

**HIT Policy Committee
Information Exchange Workgroup
Provider Transitions of Care and
VDT Listening Session
Transcript
February 20, 2014**

Presentation

Operator

Thank you, all lines are now bridged.

Michelle Consolazio – Federal Advisory Committee Act 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 Information Exchange Workgroup. This is a listening session to hear about transitions of care and view, download transmit. 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?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Here.

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

Hi, Micky. Deven McGraw?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Here.

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

Hi, Deven. Amy Zimmerman? Arien Malec? Chris Tashjian? Cris Ross?

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

I'm here.

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

Hi, Cris. Dave Goetz?

Dave Goetz – Vice President for State Government Solutions – OPTUMInsight

Here.

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

Hi, Dave. Gayle Harrell? Jeff Donnell? Jonah Frohlich? Larry Garber?

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

Here.

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

Hi, Larry. Peter DeVault?

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

Here.

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

Hi, Peter. Steven Stack?

Steven J. Stack, MD – Chairman – American Medical Association

Here.

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

Hi, Steven. Ted Kremer? Thomas Greig? And are there any Meaningful Use Workgroup members on the line?

Paul Egerman – Businessman/Software Entrepreneur

Yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, this is Leslie Kelly Hall.

Paul Egerman – Businessman/Software Entrepreneur

Yes, this is Paul Egerman.

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

Hi, Leslie, hi, Paul.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

Jeff Hatcher from Margaret Mary.

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

Are there any other Meaningful Use Workgroup members on the line?

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

Yes, Jeff Hatcher.

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

I don't think you're a Meaningful Use Workgroup member, I'm sorry. Are there any ONC staff members on the line?

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

Hey, Michelle, this is Charlene, I'm on.

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

Hey, Charlene, thank you.

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

You're welcome.

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

Kory Mertz with ONC.

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

Hi, Kory.

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Kim Wilson.

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

Hi, Kim.

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Hi.

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

Any other ONC staff members on the line. Okay, with that, I will turn it to you Micky. Actually, before I turn it to Micky, I just want to go over a few logistical things for the workgroup members. After all of the panelists speak, as a reminder, we're going to use the raise the hand feature today. So there is an icon on the top of your screen that you logged in to Adobe Connect, it's next to the microphone, this little man with his hand raised. So as we open up to discussion, if you could please use that raise the hand feature and it will put you in the queue, and I will call on each of you in the order your hand was raised. So with that, I'll turn it to you Micky.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Okay, great. Thanks, Michelle. Welcome everyone to what is the second part of a two-part set of hearings – listening sessions that we're having, looking at the Meaningful Use Stage 2 requirements related to transitions of care and view, download, transmit. The first one, which we had a week ago was with a set of vendors and this week what we want to do is talk to a set of providers. And we've got two excellent panels, I want to thank the panelists for, on short notice, being willing to offer their experience, advice, wisdom to us as they're going through this at the ground level. And I think that will be very informative for the HIT Policy Committee as it starts to think about the kinds of thoughts and ideas that we can forward to the National Coordinator.

We've asked each of the panelists to provide their input sort of in a number of areas related to their planning for Meaningful Use Stage 2, any implementation or adoption issues and then to the extent that they've – that they're already in attestation. I know there's at least one provider who's going to be participating who already is in attestation, so to the extent that there are steady state or ongoing issues once they've implemented and they're up and running that would help inform sort of the lessons learned, barriers – key success factors as well as barriers and challenges. That would be really useful and that's what we've asked them to comment on. And also from a technology as well as a workflow perspective as well, there's a human dimension to this that we know is at least as important, if not more important than the technology, and we want to be able to capture that side as well.

So, really want to welcome everyone. I thank all the panelists again and I'm going to turn it back to Michelle to introduce the provider panel that's going to focus on transitions of care.

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

Thanks, Micky. And before we get started, and I run through the panelists, just a reminder to our panelists. You hopefully have been notified, each of you have been provided five minutes to share your verbal testimony. As a warning, I will give you a warning of 30 seconds reminding at four minutes and 30 seconds and at five minutes, I will ask you to end your remarks. I hate doing it, but, I'm sorry, we do have to keep to the five minutes so that everyone has the same opportunity. After each panelist has spoken, we will then open it up to the workgroup for them to ask questions. And with that, I think we'll introduce the first panel. So on Panel 1, our provider panel of transitions of care presenters, the first is David Kendrick, the second is Stasia Kahn, Lori Johnson and then Ryan Bosch.

Also a reminder to our panelists, hopefully all of you have shared your bios beforehand, so you don't need to take up any time of your precious five minutes letting the group know who you are. So, if David Kendrick is available and ready to start, I'll ask you to please go ahead.

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

Sure, I'm here, thanks. Thanks for the opportunity to present. I'm not sure which bio you guys were sent, so I'll just very briefly mention I'm the Chair of the Department of Medical Informatics at the University of Oklahoma. I oversee the group that runs the EHR there and am therefore responsible for Meaningful Use. And I also Chair our health information exchange program, which happens to be a Beacon Community as well, called MyHealth Access Network. So I have encountered this particular issue for a number of years, and it's actually been part of the focus of my research as well. So I can't claim to be the rank and file physician practicing in the community trying to deal with this, but I have experienced some of these issues both at the provider level and the CIO trying to implement, and at the community level, trying to support these care transitions in an effective way.

We have been following the development of this requirement, and then also participated in a number of meetings in Washington, sponsored by ONC, to further discuss this issue because of the requirements that have been put in place to put Direct – to build a workflow that seems to take a care transition or a referral order. And push it through as a lens or the capacity of a Direct messaging stream and embed in that Direct message, the CCD or the continui – the summary of care document. And some of the issues that we raised with that workflow were one, that it – the receiving end, in our experience, the receiving end in care transitions is not always going to be needing a summary of care record, there's a lot more metadata that's needed to make an effective care transition. Why is this transition happening? What's the timing?

In fact, our observation has been that the care transition is not just a message going from point A to point B, but is actually an order, a medical order, and as such, needs all of the status tracking and steps that are involved in ordering everything from a prescription to a lab test. We should apply that same rubric to making care transitions effectively. And then the content that goes with that message in terms of patient's history and background can still be attached to an order. So we have been using in our community for some time, an interface built on ORM messaging, HL7 ORM messaging, to exchange data from one place to another. And it was only with the implementation of that process that we discovered just how many care transitions were being dropped, how many were dropped balls that were landing at that point on FAX machines. But we have a significant concern that when care transitions are sent through Direct messaging, which we're finding presents some challenges of its own, for example, that the recipient is often difficult to find the Direct account for, there's not any status tracking beyond possibly an initial receipt coming back. And so we've raised the concern in several situations – several places that these messages might be landing on the other end without anybody listening.

