so if I get your point right Carl, is you are worried about individuals who are ready to send the care summary and have nobody to send it to.

**Carl D. Dvorak – President – Epic Systems**

Yes.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

And I think that's a very important distinction because you should not punish somebody for somebody's inability to receive it but then that opens up a whole new can of worms, right?

The question is, what does it mean to be unable to receive it? You know if I choose a specific format of transmission that the other end is not able to accommodate but they are able to receive the information through another channel electronically would that also count? So, that's, you know, there is a further differentiation there.

And then as an Informatician and as a Programmer I really think this is poorly worded, the electronic exchange of summary of care record, it doesn't say at all who the recipient is. I mean, theoretically it could be to my grandmother the way it's written right now. I know it's implied that it's going to another care setting where the patient is taken care of, but it is really terribly formulated.

So, anyway, going back to the point, what do we do...how do we approach if we say "nobody should be punished for another entity not being able to receive it" how do we approach the issues of multiple channels that the message could travel through?

**Carl D. Dvorak – President – Epic Systems**

We could also do one, this is Carl again, we can do one modification that is instead of 50% do some sort of calculation at the time this rule goes into effect that would be based on how many successful Meaningful Use Stage 2 attestations had been placed in some reasonable geography maybe in your state, maybe in your area, I don't know how you draw that boundary but we probably have the data to draw that boundary if we wanted to take that step.

And maybe it's a complicated step I guess, but it would be nice that if your entire community is MU Stage 2 at least well then you ought to be held to a pretty high standard but if you happen to be in a zone where most people didn't get there you don't get penalized either if you were the one that got there.

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

Yeah, this is Arien, I've also seen a lot of areas where the discharge or the transition is to a long-term post-acute care facility now sometimes that's created interesting business relationships where the hospital will sponsor for that long-term post-acute care the technology to receive and that seems like it is a good idea but it is a reality that in some cases the discharge is actually irrelevant relative to the Meaningful Use Program it may be relevant for another kind of program so you need to take that into account if you are going to go down that kind of flexibility approach.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, this is Brian...

**Carl D. Dvorak – President – Epic Systems**

...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

This is Brian, I think we...well, I just want to read something from the proposed rule itself just to bring some clarity to the conversation in my own mind and put this on the record that this is what we're discussing.

So, it says in the proposed rule, in the Stage 2 rule we limited the action required by providers to sending an electronic transmission of a summary of care document, we did not have a related requirement for the recipient of the transition...the transmission.

However, in Stage 3 of Meaningful Use we are proposing a measure for the provider as the recipient of the transition or referral requiring them to actively seek to incorporate the electronic summary of care document into the patient record when the patient is referred to them or otherwise transferred into their care. This proposal is designed to complete the electronic transmission loop and support providers in using certified EHR technology to support the multiple roles a provider plays.

So, I think it is over simplified and maybe what we're looking at on the slide I think they go into a little bit of...there is even a lot more than that than what this little snippet I read, they go into a great deal of conversation in the proposed rule on this measure and in particular on what their intent is around the electronic exchange of a summary of care record. It is more deeply defined in the proposed rule than what we have on the screen in front of us.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yeah, so Brian...

**Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative**

This is Shelly Spiro, I'd like to comment on this also and this goes back to, you know, we're looking at a piece of what this is and what the intent is. I mean, we're looking at a process measure instead of leading us to an outcomes measure which is now once something is done how do we get that back to whoever sent the original proposal to close that loop. So, it needs to be more bidirectional.

Right now the measure is just a push of information out and the requirement of the push but where is the aspect of information coming back for the follow through, for the follow-up.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Well, this is Troy and I'm looking at that very aspect as well and it seems like the proposal is actually misguided...responsibility for the recipient to say that they were able to receive it instead of the action of the provider pushing it. I mean, that's really the goal is to have more people be able to receive it, right? And then of course later on down the line to integrate that data into their EHR.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

This is...

**Wes Rishel – Independent Consultant**

Well, you have to have both, right, this is Wes. You can't...if you said somebody has to receive 50% of their incoming transitions of care, receive this information, then we'd be having the exact same discussion in the opposite direction. Other than that...

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Well...

**Wes Rishel – Independent Consultant**

I haven't heard anything...I haven't heard anything that it changes the fundamental dilemma that Carl raised. I am in a rural area where we have an HIE and we have two hospitals and a few hundred practices and the ability to...and no information technology in the skilled nursing facilities...the ability to assume that we're going to get a level of community-wide compliance to the criterion for receiving 50% and parsing the data into the database in the timeframe needed by the leading edge vendors is just unrealistic with respect to the rate of rollout of this technology in the community.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

This is Melissa, could I ask a follow-up question?

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Well and then the same thing holds true of course with sending it because if I send it...so it's one of those measures that what purpose does it serve if I'm sending 50% of them if they're not being seen.

**Carl D. Dvorak – President – Epic Systems**

I think though...this is Carl, I think we're all comfortable or should be comfortable in a startup mode using process measures as proxy for outcome measures. There will come a day when we should just switch over to pure outcome measures but I think sometimes as you begin a new thing you do have to get comfortable with process measures as a proxy for outcome.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

This is Melissa, I have a...

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

I think...

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Follow-up question for Arien. Arien you said that you had seen, I think you said this, and I might be...I apologize if I'm butchering it, you had seen interesting business practices where maybe the hospitals sponsor the technology so that the discharge facilities would be able to receive it.

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

Yes.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

This of course...you know, I'm the lawyer, right, so, you know, this worries me a little bit that...I'm trying to think of how to phrase this. I don't want to limit the ability of patients to be able to be discharged to the facilities of their choices because of the requirements that we're putting on the place that's discharging them. Does that make sense?

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

Yeah, in this case the technology was provided such that the receiving facility could receive from anybody not just the sponsoring organization but it did put the hospital in the position of not being able to meet their 10% measure because a lot of their discharges were going to LTPAC facilities that had no technology.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

It's very interesting because what we don't want to do is force, for instance, hospitals into a position where they are, you know, almost creating a dangerous kickback problem for themselves. Do you see what I mean?

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

Yeah, no, as I said, in this example...

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Yeah, that's why...

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

That I gave...

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Okay, good.

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

There was no kickback because that receiving facility could use the technology for any discharging hospital.

**Wes Rishel – Independent Consultant**

Yeah.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Right, but the hospital essentially had no choice but to provide it...

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

Correct.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Unless they weren't going to meet their measure.

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

Correct.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Well, so this is Hal Baker...

**Carl D. Dvorak – President – Epic Systems**

To your point though there is probably an incentive for the hospital to prefer that nursing facility because they get to count if it if they get the patient to the...

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

Absolutely.

**Carl D. Dvorak – President – Epic Systems**

Over the five others in the community that don't have the technology where they would not be able to count it. So, I think your original concern...

**Wes Rishel – Independent Consultant**

And...

**Carl D. Dvorak – President – Epic Systems**

Is still very valid.

**Wes Rishel – Independent Consultant**

This is Wes, but there's also a reason for us to prefer that incentive if we believe that sending the information creates an improvement in care.

I just want to point out that Kory's comment going back makes this less challenging and I think Arien's comment really was based on it being less challenging. In effect, the sender has to create a structured document for transmission that could be ingested into...you know, parsed and injected into the electronic health record...

**Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership**

Thanks for letting me know that my automobile insurance...

**Wes Rishel – Independent Consultant**

Hello? Hello?

**Carl D. Dvorak – President – Epic Systems**

This is incredible where we've got a baby, we've got a chicken in the background and a call...

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

And insurance...

**Wes Rishel – Independent Consultant**

Well, I'm responsible for the chicken, but...

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, we'll try to mute whoever that was.

**Wes Rishel – Independent Consultant**

And it will go away as soon as I finish my statement, but...

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

...sorry.

**Wes Rishel – Independent Consultant**

But, we're not requiring that the recipients be able to do anything but receive and print out a text version of the document that's sent. So, the level of activism in the community that it takes to get up to the 50% transitions...the 50% referrals is not as high as if we were requiring them all to have sophisticated EHRs, thanks.

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

Yeah, let me ask a follow-up, this is Arien, let me ask a follow-up on that question, because I'm trying to make sure I understand the text. If I created a summary of a care record and electronically exchanged the summary of the care record to a health information exchange or other kind of registry where it could be pulled down by the receiving facility is that intended to meet the intent of the measure?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yes, I believe so. We can jump to the measures if that would be helpful...

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

So, this...

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Or the numerator and denominator if you want to see the next...if we go to the next slide, I don't know if that would be helpful.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yes, let's go to the next slide and look at this and as an order of business can I ask everybody who is not talking to put themselves on mute so we have a little bit of less background noise. If we can go to slide number seven.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yes.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

You can see that the denominator for this, as it's written right now, so number of transitions of care and referrals during the reporting period for which the physician or hospital was transferring or referring providers, so all transfers of care or transitions of care are eligible as the denominator and the numerator here, as it's defined, is the number of transitions of care and referrals from the denominator where a summary of care record was created and exchanged electronically.

And again, you heard me whine about the underspecified exchange information and as Kory just said there is a potential that this could include health information exchanges where somebody else can then actively download at a later point.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

So, this is Hal Baker I'd like to make a couple of comments, the purpose of this is to have coordination of care and the reality of what is happening is that coordination of care is taking place in transfer of notes and the CCD document is being exchanged in PDF format to achieve compliance. But the reality is that most PDF documents are not being incorporated in any way into the record and it really is becoming a compliance act.

And the exclusion here of Internet availability makes little sense because if only 60% of the possible transfer points in your community are able to receive a document then you actually have to receive over 80% successful transmission in order to comply with the 50% rate. So, the exclusion here does not make sense. The real problem is, is people that can receive this in the community.

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

This is Arien, I want to...I was going to hold this comment, but Hal kind of introduced the topic, there is a means approach that I feel is too hardwired. I think one of the lessons of Stage 2 Meaningful Use is that the focus on structured documents that include everything isn't terribly clinically useful and that what clinicians need is the textual clinical summary and that what computers need is access to discrete clinical data to be able to reconcile for example a medication list or a problem list. Combing both of those in a single summary document is one way of achieving that outcome but it is not the only way and I don't believe these measures should be worded in ways that make only a single aggregated clinical summary document the way of achieving it.

I'd like it to have some flexibility such that for example a textual summary document and FHIR-based discrete data access could be reasonable ways of achieving the process measure.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

I'm in.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Let me follow that up with a question. Don't you potentially, with that proposal that you just made, make the job of receiving that care transition significantly more difficult?

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

The current experience right now, this is Arien, the current experience with receiving a Consolidated CDA probably couldn't be more difficult in the sense that as Hal said, many people who receive these documents receive them as a 20 or 40 page printout or, you know, web translation where it's very difficult to get to what the clinician actually wants to see which is the clinical narrative and it makes it very difficult for the computer to get what it actually needs which is the discrete parsable medication list and problem list that can be...that can automate reconciliation.

So, I'd feel very different about this if the clinical experience and the computer experience of receiving structured Consolidated CDAs was very strong and my experience is that it is not very strong.