We also have a situation arising in our community where providers are finding themselves having several Direct messaging accounts and those accounts are listed in separate directories. So for example, the health information exchange provides them an account, their EHR vendor usually is partnered with a HISP, which gives them an account. And then if they want to make their workflow the same, they will create additional accounts for their staff members and perhaps even for specific purposes. And so we've become concerned that it's difficult to know precisely which account these transactions need to go to. So our feedback on the workflow would be, yes it's most definitely time to start tracking care transition in a more granular way and trying to make sense of them in such that you can actually monitor statuses and so forth. But we have some concerns that using an SMTP standard to get something from one place to another is shortsighted and that using something like ORM messages with status tracking would be a much more effective way to build a foundation for effective care transitions going forward.

And to demonstrate that, we've been a part of some of the pilot testing in our community with the tools we use. Pilot testing of these new measures that ONC is looking at to actually measure loop closure and how often does a referral leave the system –

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

Thirty seconds.

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

– get reviewed, accepted or rejected or the patient no-shows by the receiving provider and then get back to the same provider with message content closing the loop. And we're actually able to measure that very granularly, but try as we might, we cannot do that out of the EHR effectively in any standard way. And I think this approach with Direct messaging is going to leave us in the same boat. Our experience is that every EHR vendor has implemented this workflow in a slightly different way, which also is going to make capturing the potential problems this could cause difficult.

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

Thank you David. Hopefully we can get to the rest of your testimony within the questions from the workgroup.

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

Sure.

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

Is Stasia available?

Stasia Kahn, MD – President – Symphony Medical Group

Yes, this is Stasia.

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

Stasia, I'm sorry. Please go ahead.

Stasia Kahn, MD – President – Symphony Medical Group

Good afternoon, thank you for this opportunity. I wanted you to know that I've answered the questions that you posed to me in a narrative document and I included two additional handouts that I hope you find helpful. Now I would like to focus your attention on the tools that I believe are critical to improving the sharing of data between healthcare providers on transitions of care. I also want to discuss some obstacles that I believe prevent widespread electronic sharing of transition of care records.

I do have a PowerPoint presentation, I'm not sure if – yes, now it's up, I see. So, on this first slide, I just want to begin with the journey that I've taken towards transitions of care becoming part of normal operations. For me the journey began in the fall of 2005 when I first started exchanging CCRs for referrals with my peers. At the time, I was using a custom CCR generator, which was layered on top of my EMR. I continued to share data electronically with this tool over the next four years, but never once did I receive a summary of care record in return. The process of generating and uploading the CCR files was really outside of my normal workflow and very labor intensive.

Three years ago, I left my previous practice, started my own practice and implemented a new EMR. I started using my new EMR transitions of care tool 13 months ago and initially was sending out CCDs and now sending out C-CDAs. I have been diligently building a network of providers willing to accept electronic transitions of care from me. Last month, for the first time, I received a C-CDA from a peer. I talked him through how to send me the transition of care record on the phone and before we hung up, I was able to view the C-CDA and the referral document in my patient's chart.

So from my standpoint I've now achieved normal operation for the transition of care. I believe part of this is really due to the EHR Incentive Program that has allowed this transition of care to now become part of normal operation. It is possible, over the past 13 months I've exchanged data with 14 consulting physicians and two facilities. Facilities are places I refer my patients to such as physical therapy, OT, other allied health professionals. Some physicians I exchange transition of care records more frequently than others. Initially when the Meaningful Use Stage 2 measures came out, I was concerned that the benchmark for Meaningful Use Stage 2, Part 2, 10 percent electronic referrals was set too high. I think it's probably too soon to tell for other EPs at this time, but for myself, I'm planning to attest quarter 1 of this year for Stage 2 and now 42 days into the reporting period, my metric is now at 27 percent, which more than meets the measure.

I'd like to move on to slide 2 now. So, from my standpoint, the necessary tools to accomplish transition of care exchange include a user friendly EMR, vendor supplied Transition of Care Tool. The required functionalities of that tool include provider search, referral document and most important, the ability to select attachments based on the problem being addressed. My vendor has done a good job at fulfilling these functionalities. Next, it is necessary to be able to tap into a network of providers that have agreed to exchange data. My vendor has created a proprietary platform that allows me to invite physicians who are on different EMRs to join the network. We call transition of care exchanges using this network, P2P. Lastly, I believe the most important tool is a tenacious physician champion. The nature of the work involved in building the network is outlined in the two handouts that I created for you.

Next I would like to go on to slide 3. So I put here what I consider nice to have tools and that includes access to HISP to HISP exchange or widespread community participation in state or regional HIEs. These type of HIE activities are not happening now in my local physician community and are unlikely to increase as rapidly as I would like. This is despite being on the Advisory Board for the State of Illinois HIE. I'm very, very –

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

Thirty seconds.

Stasia Kahn, MD – President – Symphony Medical Group

– and my ability not to be able to increase either of these activities locally. Slide 4, I'm going to briefly go over the obstacles that I believe are preventing this. Number one, physicians are hesitant to accept the role of medical records transition. Two, lack of HIE participation among local communities. Three, physician vendor community has limited understanding of the terms Direct, Bundles of Trust, HISP-to-HISP exchange and lastly, vendor fees. Final slide.

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

Thank you very much.

Stasia Kahn, MD – President – Symphony Medical Group

You're welcome.

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

Is Lori Johnson available?

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

I am.

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

Please go ahead.

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

Okay, thank you for the opportunity to provide some feedback about our experiences. We are very excited about the use of Direct messaging for provider-to-provider exchange of information but there are four main issues that we have found quite challenging with implementing the transition of care. First, its designing a document that meets the regulation and provides the information that our clinicians deem is essential when transitioning a patient. Some information is fairly straightforward and can be captured as discrete data such as the med list, the allergies and the problems. But other items such as care plan and discharge instructions are often in a provider's note, which is difficult to record as discrete data. We have had to change documentation processes and even switch which staff records specific data points to meet the requirements, and this has led to some clinician dissatisfaction.

The second issue is the SNOMED problems. Ensuring problems are recorded in SNOMED on a go-forward basis is really not an issue. However, we've used our EMR for many years and have much historical data that is not mappable to a SNOMED code. Structuring our transition of care template to keep that historical data from pulling into the transition of care has been very difficult. It also makes the reporting algorithms very complex. The report has to determine if a transition of care should have been sent, if it was sent, if it contains the required data elements of medications, allergies and problems, and additionally, ensuring that those problems are only recorded in a SNOMED code. We spend a great deal of time validating and trouble-shooting our reports on a day-to-day basis.