**Carl D. Dvorak – President – Epic Systems**

Chris, this is Carl, two things. One is with regard to Arien's point, I don't think it's a bad thing to in addition have access to something like FHIR but I think the presumption that simply having access to something like FHIR and sending a text only would really more or less hold the discrete data hostage and I think you want to send the discrete data, send it in a way that you can find the clinical note pretty concisely which having a good single standard will help people adapt to that quickly.

And then think of FHIR as maybe icing on the cake if need be. But I wouldn't withhold or allow the discrete data to be withheld from the document because I do doubt that everyone involved is going to be able to program up all those programs to try to pull that data back as quickly as it's needed.

And then second point, I wonder if under the exclusion this 50% of the housing units with 4 megabit broadband, I don't even have 4 megabit broadband yet unfortunately in the country, but I'm in a very well high tech area, so I think this conclusion may have been appropriate for view, download, transmit or portal access but I don't think it's at all appropriate for this measure so I would suggest that be struck in its entirety.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

This is Hal, I would...but somehow Carl don't we need to get into how many people in your community are able to receive because otherwise people who can't receive but who you transfer to counting your denominator but are not possible to include in your numerator.

**Carl D. Dvorak – President – Epic Systems**

I agree and I think that's where I was making an earlier suggestion about providers in the community that have achieved Meaningful Use Stage 2 ought to somehow moderate the percent required. So how...

**Wes Rishel – Independent Consultant**

This is...

**Carl D. Dvorak – President – Epic Systems**

Speaks more to consumers I think than to healthcare entities.

**Wes Rishel – Independent Consultant**

This is Wes, if we can...I'm just so skeptical that we can find a measurable phrasing of that for example, something based at the state level is really useless for people who...for a state that has both rural and highly urbanized communities.

So, I would suggest that we take that issue of finding a formulated constraint on this criterion, you know, to be a topic to discuss and if we can come up with something that we think is sufficiently objective and sufficiently measurable by an auditor than I think our solution ought to be to propose that addition.

**Carl D. Dvorak – President – Epic Systems**

Yeah, I'd be...

**Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative**

This is Shelly Spiro, I have to comment on this particular point especially because those who are not Meaningful Users, you know pharmacy, long-term post-acute care, behavioral health who are really going to benefit from this type of measure, if we don't push the measures to the level that we do for those who are needing the incentives it's never going to drive...there is nothing that is going to drive the other end. And so we have to be able to work together.

So, I don't know if...I mean, I think we need to drive...this is such an important measure for patients and for the care of our patients that if we can't drive the electronic exchange of this information in both directions than we're never going to have the benefit to the patients that we really need.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

But, this is Hal, to achieve the benefit the physician has to be able to consume the information or it has to be presented and digested by the EHR and re-presented to the physician in a way that they can get the information.

The reality is that if you get a 20 page document and the physician can't access the information they need to make decisions in 15 to 20 seconds they click the "close" button and move on. And so meeting the data needs of the exchange and the information needs are somewhat in competition with each other.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Okay, so I'm going to...

**Wes Rishel – Independent Consultant**

This is Wes...we're also talking about two different communities here. We're talking about physician-to-physician, provider-to-provider exchange and we're talking about trying to bring in a number of other stakeholders and classes of providers in the healthcare system and I think it's going to be a high-level of art to use a single criterion for both...to meet both requirements.

I also want to comment on Shelly's comment that the need doesn't by itself generate success one of the most...one of the basic causes of the failure of interoperability everywhere has been creating a need for somebody to send when the receiver doesn't have an equal need to receive.

If we have policy levers that can create an incentive to receive based on these other...of these non-EHR using providers in the community I think that's fine, but if to say, we're going to push the hospitals in order to get the nursing homes to participate it's okay at low thresholds it's not okay at a 50% threshold.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

And this is Troy, that's exactly the point I was trying to get out there is that there is a disincentive without that receiver. I mean, it's almost an impossibility. So, the incentive should be to receive the data and, yeah, there is an incentive to push, but it's more...it's better to receive it and integrate it into the record in some way.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

So, this is Kory, just to be clear, measure two is about receive we just haven't gotten to that because we were trying to talk about them in some sort of flow order. So, just...you know, just so everybody knows there is a measure two that is focused on receiving 40%. So, you know, I don't know if it would be useful to jump around to some of these pieces when having this conversation but I want to make sure everybody is aware of that.

**Wes Rishel – Independent Consultant**

We recognize that but measure two doesn't apply to all of the people that measure one applies to and the at the same...

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

No, I know, Wes, I just think some people knew that and some people didn't it sounded like from the conversation. So, I just wanted to make sure everybody was on the same page.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Now I knew it was there but, you know, much like was pointed out...even if you're working with certified technology, so why do we have an incentive to send? I mean, we've had that and now we need to work on the other side that says, okay, here's an incentive to receive.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you, this is Chris, I'm trying to make a little bit order out of this discussion that we've had so far. So, I see three themes emerging and I would like for you to correct me if I'm missing something.

First, we are looking the issue related to being penalized if there is nobody there, if you're ready to send the information and there is nobody there to receive it, you know, it's the falling tree in the woods but there is nobody around to hear it. That's the one issue and Carl raised that one and I'm particularly interested in it because it's looking that pediatricians are not moving to higher stages of Meaningful Use, so I'm particularly interested in that one.

Then I hear that there is a discussion about the quality of what's being exchanged and there is a question of does it really need to be a summary of care record or should there be other modalities and my caveat to that is the more modalities you add the more you make it difficult to find receivers of your information.

And then the third point that I heard was that there was great interest in keeping the number high of items that must be sent to drive the value of this measure and to bring people to open their ears to be able to receive that message.

So, those were the high-level things that I heard. Did I miss anything?

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

Yeah, this is Arien, just one other point is that lower thresholds that still drive meaningful workflow maybe a more appropriate way of letting the market and ecosystem evolve than upping the thresholds and what I mean is that, you know, the 10% threshold has driven some of the ecosystem considerations.

I think if the actual electronic exchange has limited...has significant utility we will see that ecosystem catch and start based on the appropriate base threshold. If it doesn't provide utility I think we should be looking at why it doesn't provide utility and fix those issues.

So, what I'm saying is that there is a meaningful threshold, and 10% may well be meaningful threshold, that drives the ecosystem to start up and go at which point value and utility need to be the pull. So, it may be appropriate to not push the threshold up so high as long as that threshold is set at a place where it does drive the ecosystem.

**Carl D. Dvorak – President – Epic Systems**

And to Shelly's point earlier I think, Arien, if the threshold is too high you almost create patterns of abnormal behavior like pushing all your patients to one nursing home just so you can meet the measures.

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

Correct.

**Carl D. Dvorak – President – Epic Systems**

And Chris, one more point, I do think that this exclusion, the second exclusion on the current slide is probably there by accident because it's likely that all the healthcare places do have Internet and could perfectly well share this information regardless of whether the housing units had 4 megabit per home Internet.

So, I would suggest that this exclusion be removed, maybe replaced by if you can get an attestation from your nursing home that they simply do not have the Internet, fine, I think that's worthy of an exception, Barrow, Alaska, might have more problems than Boston, Massachusetts.

But I don't think the housing units, 50%, really has anything to do with it here because most healthcare institutions in those areas will likely have Internet.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you, this is great. So, I added to the list of things that I heard that the thresholds may be too high that a threshold that is more in line of what can be done might actually motivate people more and that too high a threshold may cause gaming of the system like referrals to those that can receive what you send them.

And the other issue that Carl just added, again, and I'm sorry I didn't list it Carl, is that the second inclusion probably should be stricken or replaced for something that is a more realistic barrier to being able to receive.

**Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership**

This is Beth, if we do reduce the threshold does it also give an opportunity to drive towards what we really think is the ultimate aim?

So, I'm looking at the measure and the decision to write Part 2 about electronic exchange via any mechanism, I don't know if we're driving towards or hoping ultimately for sending using CEHRT and if you lower the measure you could both have create the summary of care and sending via CEHRT because I'm just wondering if Meaningful Use Stage 3 is the end of this set of measures when are we going to take the next step that's sort of presumed pushing the right direction.

**Carl D. Dvorak – President – Epic Systems**

Beth, I thought the Stage 3 was the last stage with the exception that they reserve the right to change the percentage thresholds over time. So, I think if...and maybe the ONC folks could comment on that?

**Beth Morrow, JD – Director, Health Initiatives – The Children’s Partnership**

Yeah, though, this wouldn’t be about changing the threshold it’s about whether the...so this is creating a summary of care record using CEHRT but then allowing the exchange via sort of any electronic mechanism rather than designating a preferred mechanism of CEHRT, which I presume is partially to recognize that that’s not achievable at a 50% level at this point, but if we lower the threshold maybe it gives an opportunity to make a change like that which might be desirable and I’m not 100% sure that is desirable, but I just raise it.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

This is Brian, I think to your point and Carl I agree it would nice to have the ONC maybe give some clarity around this but the notion that the measures aren’t going to change after this but they may increase thresholds post Stage 3 to me means that we really, you know, focusing on the thresholds is probably not the best opportunity we have to provide effective comment, but focusing on the measures themselves and whether or not we believe if you were to reach 100% of this measure or, you know, a higher percentages of this measure would over the next 10 years would that really achieve the goals of the interoperability roadmap and help us to achieve a learning health system.

And if the answer to that is not a resounding “yes” than maybe it’s more that the measure is not, you know, is not taking the right approach. I would hate to get us locked into a measure that five years from now we find out wasn’t really the right measure no matter what the threshold ends up becoming.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

This is Hal, Chris, to extend your metaphor of the tree falling in the forest, if documents are exchanged but never read has anything useful happened?

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

I couldn’t agree more.

**Beth Morrow, JD – Director, Health Initiatives – The Children’s Partnership**

Well, I think the key on that one might be that maybe that provider that it’s sent to may not read them but they would now be in a central record for that patient to get a copy of.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yeah, I was just talking on mute, this is Chris, so the caveat with that one is that if you have stuff in your electronic health record that is not indexed and can’t be searched for the only person who is ever going to read the whole medical record is the plaintiff’s lawyer. So, that’s...I’m very worried about stuffing things in there that are not usable because they are not indexed and can’t be searched for. So, do we have any other comments on measure one at this point?

Then let’s go to slide eight, this is a slide to clarify something. One of the questions that is, you know, to whom do you exchange and send the information to, so it has to be...you have to send the information if the setting of care is considered distinct from the originating setting of care.

So, the clarification here is that if a provider has a different...if a program has a different national provider identifier or a different hospital certification numbering they count as part of the objective of this measure. So any questions, concerns or discussion around this item?

Kory, was there anything that I missed on this one, on this clarification?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

No don't think so.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Okay than there is no discussion then we'll...

**Carl D. Dvorak – President – Epic Systems**

Chris this is Carl...

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yes?

**Carl D. Dvorak – President – Epic Systems**

Maybe it's a question to Kory. I was aware that there were some providers that interpreted this in such a manner that as long as they packed it up and sent a document to nowhere if they shared a system than this would somehow count and ONC was asked about that and actually to my surprise clarified that, yes, that counts even if you intentionally sent it to the bid bucket because you knew the other provider would actually share the system with you.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Yeah and it says that in the rule.

**Carl D. Dvorak – President – Epic Systems**

Yeah.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yeah, so there is a section in the rule talking about how instances where if you are on a shared electronic record if your NPI is different and you meet this part if you send an electronic summary of care record and meet the other requirements of the measure you would be able to count it. You have to treat that transition the same throughout the...it has to count the same throughout the system, so, you know, the sender would have to count it and the receiver would have to count it, but, yes that is in the rule.