The third item is fitting the transition of care into a clinical workflow. There are different clinical and clerical staff that are involved, depending on a patient's discharge disposition such as home versus a facility. Data may have already been sent during the referral process so the transition of care sometimes sends redundant information and our document for an inpatient tends to be quite lengthy. Training a large clinical staff about the workflows in order to be able to generate it and send it is also a barrier to adding this into the clinical workflow. The outpatient workflow has been easier to manage, mostly because the volume of the summaries that have to be sent is far less for the eligible provider versus the hospital.

And the final point that I would like to make is that we have a lack of Direct exchange partners. I imagine that as we progress through this calendar and fiscal year that the number of folks who have Direct email addresses and are ready to accept and send transition of cares, will increase. But finding them now has been difficult, especially finding them during your 90-day report period, when you've met all of the other metrics in addition to the transition of care metric. That's one of our biggest concerns is being able to meet all the metrics at the same time. And that's it.

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

Thank you very much. Is Ryan Bosch available?

Caitlin Collins – Project Coordinator, Altarum Institute

Ryan, if you're on the line, you're on mute.

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

Thank you very much. This is Ryan Bosch. I appreciate the opportunity to give feedback today. I have six challenges that I'd like to share with the transition of care here at Inova Health System. We're an integrated health network of 11 hospitals on our clinical platform, about 145 clinical sites outside of Washington, DC. Luckily we're on one common platform, but my first challenge to share with the group is just a fragmented process by which the vendor, as well as our prior decentralized credentialing and security systems are all coming together. So it's a very fragmented process to get those team members to understand what we're really attempting to do when we say a transition of care.

Number two, and very importantly, the concept of referring is used and quite often misinterpreted. Referring, referral, referrers; obviously we want the contextual information of a summary of care to go to the next level of care and provide that context. There's an awful lot of confusion there.

The next thing I wanted to bring up is early recognition whether it's eligible provider Meaningful Use or hospital entity Meaningful Use, that there's an asynchrony to when the data is captured about the provider, the provider's Direct address, the provider's name, the provider's FAX number. There's an asynchrony to that workflow and the ultimate workflow that actually, the discharge of the patient or the movement of the patient to the next level of care. Those two workflows occur in an asynchronous time and with different drivers. So it requires an awful lot of coordination along the process, and people have to understand in their head, is this a provider that's part of our network or not part of our network. Is this a true referral or we're trying to refer for care or is this more a communication and it falls into a different bucket.

Another very important challenge for us that I wanted to highlight and I'm picking my answers here carefully so I'm not redundant with my colleagues on the phone, but I'd like to describe this as a duality of the provider database. So we have an opportunity with our vendor, obviously, to have a database of credentialed inpatient providers, as well as a database that runs off the same credentialing, for the outpatient providers that are delivering care in our system. For us to exchange Direct addresses in a manner of trust with an outside entity through an HIE or a HISP, it requires a duality or a second database for us to keep track of, because doctors and providers are in that database that are separate. And we can't warrant that they might not be felons and they might have not been checked against the OIG list at the National Provider Data Bank.

So it creates a real challenge on our inpatient and outpatient credentialing operation and the way we provision security within our system, because we have to have a second database just for this communication. And not the least of which is tracking, which I like to call that "return receipt" requested, you know, did they actually get that report. Our vendor has been solid in providing us some guidance on this, but not a position of expertise and so there's a lot of confusion around what actually counts. And if you look at obviously the submissions of questions to ONC and CMS, there's further confusion around some of the things that count. How far do we have to go if we were audited to prove in a "return receipt" requested sort of way that when a patient is discharged from my hospital, the outpatient doctor out there in the community running a separate electronic health record system, but participating in a HISP, actually got that message? You know, what counts as a trigger that they actually got it?

And then lastly, like the colleague before me that shared, there is an extreme unawareness of what HISPs are what a Direct address is. And most internal medicine doctors like myself out in the community around Northern Virginia, work in a one and two doc shop, have no idea what a Direct address is, they don't realize they get one automatically by being part of our inpatient credentialing system. But they don't know even how to get one on their own, and there have been a lot of mixed messaging about this, especially in the State of Virginia, how to get a HISP and who should get a Direct address and how that whole process should affect an individual community doctor. So in summary, this process has been very confusing for all involved. We have a lot of opinions but we haven't mapped it out yet, and we're right in the middle of the Stage 2 Meaningful Use process this year.

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

Thank you very much Ryan and thank you very much to all of our panelists on Panel 1. We will now open up to questions from our workgroup members. As a reminder to members of the workgroup, we're going to use the raise the hand feature, so if you could use the icon on the top of your screen to raise your hand, it will put you in the queue. And a reminder to our panelists, as the workgroup asks you questions, if you could state your name before responding for our transcript, so we know who is responding. And with that, Larry Garber has a question.

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

Thank you, I have lots but I'll just start off with one for now. So how difficult as providers and provider organizations, has it been to get the connection to HISPs set up? The actual just the connectivity and certificate, how difficult has that been?

Stasia Kahn, MD – President – Symphony Medical Group

Hi, this is Stasia Kahn, I'll take a stab at it. First of all, it's been very difficult. Currently my EMR vendor has not really rolled out the HISP for me; I've asked to be able to communicate with providers that aren't part of their proprietary network. But at this current time, that hasn't been developed. The other side of it is, there is an additional fee for me to communicate with a, what they're calling "out of network" proprietor and that's a fee that would be per physician per month, to be able to use what they're calling "out of network." And in that situation, they would actually go to the other HISP, and on my behalf, set up the Bundles of Trust. So, I haven't done that yet, I would like to do it, but right now, I'm still using the proprietary network and it's working for me. There are doctors I can't reach that way, though.

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

This is Ryan Bosch. I echo those comments it's been very difficult. Our vendor has been working with two different HISPs and we have had a very slow process to making those connections.

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

This is David. I'm dealing with HISPs both as an E – the operator of an EHR and as a health information exchange and I would agree. And especially once you throw in DirectTrust.org certification and the fact that when an organization – when a HISP gets certified in DirectTrust.org, they have to sever connections with every other non-certified HISP, which is a downside to the certification, I suppose.

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

Thank you.

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

Do we have any other questions from the workgroup?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, hi – oh, Michelle, hi, I guess I should raise my hand. This is Micky Tripathi.

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

Go ahead Micky.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

You know who I am –

Dave Goetz – Vice President for State Government Solutions – OPTUMInsight

Where is the hand raise – there it is.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Dave, did you want to raise your hand? Go ahead.

Dave Goetz – Vice President for State Government Solutions – OPTUMInsight

I just really, I just wanted to clarify the last point. Is it a matter of business process that in order to be part of DirectTrust that you have to agree not to communicate with any non-DirectTrust or is it a preference of the – is it a requirement of DirectTrust or is it a preference of the business not to communicate with anyone who is not DirectTrust certified?

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

This is David Kendrick again. You know, I have to confess, I haven't read the actual regulation, I've only been told by our vend – our HIE vendor, who is moving into the DirectTrust.org space now, that they'll have to cut some of the important connections we have with other HISPs because of it.

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

So, this is Kory Mertz with ONC. The – it's more – it's a preference by the vendors. DirectTrust in and of itself does not require its HISPs to do that, it's that each accredited entity kind of makes decisions on their own and some are deciding they only want to exchange with other people who have gone through that process. Whereas others are not making that decision, so, it varies.

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

This is David again. I would just say, I mean it's logical, I guess, that they would do that because of the added identification requirement and that they – the weakest link in the security chain is going to be the group that doesn't have that identification link. So, can't fault them, but it creates a ripple.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

So, this is Micky. I'd love to hear from all the panelists on the HISP-to-HISP kinds of barriers. We heard from Stasia on that. And the – I know that there's a numbers piece to this where if you're going to be able to hit your 10 percent, it may very well be that when you start doing the math, it's quite an obstacle to figure out how you're going to do that without having to have some kind of HISP-to-HISP. And I'm wondering if any of you have confronted that and what you're doing about it, or what you hope to do about it.

Stasia Kahn, MD – President – Symphony Medical Group

This is Stasia Kahn again. I'll tell you from my personal standpoint that I got the numbers only by my own determination to reach out to my peers. I did that without HISP-to-HISP, it took a lot of time and energy, and that's why I included those two documents for you, because I didn't want to take up everybody's time. But –

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

But they're all on the same platform, is that how you're getting the numbers?

Stasia Kahn, MD – President – Symphony Medical Group

No, I have to call – no, they're not on the same platform. So I had to call up colleagues and I've actually had to call up facilities and explain everything to them, because nobody understands what Direct is, you have to explain all of that to them and in some cases, you have to explain to them how to use the software. And then that's not even enough, you also have to make sure the whole concept of "return receipt," you have to make sure they actually got the referral. So I found the best way to do that is I actually send a letter out now and it's a personalized letter just because, how do you know that they actually saw it, you can't know that. On my EMR I actually have, there's a place that says that it actually went out, but just because it says it goes out, doesn't mean the physician actually reads it. So –

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Stasia Kahn, MD – President – Symphony Medical Group

– I took that personal approach and I have my numbers. It was a lot of work; it took me almost 13 months to call all those doctors up on the phone.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

So can I ask a clarifying question? So, I think you're on eClinicalWorks, I'm just looking at the P2P, whether you are or not is beside the point, but if I'm understanding it, your EHR vendor has implemented a HISP, so it's a vendor HISP with the EHR vendor. By definition, if you're going to connect with someone who's on a different EHR, isn't that HISP-to-HISP? Or am I missing something?

Stasia Kahn, MD – President – Symphony Medical Group

No, this is not HISP-to-HISP. It's a proprietary network and they call it P2P Open –

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yup.

Stasia Kahn, MD – President – Symphony Medical Group

– and you're right, I'm on eCW.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yup.

Stasia Kahn, MD – President – Symphony Medical Group

So it's called P2P Open and it allows me to send an invitation out to other doctors and I kind of jury-rigged it to send it out to facilities as well. And you have to invite the doctor, they obviously – you have to get an email, now that's not their Direct email; the email is just to send them the invitation. And believe me, that's hard to get, and that's why I put in there, doctors don't want to act like medical records technicians, because if they're not on the same EMR as you, they are acting as a medical record technician. Because they'll have to go to this proprietary website and they'll see the data, but then how do they get it into their EMR. It's a lot of movement of that data.

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

First – this is David, I apologize for interrupting, but that workflow doesn't validate the identity of the user. How does that keep the trust chain unbroken?

Stasia Kahn, MD – President – Symphony Medical Group

So once they've accepted the invitation, they are given a Direct email address, and they have –

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

By eCW – by eClinicalWorks?

Stasia Kahn, MD – President – Symphony Medical Group

Yes, they're being assigned a Direct address.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Right, so it's within the HISP, it's basically eClinicalWorks is having them join the eCW HISP.

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

Right, but nobody verified the identity of the person when they got an email, to be able to give them an account –

Stasia Kahn, MD – President – Symphony Medical Group

Well, I identified the person because I called them on the phone personally and got the doctor's email address and, it's social networking – just using the phone and saying hey, this is something we can do together that's really cool, but I really need an email address that you're going to accept the invitation from.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right, right. And then, just to be clear, that – sorry, just one last question. So on that...so they are then able to get their – either send or receive through a Web portal, an eCW hosted Web portal, correct, and then they'll have to manually upload it into their EHR if they have an EHR.

Stasia Kahn, MD – President – Symphony Medical Group

Exactly, you've got it.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Right, it's not integrated in their EHR, okay, great. Thank you. Sorry Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you, I just want to follow up on that identity because what you've received then by calling and establishing that relationship is an email address. But to know whether that goes to a unique, identifiable email associated with a provider or it goes to staff inbox or it goes to any number of people who could be assigned email addresses within the organization. So you – could you comment on that, how do you know this is going into the doctor or is this going in to their staff or do you look at that at all?

Stasia Kahn, MD – President – Symphony Medical Group

So there's – sorry, there are two parts of this. Number one, some doctors are willing to use their email and accept that invitation and some are not, they want you to send it to a staff person, like you said. But the invitation is not the same as the actual sharing of the data. The invitation just allows them to join the network. I cannot send anybody any documentation until they join the network and then –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But – on the network it's assumed that that's a provider, if that's –

Stasia Kahn, MD – President – Symphony Medical Group

Well, they have to have an NPI number, and you can only like –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you very much.

Stasia Kahn, MD – President – Symphony Medical Group

– you can only invite one doctor, because of the NPI issue.

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

This is Lori Johnson. We have had a very similar situation. So in order for us to get any Direct Partners, our vendor actually sponsored standalone inboxes for some of the centers to whom we refer most frequently for our hospital, and they actually go out and have a business agreement. But what we have found is for some facilities, they really prefer to receive the transition of care documents into a facility inbox and then they route it to the individual provider to whom its most appropriate for it to go. And that is our process, when we are receiving transition of cares, we haven't received any yet, but when we do, we have a facility inbox that is monitored by our HIM Department. And they will review that transition of care document and then they will determine which physician it needs to be routed to, and then they will route that transition of care internally to their inbox in our EMR.