**Carl D. Dvorak – President – Epic Systems**

It seems like it...you know, obviously this is something that benefits the kind of organizations I work with but it seems like it inappropriately gives a benefit to large integrated health systems or most of the referrals are within and I had suggested, back when this first came up with Stage 2, that a solution might be to take them out of both the numerator and the denominator and just go with the notion of an external referral which would be to anyone outside of your...the IT infrastructure that you shared with, you know, people who maybe in an ACO or another business relationship with you.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, I wholeheartedly, this is Brian, I wholeheartedly agree with that Carl and thank you for raising that because I think you're exactly right it does give definitely a distinct advantage to large facilities, organizations that have a lot of resources and have a lot of internal referral activity taking place such as those that you serve. So, I appreciate your honesty in raising that point.

Taking them out of both the numerator and the denominator while certainly making those numbers lower I think gives an more accurate final threshold percentage of true interoperability that is really taking place.

**Carl D. Dvorak – President – Epic Systems**

Okay.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

And this is Troy, you know, working for Kaiser Permanente I do agree with that. I mean, it does give us a distinct advantage over others, so I agree.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

So, if you guys wanted to put a proposal like that forward how would the...I mean, would you be recommending changing this definition of setting of care as well? Because I would imagine this wouldn't really align with that.

**Carl D. Dvorak – President – Epic Systems**

Yeah, I'm not sure, this is Carl again, I'm not sure where all it would need to be changed.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Okay.

**Carl D. Dvorak – President – Epic Systems**

But there are probably staff members that have studied this one in depth. I know it was an issue that required multiple clarifications from ONC during the Stage 2 process but I do think it's worthy of reconsideration. It seems to me to create a false measure that benefits the large and, you know, doesn't really disadvantage the small but it does certainly benefit the large.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Yeah, and...

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

And...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, Kory, I think...I don't know that necessarily it's the definition that we're focusing on here, it's the application of the definition to both the numerator and denominator.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yeah. One thing I'm just curious from your guy's perspective, one thing I've just...and this isn't, you know...one thing I've just heard from some folks is instances where, you know, a large provider organization is for instance a reseller of certified EHR technology that...you know would there be challenging consequences of this sort of approach where you wouldn't allow that to count if they are reselling technology to others and it's considered a single instance, you know, to non-affiliated providers? I don't know...I just know that's something I've heard from some folks.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

I mean, not to get too deep down into the weeds on that, but my perception is that what we're trying to accomplish here first off is better care coordination and so if they're unaffiliated providers using different systems and they're able to exchange that's a good thing and so that's where we're driving towards.

And so, you know, I think probably, you know, to address the issue that we're raising right now and give a more accurate picture of interoperability and a more accurate challenge to the community it would be that we apply this to both the numerator and the denominator and then that way I'm only looking at...I'm only looking at the transitions that occur outside my system and then I'm only looking at those that were done according to the measure. And then I'd calculate my threshold.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

This is Hal, the gaming that I think we want to avoid is where a large integrated delivery system with 60 to 70% of its referrals are internal to be able to do that with 100% reliability where it's actually useless because they share a record and then not do a good job of doing it when the referrals go outside because it's such a small percentage.

Keypage or leakage control is such a big issue with accountable care organizations and large integrated delivery networks that the percentage of referrals going out is going to be shrinking. We'd hate to make...when that does happen that exchange doesn't happen because we've somehow been compliant with the rule by a loophole doing it internally.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Sure, but, you know, when...to put that...when you bring up ACOs often times in value-based contracting you end up with multiple organizations that are on multiple systems so it's still okay and beneficial to have exchange occurring across multiple organizations and multiple systems in a value-based world. As a matter of fact I'm hoping that the business case of an accountable care organization would help to drive this measure more than the measure itself.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Yeah.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

This is Chris and I think the point is well taken, if we use interoperability to actually...as a competitive measure by exchanging well internally and not well to the outside world then it becomes problematic. So, I think some adjustment based on the amount of internal referrals is clearly something that I would rally behind.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, then maybe by e-mail those that have been talking about this issue could circle back with you by e-mail notes and put in some propose language to our comments to that effect.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

I would greatly appreciate that and I think this was a great topic to raise and I appreciate the discussion. All right, I think that kind of concludes the issues related to send and we are at about the hour mark that means we actually will be able to start talking about the second measure “receive” the “capture” unless there are any other comments on send?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Hey, Chris, sorry there is actually one more slide, slide nine on patient self-referrals before we get to send or to capture.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yes, Kory, thank you so much for reminding me, let’s go to slide number nine. And this is a clarification that focuses on patient self-referral, remember we’re talking about the measure “send” and the numerator where patients that are sent from one institution to another triggering the requirement to send information about this patient.

Now there might be the circumstance where somebody like me bypasses their PMD and goes right to the gastroenterologist for a problem and so this is the self-referral clause that...the clarification that’s put in here.

And the proposal, as it is here, is that these referrals maybe included in a subset of the existing referral framework and should be counted. So, the recommendation is that providers should include these instances in their denominator for the measure if the patient subsequently identifies the provider from which they’ve received care. So, that’s a big caveat, right?

So, this patient is supposed to be in my denominator, so it makes my work a little bit more difficult, if they tell me where else this...when to get care. And in addition you may count them in the numerator if you do an action to get the information on the patient to this provider that the patient self-referred to.

So, I have a whole host of technical and workflow issues related to that but I’m going to go and open this up first for the group discussion.