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

This is Larry. I was actually wondering if the others – if the other panelists could speak to that same experience as the recipient of these, what you've had to do to match these documents, the medical record numbers, how to get them routed to the right person, what sort of labor is involved in that?

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

So this is Ryan Bosch, I'll take that as my cue. I echo the sentiments of the prior panelist that just spoke, that is our workflow and intent to receive them in a common work queue and then through our HIM department, to be able to distribute those effectively going to that next level of care recipient to provide context around that "incoming patient." So that's how we're handling it. And then I just want to give one other comment to part of the prior discussion and say, from a large, integrated provider standpoint, as we look for more agnostic HISPs. Because we don't have a HISP associated with our health information system, we are at the whim or incarcerated if you will, by the people on the other end of the phone, who is in the HISP? Some of our local HISPs that we find most prominent in the direction they want to go only have a couple dozen doctors signed up. And so we don't really have a choice as we try to figure out where to go because even if we go connect with them, they can't provide us the necessary "ears" so to speak to hear what we're sending out.

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

This is David again. I would just say that when we – we haven't defaulted over to the Direct side yet with this, but we have tracked these through a different process where we can indeed follow the statuses. I mean, what the other panelists have said is confirming our concerns that these messages are sort of going off into a black hole and nobody knows. Instead, we're – because we've used a rubric that is common in every EHR that is the order entry process, which is tracked with statuses and so forth, we've had much better success at following things all the way to close loops and we're not really beholden to any other vendors to do that. So that's – that would be my comment on that.

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

This is Michelle; we have a number of people in the queue. We have Charlene, Larry and Deven. Larry, did you ask your question or do you have an additional question.

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

You can come back to me, because I do have more.

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

Okay. Charlene.

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

I think it would be helpful if each of the panelists would kind of step back. I first of all want to thank you for speaking today and for many of you, for being pioneers and driving this change in the process. I thank you for your leadership. But as being pioneers, can you just net out one or two of the lessons learned that would have made – I think we've heard them spoken to, but that would have made this process more workable, more obtainable for those that are going to go forward after you. Because again, we've got to use your lessons to maybe make it easier down the road for the rest of the community.

Stasia Kahn, MD – President – Symphony Medical Group

This is Stasia; I'll take a stab at that. You're right, we're all pioneers; we wouldn't be at this point without a lot of determination. I've been doing this since 2005 and the number one take-home, I can't emphasize enough is, physicians have to talk to other physicians. It's really key and there is such a lack of education about what we're talking about today, among physicians. And we just can't trust the EMR vendors to do all the education, so, I don't know how you go about it, but there needs to be a campaign to talk about Direct and explain what the DirectTrust is, because doctors have no idea what DirectTrust is. And so my main, if there's one take-home is please, let's educate our doctors. They need to be brought into this picture, because ultimately a physician and a physician are the ones who have to determine that that information was shared so if they don't have an understanding of the process and they don't understand what's going on, it's not going to be safe, it's not going to happen.

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

This is Lori –

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

This is Ryan Bosch – oh please, Lori, go ahead.

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

No, go ahead. This is Lori Johnson. I think one of the most important steps is to have a very strong understanding of your current state, because information gets sent out about patients and provider-to-provider communication happens when a patient is leaving our facility. There is always a direct phone call with the receiving provider when we're referring a patient out of our facility. And there is a lot of information that's already exchanged, discharge summaries are sent, labs are sent, throughout the referral process information is sent to these centers about this patient. So really understanding your current workflows, who sends what information, what information is sent and then really working with your EMR vendor to create a transition of care document that not only meets the regulatory standards. But also can take the place of some of that information that you already send on patients, so that you're not resending the same information through multiple sources, multiple times because on the receiving end of that, our referral centers don't like it, it's a lot of paper. And a lot of them can't receive it electronically, so it just...it ends up being a lot of paper for them to keep track of.

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

And this is Ryan Bosch. I would just add to that, my lesson learned recommendation would be to emphasize that despite traditional relationships in hospitals and integrated ambulatory networks where credentialing is viewed as part of an insurance, kind of let's make sure we're all credentialed to get paid kind of thing. And then, of course, there's a separate part in your electronic health record or your hospital information system where you have a security department provisioning physicians and providers and keeping track of that active credential that can do orders, can prescribe, can do this. It's clearly a need to recommend that the hospitals and the integrated health networks recognize that somebody in the institution now has to keep a completely separate roster of all of these providers. And that's separate because these providers that we need to message to for transition of care are not in our security and they're not in our credentialing. And that whole concept is very, very transformative to the current way business is done. The credentialing department see it as foreign; they don't want anybody touching their database, so I think it's extremely important to recognize that that's an added layer of work that has to be done if we're ever going to have any accuracy around the sort of "return receipt requested" type of messaging.

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

This is David. I think I probably sort of made my views on this clear, but I'll just state them again. To me, referrals are orders, just like a prescription, a lab test order, and I expect it to be trackable all the way through to completion if I'm the responsible, ordering party. And this process with Direct messaging does not allow that, in addition to all the other problems that have been mentioned. I need to know the status, I need to know the owner and the responsible party at every step of the way, and I need to know that I can audit that and see it. EHRs have, for a long time, had this capability to track orders and statuses and we've sort of ignored that process to use Direct.

The second thing I would say is that, of our lessons, is that each endpoint requires endpoint specific data, whether I'm referring to a nephrologist or a cardiologist or a physical therapist, they've got specific information they want. And the universal chart summary doesn't exactly confer – convail the specific things that they need, so we have to have a better way of getting at the content they want when we order it.

And then the last thing I would just say is safety is key. We've managed more than 150,000 referrals electronically using an order process and in – prior to implementing that process, we did a study in which we showed that some practices were 3000 referrals behind and having them stack up on the FAX machine before they could deal with them. I am very concerned that this process that's being put in place is creating a similar stacking up of referrals, but in an inbox that no one can see or is monitoring.

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

Deven, you had your hand raised, did you get your question answered?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

I did, thank you Michelle.

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

Thanks Deven. Steven Stack.

Steven J. Stack, MD – Chairman – American Medical Association

Yeah, I – thank you. It's a question, but maybe rhetorical. One of the presenters commented about educating physicians and the speaker who just finished talked about maybe a mounting inbox that no one's monitoring. I'm just wondering if anyone can comment on what you realistically see the role of a physician in any of this is. I mean if they acquire certified technology, shouldn't the technology and the processes put in place by the system automate these things, because there is no more bandwidth for physicians. It is hard enough for them to keep up with medical science and technology and there is no way they can become IT experts. And this level of discussion is way outside the purview of probably 99 percent of doctors in the country. So, what role do you think is reasonable for a clinically practicing physician to play in this one single facet of a much larger program?

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

This is David. I think I'll take a stab at this because we've got a workflow that is no different than it was before right now, because we've not yet implemented Direct. And that workflow is, physician orders the referral or the care transition, chooses the place it's going to go or indicates the general specialty and then can attach anything they want from the chart to it. And that's the end of it until they get status updates back from the other end. I think that's about as much as we can expect the clinician to do in this case and to of course, to pay attention to the status –

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

– Lori Johnson and in our workflow in our hospital, our providers do submit an order for a patient to be transferred to a facility. However, it's the social workers and the case managers that are finding the facilities that are accepting, and they will communicate back with the provider. So in that order, the provider wouldn't necessarily indicate which specific facility that the patient was going to be transferred to or which home health company or hospice or what have you. And often times even if they are discharged to home and following up with an external provider, in the order they will enter a general clinic that the patient should be seen at. But the individual provider with whom the patient is going to have their appointment is determined when our scheduling staff contacts the patient and actually set up the appointment.

And that's why our – sending the transition of care has resided in our HIM Department. For that reason, because they need to know where they have to send it and they also have to ensure that there is proper consent from the patient to send this information. And that inadvertently some protected health information like mental health, substance abuse information doesn't inadvertently pull into the transition of care and get sent, when they don't have explicit permission to send it. So, for all of those reasons and HIM, that is their area of expertise, that's why it lives in our HIM Department and not in our provider's department. But also because of those reasons, I think it would be extremely hard to automate the process just based on orders.

Stasia Kahn, MD – President – Symphony Medical Group

Hi, this is Stasia Kahn again. I would say that my viewpoint obviously is different, I'm purely from the ambulatory world on this and I really do believe that we do need to expect our physicians to understand the process. And I don't think it's out of their expertise. I have 14 doctors that are now accepting from me these transition of care records, it's been a lot of work on their part, but they now understand it and now they're sending me back messages. So that – I don't think it's out of the realm of primary care physicians or specialists in the ambulatory world, I don't think we should lower the bar on this, I think we just need to educate people. Now I think that the facility inbox is a wonderful idea and we should be able to configure the software so that it does go to a facility if there are a lot of doctors in a group. But if it's a single doctor group, that doctor's going to have to know what's coming to him and be responsible to – for him. So I really don't want to lower the bar, I think physicians need to understand this whole process in the ambulatory world, at least in the small to medium size practice.

Steven J. Stack, MD – Chairman – American Medical Association

Well thank you everyone for those replies, I appreciate it.

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

Larry, your turn again.

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

Okay and this is my last and just a quick one. So each of you are really leaders in each of your communities. And if you look at your whole community, not just your organization, but the healthcare providers and hospitals in your community, what do you think the likelihood is that come the end of 2014 half of – more than half of the providers in your community will have passed this measure?

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

I'll start and say 0 percent. This is Ryan Bosch; I'll start and say 0 percent.

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

This is Lori Johnson. I would say that I couldn't really put a percentage on it, but likely there will be a fair amount of providers who will meet this metric. However, the information that's sent, that it being meaningful the information that they receive just in the transition of care. I think there's a whole different utility in the Direct secure messaging back and forth between providers and facilities, but just in sending this specific document in the specific way that it's regulated to be created, I think they'll meet the metric but I don't think that people will find the actual document very useful.

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

This is David. I would agree with that. We're, on the health information exchange side, we're working very hard to help providers meet that metric, by providing them a HISP and all those services, but it's going to be a bit of a game more than it's going to be really honest to goodness health improvement. People are going to be trying to figure out how to check the box. That's at least the experience we're having.

Stasia Kahn, MD – President – Symphony Medical Group

Hi, this is Stasia Kahn again. I think you're going to see the numbers drop significantly for the people that are going to attest for Stage 2. I think you're going to be down in 50 percent, that's my gut feeling, that that many doctors are not going to be able to meet the measure, because it –

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

And this is Ryan Bosch, I don't know if I heard the question correctly, but I heard you say, what's the likelihood that it would be over 50 percent? I agree with my colleague who just was speaking, apologize for jumping in, I think it will be lower than 25 percent,

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

Thank you all, thank you.

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

Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks Michelle. This conversation has been great and I harken back unfortunately to the 80s when putting up email the first time and we all wondered why anybody would ever want to communicate outside of the organization putting up the email, because it was so difficult. But the market did move. And I had a question about the "return receipt" specifically. Just as a FAX has a "return receipt," the mechanisms within Direct provide a "return receipt" to say that it's been delivered. Back to the earlier comment a provider made, it's not telling us whether the doctor read it and I wanted to see if, other than the order construct, if folks had investigated the delivery receipt through their vendor and/or other methods to know that complete circle took place digitally.

Lori Johnson, MHA, RRT – Department Administrator, Family & Community Medicine – University of Missouri Health Care

This is Lori. In our system, it's actually the absence of a failed delivery, so if you send a Direct message and it goes through, you don't really get any indication; however, if it does not go through, you do get a bounce back message that it was failed to be delivered.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

Stasia Kahn, MD – President – Symphony Medical Group

Hi, this is Stasia –

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

And this is Ry – go ahead Stasia.

Stasia Kahn, MD – President – Symphony Medical Group

So we have the same thing, we have a special place to go to check the status of the outgoing messages. And it says either it was delivered or that it was not delivered, but delivery doesn't mean read.

M

Amen.

Ryan Bosch, MD, MBA, FACP – Chief Medical Information Officer – Inova Health System

Our HISPs, this is Ryan, our HISPs don't have that level of complexity to hand that over right now, and we're talking to a few different HISPs. In addition, that "return receipt" requested information, our vendor is currently using a threshold of did the HISP receive it, and that triggers the success, if you will. We don't feel that's enough for our own internal auditing, but that is enough for the metric that was certified for Meaningful Use for that vendor. So we're struggling with those same kind of interpretations that you're question ponders.

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

Yeah, I mean, this is David. I will just tell you, I mean, our analysis of care transitions is there are about 25 unique states that matter that a care transition can be in, everything from initiated all the way through to the patient no showed the visit to the visit's final. And we just have not found a way in this protocol to put – to represent those things.