**Carl D. Dvorak – President – Epic Systems**

Chris, as a fellow programmer I'll appeal to the programmer in you, I think although it is an interesting edge case it's probably not worth the technical time and effort to try to capture it. I think if we focus on the core we'll achieve the objective even if we miss out on this among probably a dozen other boundary cases that someone might be able to raise.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

I agree with you this is an awful amount of work and potential programming and workflow modification for a relatively small end in my experience.

**Wes Rishel – Independent Consultant**

This is Wes, I share your feelings I just want to point out that this provides an incentive for using capabilities to look up a record as opposed to receive it proactively, being able to receive it proactively to the extent that this was the goal it's laudable. I hope we can find another way to encourage that rather than this particular...I mean, I'm going to assume, by those who are closer to it, that patient self-referral is really not that big a segment of incoming patients for specialists, if that assumption is true then what you all have said sounds exactly right to me.

**Carl D. Dvorak – President – Epic Systems**

Well, Wes, I think it would be a good idea if we could somehow count the pull cases, so someone showed up in an ED and you pulled the record from primary care, God Bless them that's meeting the spirit of the objective. So, I'd like to see a pull use case identified and counted rather than just a referral push case.

But this particular post knowledge of a self-referral seems like an edge case, but I'm with you on the "we should count the pull cases" because that would provide another opportunity for people to be recognized for a really important element of interoperability.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

And this is Hal, I'm struggling to see a situation where a post visit request for information would be meaningfully harder or precluded if you could successfully do a pre-visit exchange the amount of effort for this measure doesn't seem to meaningfully impact the frequency with which it was done. If you can do a pre-visit you can certainly do a post visit and then it's a matter of courtesy and patient interest to do it.

**Carl D. Dvorak – President – Epic Systems**

Yeah, it's a good thing to do but just thinking through how you measure it and monitor it through time and meet your Meaningful Use auditable reports with it. It starts to become a focal point of how to count correctly.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

I agree.

**Carl D. Dvorak – President – Epic Systems**

Where it's probably not worth trying to count it right.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Yes.

**Carl D. Dvorak – President – Epic Systems**

It's more of a counting administrative thing rather than is it a good thing. I think it would be a good thing if people would actually do it.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

The measure is...

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

But aren't you losing focus on the point of the measure? This is a patient centered measure. So, this is a patient forward one, this is where the patient actually is able to gain access to the...C-CDA or the summary of care and send it to a self-referral, right? It is not really a pull or a push situation.

**Wes Rishel – Independent Consultant**

I don't read it that way at all.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

No.

**Carl D. Dvorak – President – Epic Systems**

No.

**Wes Rishel – Independent Consultant**

I read it as the receiving provider has to take an action to obtain the information from a provider that has previously seen the patient and that thing of doing...

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Yeah, that's...

**Wes Rishel – Independent Consultant**

That over history is what makes it so very difficult to get to count.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Even that is not quite correct, because the way...this is part of send right? This is not part of receive. The onerous is on the provider who has seen the patient in the past, has currently no involvement of...with a self-referral that the patient did but once this provider hears that a patient self-referred to another provider has the onerous of sending his old information or her old information to the new self-referred provider.

So, it's actually even more complicated, you know, so the question is what triggers this? What event does the patient send to the original provider...

**Wes Rishel – Independent Consultant**

Well...

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

And gives him that information.

**Wes Rishel – Independent Consultant**

I would say a medical record request triggers it that actually makes it simpler. There is a single action done by a certain category of user, probably someone in medical records that is countable.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

But if a patient goes to the emergency room and then tells me that they went to the emergency room and then I, as a primary care physician, send the emergency room a summary of care record a week after the patient has been there that doesn't help anybody and yet this measure seems to ask me to do so.

**Wes Rishel – Independent Consultant**

Right, I think...

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

So let me...

**Wes Rishel – Independent Consultant**

This is addressed more to self-referral to specialists rather than ED.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Okay.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Well, but the point remains the same, this is Brian, so if I go to the emergency room or instead decide to go to see a rheumatologist and I don't have a referral the point remains the same whether it's the ED or some other type of specialist or really any other care setting and so this is where I think actually the query use case is valuable but it's not so...so it's not so much that I would...that the primary care doctor would send information post visit, which wouldn't be very useful, but would query for new information as a result of that self-referral.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

I would...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

That's not what this says, I'm suggesting that would be useful.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Well, I think that makes more sense.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

There is overall agreement that this self-referral clarification is not...it's an interesting use edge case but probably not high volume and what would be way more interesting and maybe even worthy of a measure is a pull use case instead.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Yes.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Yes. I think a query use case here would be more valuable and I think that as its stated in the proposed rule it's entirely problematic.

**Wes Rishel – Independent Consultant**

This is Wes, I wonder if I could ask Kory a question?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Go ahead.

**Wes Rishel – Independent Consultant**

Kory, in the NPRM workflow, which is probably as complicated as almost any medical workflow, is it feasible to create new measures in the final rule that weren't described in the NPRM?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Well, so that's a great question, Wes. There has to be logical outgrowth for it. So, if there were questions around it or other, you know, and I mean I'm not a lawyer so I can't, you know, give you the exact definition of what it is, but, you know, for instance they would not be able to create a measure whole cloth that had no reference in the rule and then finalize it in the final rule, you could not do that.

**Wes Rishel – Independent Consultant**

But, discussion arising from this that created in effect a new measure at a paragraph level higher, you know, in the outline that is at least potentially feasible?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yeah.

**Wes Rishel – Independent Consultant**

Okay, great, thanks.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, then great, thank you for clarifying that Wes because there maybe could potentially be a different measure here that we'd be looking at around patient self-referrals that provided for a query use case.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Okay, all right, interesting discussion. Let's move on unless there is anything else related to "send" let's move onto to measure two "capture." Slide number ten. And Michelle, I have...we have another 15 minutes is that correct? Kory?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We have until 4:00.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Okay.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

But we do need a few minutes for public comment, but, yeah.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

That's right, yeah, so that's what I...