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

All right, well thank you everyone. We are about at time for Panel 1, so I want to thank all of our panelists from Panel 1 and get ready for Panel 2. Micky, did you want to make any initial comments before we pivot over or do you want to just get started.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

No, I too want to thank the panelists from the first panel, that was terrific and I really appreciate your taking the time and being so thoughtful about – in responding to all the questions. And Michelle, why don't we get started, I think we're going to take up the full time, so let's not waste any more time on introductions.

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

Okay, thank you.

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

Micky and Michelle, I just want to say – this is Amy Zimmerman, I joined and I don't have Internet access so if I have questions, I'm just going to have to politely try to chime in, but I will try not to be disruptive.

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

Thanks Amy. So for Panel 2, for our provider panel on view, download, transmit, we have Fred Brodsky from Group Health Cooperative, John Berneike from Utah Health Care Institute, Jeff Hatcher from Margaret Mary Community Hospital, Greg Wolverton from ARcare and Amy Feaster from Centura Health. So as a reminder, you have 5 minutes and I will give you a 30-second warning and Fred, if you are ready, please get started.

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

I am ready. I'm Fred Brodsky; I head up Clinical Informatics at Group Health Cooperative in Seattle. I'll try to keep this short because I think the discussion part is – was by far the most interesting part of the last thing, so, we are a large, multispecialty group practice structured similarly to Kaiser. And we have a very robust patient portal implementation, about 70 percent of our patients are active users of our patient portal so the view, download and transmit objective is of particular interest to us. And I guess that I would say for starters is it feels to us as more of a philosophical stake in the ground than something that's going to be of real practical utility out of the box; it's sort of a solution in search of a problem.

And we implemented – with Stage 1 we implemented the ability for our user base to download a CCD – 2 months or 2 years ago, I can't remember exactly when and I asked our Web team to give me some stats about the usage rate. And so of our unique users over that period of time, about 5 percent of them have visited the download page and a tiny, tiny percentage of them actually ended up downloading the document. And of course, we don't yet have the ability to transmit, but I think it's a little bit of a window into what the appetite is for the user base.

So in terms of our concerns with this, I guess basically its everything that the last panel said and then you throw patients on top of it and figuring out how they are going to sort of enter this HIE channel. And so we have some practical concerns that we were just discussing at our team meeting yesterday and that is, who are patients actually going to be sending this to? Are they going to be trying to send it to individual physicians? Are they going to try to send it to individ – or to facilities, to departments and how are they going to cope with the variety of naming conventions that different organizations might use? It's hard enough for physicians and other healthcare professionals to figure that stuff out, but for a patient who's an occasional user of HIE, we suspect that this is going to be a real challenge.

And again, the other thing is – maybe this is a little bit specific to our healthcare community out here in the Pacific Northwest, but we have an extremely high penetration of HIE among the organizations, most of whom are EPIC customers, as it turns out. I did some stats today and we had just since the beginning of the day, something like 3000 documents exchanged via EPIC's Care Everywhere, which is their brand of point-to-point HIE. And so in terms of the use case for patients needing to send a document to a clinician in this area, it almost has a redundant feel to this. So, we are honestly in this case kind of in a check the box mode, in terms of fulfilling this objective. We need to make this functionality available and make sure that it meets all of the specifications and I think we're sitting back and waiting before we actively promote this to our patient base and figuring out exactly what the right use case will be.

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

Are you all set Fred?

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

I'm all set.

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

Thank you. John Berneike.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

Yes, John Berneike, I'm a practicing family medicine physician at St. Marks Family Medicine in Salt Lake. Unlike Fred, we are a small practice, we're not part of an integrated system, but yet we have many of the same issues with the VDT. I'm a General Electric Centricity CPS user and I see that they were not part of your vendor panel the other week, so, I will start out by saying that I am quite impressed with their implementation of the Meaningful Use 2 requirements. It's not released yet, it'll be available next month in fact, but a number of the VDT requirements were actually available in the previous version of the software, which is what I currently have. We have an integrated secure messaging patient portal application that works with Centricity that has for a number of years now, offered the view and download options both in a printed PDF format and in an XML CCD format, so we've been able to do that all along.

The transmit part of it will be new in the upcoming release, but like Fred, I think I'm concerned about patient engagement and patient education and more specifically just the utility of allowing patients to do that. Again, I think there was a great discussion on transition of care in the previous part of the discussion and I echo a lot of the comments that were made there and I think that's actually a much more interesting discussion from a technical and implementation point of view. But if transition of care is done well and done right and fully implemented, I think there will be very little need for patients to have to do the transmission themselves.

Part of what concerns me about it is – and I know we're not here to discuss the Meaningful Use requirements, that's done. But the arbitrary percentages that were picked, and 5 percent for view, download, transmit and with the exclusion that it's based on broadband availability in an area rather than broadband usage in an area and depending on the patient population, for instance, lower socioeconomic status, lower education, geriatrics populations, the use of technology may vary greatly, regardless of the broadband availability. We have a unique problem here in Utah that we have a Medicaid plan available that we actually happen to see quite a few of these patients in our clinic, but it's called PCM Primary Care Network, that they only have the primary care doctor, their insurance does not cover them seeing any other specialists. So for those patients, we are typically their only doctor so they wouldn't have anybody else to transmit their data to; so that's just one of the challenges there.

I think in – that I'm – I wished I had been part of the transition of care discussion, I think much more lively. But like the discussions about HISPs and with Direct and trust relationships and provider directories, like Fred mentioned, that, I think, is a huge issue from the patient point of view, too. If we're expecting patients to transmit via Direct or some other secure messaging format, their record to another provider. Well first of all, if the doctors are having trouble – a hard time learning about and implementing and understanding Direct, HISPs, and what not, again I think it's just going to be compounded even more from the provider point of view – excuse me, from the patient point of view.

So I think all in all I think our biggest challenge on the VDT part of it will be just patient education and patient engagement. And again, since we have not implemented the Meaningful Use 2 software yet, we're just getting started with this, but we have had a – over the last several years, when view and download was an available option, we've taken a more passive approach to it with patients. We haven't made any specific efforts to get them actively educated and engaged. We do have a handout that we give patients to inform them that it is an options and unfortunately, because I never had to report specific numbers, I honestly haven't even tracked what percentage of our patients are actually using that feature. But going forward with Meaningful Use Stage 2, that's something that I'm certainly going to have to start looking at, as opposed to an active – excuse me, as opposed to a passive patient involvement, we're going to have to be much more active about educating and getting patients engaged with that. And again –

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

I'm sorry John, I didn't give you 30 second warning, but if you could –

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

Well, I was pretty much done anyway, thank you.