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yeah.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Okay, so measure two is that...as it's formulated right now that 40% of transitions or referrals received and patient encounter in which the current provider has never before encountered the patient the provider/hospital incorporates into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system. So, here the number is set slightly lower than the 50% that is required for sending, assuming that some people will not send, and that you will be able to receive less in that arena.

Of note is that a capture is required unless a summary of care record is unavailable. Unavailable means that number one, the provider request an electronic summary of care record to be sent and did not receive one and query at least one external source with HIE functionality and did not locate a summary of care for the patient or the provider doesn't have access to HIE functionality to support such a query. So, a note that this is an "and."

So, when you get a new patient that either somebody referred to you or that just walks into your hospital and you've never seen them then you have to reach out and request a summary of care record and you have to reach out, if you don't get one, you have to reach out to an HIE, if you have one available, and reach out for the information there.

So, before we go onto the discussion of the numerator and denominator I'll open this up for discussion as it's written here.

**Wes Rishel – Independent Consultant**

So, this is Wes...

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

...

**Wes Rishel – Independent Consultant**

I think one obvious question is what does it mean not to have access to HIE functionality? Does that mean I haven't joined an HIE or does that mean there is no HIE? I mean, is this in effect an obligation to join whatever HIE is available in the community?

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Kory, are you familiar if there is any clarification to that?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

No there is no additional detail in the rule. So, you know, this could certainly be an area where you point this out and ask for additional clarification in the final rule.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

I think we just had that request for additional clarification.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Is there...this is Hal, is there a definition of what incorporate means and whether that means discrete data or whether it is purely a scanned image of a document?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

I'll have to look that up I'm not sure. I'll look and get back to you.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Okay.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

So, we have discrete versus scanned, all right, any other comments?

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

Yeah, this is Arien...

**Wes Rishel – Independent Consultant**

Well...

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

It seems to me the previous discussion of patient self-referrals could be elegantly folded into this measure if there was another clause and patient encounters in which the provider is informed that the patient has previously received care in a separate setting.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Yeah and this is Troy, I mean, this is where my concern came from is that this measure is the actual pull, so this is the query part. I don't understand the previous one which basically restates what this one is saying. At least that's the way it seemed to me.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Okay, all right, so if there are no more comments then let's move on...

**Carl D. Dvorak – President – Epic Systems**

Just...

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yes, Sir?

**Carl D. Dvorak – President – Epic Systems**

Sorry, it's Carl, can I question the "has never been encountered" or "never before encountered?" I would think if...again, just the...I spend more time writing the programs to implement these measures than to actually implement interoperability these days, but, does the...can we just say within the reporting period or...I don't understand the "has never been encountered."

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yeah, so that's...

**Carl D. Dvorak – President – Epic Systems**

I'm wondering if that's helpful.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

It's a good question, Carl, I was chewing on that actually earlier and, you know, in my simple mind what I thought, well, you have to add this patient to your master patient index that means you haven't encountered him before that's what I...that was my simple interpretation of it, but you put in a timespan, you know, if you haven't seen the patient in three years that patient might be completely novel to you because if new chronic diseases have developed and the patient had surgeries and interventions. So, this actually is a good point that required clarification.

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

And in an...

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

This is Hal...

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

This is Arien, in an ED context it may be a month later, it may be three months later and it is still just as useful to query for the most recent information.

**Carl D. Dvorak – President – Epic Systems**

Agree and the notion of “the provider” here, you know, maybe encountered into a practice or something. I guess I would suggest just removal of that. I don’t see where that helps us.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Well, I think...I think what they’re trying to get at is for new patients and I don’t know if removal...

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

Yeah, but this, again...

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

So, I...

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

This is Arien, I’m sure...I’m not sure what the policy consideration is. If I’m an ambulatory care, primary care provider and I haven’t seen my patient in 12 months and I query and discover that there is a radiology report isn’t that useful? Isn’t that helpful and doesn’t that meet the intent?

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Oh, yes, absolutely, yes. I’m not against putting a timeframe in, I’m just wondering if removal is a good idea.

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

Well, but if it’s three months and there’s a radiology report there isn’t that useful?

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Yeah.

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

Doesn’t meet the intent?

**Carl D. Dvorak – President – Epic Systems**

I’m suggesting that...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Yes it does.

**Carl D. Dvorak – President – Epic Systems**

I think Arien and I are on agreement in that suggesting removal of it means you should just be held accountable to it all the time. So, if they show up you ought to check.

**Wes Rishel – Independent Consultant**

Let me...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, I was...

**Wes Rishel – Independent Consultant**

This is Wes, this is as close to a pull requirement as I've seen. It seems like the capture in effect meets the need we were addressing under send.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

So, this is Hal, if a patient moves into town for the first time and encounters a primary care physician you're using a 999203 which requires you...is a new patient appointment, I was seeing this tied to that, but then you have to try to go get some records which sometimes we do and sometimes it's too hard and you don't it's encouraging that activity but it could easily be tied to those visits where there is a difference between a new and old patient for the billing code.

**Carl D. Dvorak – President – Epic Systems**

Yeah, but in a care team-based model...

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

You'd want more, absolutely.

**Carl D. Dvorak – President – Epic Systems**

Yeah, I would still suggest removal because it actually in my opinion makes it a stronger requirement...

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Agree.

**Carl D. Dvorak – President – Epic Systems**

Plus it gives a count to manage.

**Wes Rishel – Independent Consultant**

So, this is Wes, I wonder if we want to discuss 40% as a threshold given that we're seemingly recognizing an opportunity to strengthen this requirement and given that the ability to go out and get data requires more of an information sharing arrangement than is required to proactively send it. I'd like...I, you know, don't have direct experience but I'd like to hear from those that do.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

It is much harder...

**Wes Rishel – Independent Consultant**

I didn't mean experience with Direct I meant actual applicable experience.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Applicable experience is much harder to get information when you've got the patient in your office than it is to send it when somebody asks for it.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Well and...to your point, Wes, you know, if...you have to add a different relationship and a different architecture in place to be able to query information more broadly than it is to simply push a summary of care record after a visit.

**Wes Rishel – Independent Consultant**

Yeah and not every place has an HIE and some HIEs really do provide more value in pushing information than in establishing the capability for query right now. So, I'm not...I'm suggesting that's all the more reason why we need this measure, but questioning whether 40% is the right way to, you know, to start out with a measure like this.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

I wanted to circle back to Carl's recommendation to delete the "never before encounter" and Carl while I appreciate what you're going after there, I'm also worried about...a little bit about transmitting or pulling stuff that is already known and that just leads to chart bloat.

So, maybe there is...maybe there is a middle ground in there that "never encountered" is linked to a time period that the patient hasn't been encountered in x-months or x-weeks, or x-years whatever you want to put there as a timeframe to reduce, you know, a frequent flier having the same information pulled in from external sources everyday they show up in the emergency room.

**Carl D. Dvorak – President – Epic Systems**

I...yeah, I guess in my head I had presumed that one would kind of keep a date mark and not duplicately pull stuff but I respect that maybe not everyone does it that way.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Yeah.

**Carl D. Dvorak – President – Epic Systems**

Yeah, I wouldn't want to create that we've got enough bloat going on with too much stuff blocking...

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

This is Arien, the intent was more to provide credit for folks who incorporate a query-based access natively into their EHR and for providers who incorporate query-based access into their workflow that if you do it and it's useful it seems to meet the policy intent and it seems odd to exclude it.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Right, so it says, you know, this really gives you two opportunities, right, for a referral received or if it's a patient that you've never encountered and I think removing the provider has never before encountered the patient allowance in this actually makes it more difficult to meet the threshold.

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

I would prefer, this is Arien, I would prefer to have a different threshold for encounters and lower that threshold. So, 40% of transitions received and 10% of encounters rather than put in this particular exclusion that as Carl points out is actually harder to sum up total...

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Right.

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

And figure out from a programmer perspective.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, rather than lumping them into the same denominator separating them really as two separate thresholds within this measure.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Yes and for orthopedic urgent care or urgent care clinics you could have a situation where you're encountering the patient and then requesting records after all the care has been completed and you're really not achieving anything unless it can be pulled concurrent to the visit it may not be helpful.

**Carl D. Dvorak – President – Epic Systems**

I'm going to fall back to Chris's comment, Chris, certainly if by doing a pull you end pulling duplicate stuff that would definitely be a tragedy in all cases and yet I'm concerned about the use case where somebody shows up in the ED, one of the most helpful things to know is, have they been to a doctor recently and what for. So, I mean, we've seen a lot of...we obviously do a lot of pull cases so we've seen that be one of the most beneficial cases especially as patients move, you know, to the ED of most convenience or are taking by transport to other places then they might generally be seen.

So, I'm still thinking it's a very, very helpful thing to encourage people to just always check if you've got the capability to always check and I don't know that we benefit by creating a measure that introduces a, you know, new patient versus existing patient just because you were at the ED five years ago doesn't mean that ED really is informed the need to be about why you might be there tonight at 2:00 a.m.

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

This is Arien, I totally agree and I think that the word "incorporate into" is maybe part of what's tripping us up. It is ridiculous to incorporate into the information that is (a) not relevant or (b) duplicative. So, if we could correct the language there we may be able to address the concern about duplicative information.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

So, what would you suggest as some alternative language or clarification around "incorporates into the patient EHR?"

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

Incorporates, you know, per clinical judgement or incorporates novel and new...I mean, there are cases where there are hospital labs that probably shouldn't ever be incorporated into an ambulatory EHR so there is no reason to incorporate it.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Yeah.

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

There is...there needs to be a clinical judgement and a clinical reconciliation with respect to that incorporates.

**Wes Rishel – Independent Consultant**

Evaluates for incorporation into.

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

Yeah.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

One thought for you guys there is language in this section on clinical relevance as far as sending and, you know, CMS providing flexibility for providers in certain areas of making judgement calls about what is clinically relevant so that's a concept already in there, it could be something to use here as well.

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

Yes.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

And...

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

We'd like to give credit for somebody who queries, finds there is no new information and doesn't incorporate anything.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Exactly.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Well this is a great discussion and I think we'll have to pick it up on our next call because I think we are at the time for the public comment is that correct Michelle?

**Public Comment**

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, thank you, Chris. Lonnie, can you please open the lines?

**Lonnie Moore – Meetings Coordinator – Altarum Institute**

Yes, 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. If you are on the telephone and would like to make a public comment, please press \*1 at this time.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

So, while we wait for public comment the next call is next Friday the 24<sup>th</sup> at 11:00.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you for the reminder Michelle.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

And it looks like we have no public comment. So, thank you everyone for your strong participation, especially it's Friday afternoon and I know that there was a lot going on this week so thank you all.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Thank you.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you very much everybody.

**Carl D. Dvorak – President – Epic Systems**

Thanks.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Bye-bye.

**Carl D. Dvorak – President – Epic Systems**

Bye-bye.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Have a good weekend.

**Carl D. Dvorak – President – Epic Systems**

You too.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

You too, Michelle.

**Brian Ahier – Director of Standards & Government Affairs – Medicity**

Bye.