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

Thank you. Jeff Hatcher.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

Yes, I'm a practicing obstetrician at Margaret Mary Hospital. We're a critical access hospital in Batesville, Indiana. We started our personal health record in August of this last year and currently we've enrolled about 3600 people and have had about 1350 active users since that enrollment process, who have actually gone in and viewed and downloaded their charts. The transmission piece I think is still a work in progress, but I think it's going fairly well. Our system is a little different in that we're working through a Health Information Exchange.

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

I'm sorry Jeff; we're getting a lot of feedback. If there's somebody that has their phone on, if you could please put yourself on mute, it would be appreciated.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

Okay, I think as far as patient engagement – oh, there we go. I think as far as patient engagement, we have been very aggressive at every touch we have with the patient making sure to promote the PHR that we're using and encouraging patients to use it. So we've had a fairly good response rate. We enroll them at check-in, when they come in for their office visits. The nursing staff, when they take them back, has a handout that they go over with them and then our physicians are very engaged and active in promoting it. So at least on the surface early on, we seems to have pretty good success with taking advantage of every touch we have with the patient. It's a little work intrusive, but I think it helps us to grow it fairly quickly. Patients have been very receptive to it.

I think from a challenge standpoint, our biggest challenge is not unlike some of the others as far as when you're looking at, we use a lot of referral sources in Cincinnati and right now we're connected to Christ Hospital as well as Cincinnati Children's. And so we're sharing information from those hospitals with the patients through their PHR, but the negotiations to get those provider agreements to share that information can be very tedious. HealthBridge, who is our primary HIE, has started a Governor's Committee, which I think will streamline our process when we can apply to their Governor's Committee and get in a one-stop a greater number of provider agreements that will hopefully streamline that process for us.

I think the other thing that we run into is there's a big footprint with EPIC in Cincinnati and so it's also kind of a disincentive for those hospitals that we share information with to work with us because they already see that they have that active portal. And so in our community, which is about 45 minutes away, there's not as much incentive for them to work on those provider agreements. Overall, though, I think for us, we've had a very pleasant experience. We've had relatively good patient response, as far as patients that are using it. We've run into bumps in the road, mostly through patient interpretation of reports, especially the radiology reports, that those have been minor.

The other thing, I think being in a rural area and I think I'll speak to that last question on our information page is, we have challenges yet I think we also have some benefits. The small community, the small physician population, patient engagement I think is much easier and so it's easier to get the group moving along in the same direction because they're not dealing with large, large numbers. I think that the issues we face are the same issues that you would in a rural community, trying to engage the tertiary referral centers to work with us to help share that information of the patients we're seeing in to the city, that then come back. But, once we get those, it seems to work very well and in our position, we don't only work out of Cincinnati, we also work out of Indianapolis, so it becomes very useful for us to have a robust PHR in this system, and being able to do the VDT.

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

Thirty seconds.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

I'm good.

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

I had a feeling. Also, as a reminder, if you aren't speaking, if you could please put yourself on mute, we'd really appreciate it. And if Greg is ready.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Absolutely I am. Thank you very much; I appreciate the opportunity to opine. I think I put some – had a slide deck. There we go. So go back to the – go back to that first slide. One of the things we're – we are at Stage 2 on our Meaningful Use. Our vendor Greenway is formerly SuccessEHS, we are on Version 7. They do have their certification and certified for about 30 different CQMs. We tested with our state HIE at this point and our ADT testing is being done as we speak, as a matter of fact, today being the 20th. We anticipate a full loading, somewhere around March 1. We've already tested the basics, so we're pretty good to go at that point in time. Next slide please.

Our experience on the tools, with our product it was fairly seamless. Now I will say with it being all new territory, it – being seamless and being easy and without pain points is two different things. It's extremely difficult to get vendors to work with your partners and the other information – specifically on HISPs in the last panel is a very good example of how people do not work together. With all that being said, it required us complete new workflow and training. Bringing these C-CDAs and creating these documents is challenging for our providers.

We had to make it to where we had to build workflow that we could retrain everyone and again, it wasn't a whole lot, but the creation of it required about 30 hours of workflow production time in terms of re-doing our workflow. And about 30 minutes for each community of profession, that would be nursing staff, front office and providers, because one of the things we have to understand with this is this is just not a provider problem, this is a systems issue that has to be at least, in ARcare's opinion, in our mind, a systems solution. So we had to work together with it. The biggest challenges we had was training, I mean, trying to get to – we have – we supply IT services to 58 sites in two states, so that's a fairly large ambulatory practice, and there are a lot of places to go to and we're still in that training process. So, it takes a little bit of time. Go on to the next slide please.

Some of the problems that we've had, at least that we wanted to, is make sure that our staff are educated before our customers or our consumers, our patients. If we have patients coming in and our staff don't know what the patients are talking about, it does not lend the best credence towards working towards this health information technology products, as far as at least in the flow. So, we had to make sure that our staff understood what needs to happen. Again, back to the other conversation, do you have an inbox for each location or do you have an inbox for each provider that somebody works. We had to make sure we addressed all that.

Then we had to make sure education material was available to the public. I mean, what is this all about, what can you do. Our patient portal, one of the interesting things, has – we've seen an increase over the last three years of about an 8 percent increase in the last two years, but in the last year, we've seen about a 12 percent increase in the patients actually utilizing the portal to view and download their information. Again, we're working on our HISPs right now, we do have some patients that have emailed it to the provider outside of our warnings, directly to their – to their email spot, not through the HISP. So again, we've got to make sure that we create marketing campaigns to all stakeholders, internal and external; internal being our staff, which again we treat as a systems thing, and externally to our patients and also other providers that we do referrals to and that we have a whole community of support there.

On the existing patient portals, we just let them understand we've got quite a bit of resources out there to let the patient understand what it's all about. Create their appointments, view their information, download it and obviously transmit it, we should be ready for that complete product to be delivered – I would say we're going to be ready in the next 30-days from an HISP perspective, but certainly we can do that now, not through the HISP and secure messaging. Next slide please.

Okay, there we go. As far as the vendor fees, it's not substantial, no vendor transaction fees, it was only initial setup of about \$6500 for us, which was a deal for the amount of facilities that we had, and I'm very, very happy with that. Now on the HISP side, it's a little bit different. We're looking at about \$8 to \$10 to \$12 bucks a provider for the Direct messaging, so it's going to add up to be substantial. But again, our – we are using data –

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

Thirty seconds.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

– so, next slide please. Okay, one of the challenges, one of the issues, one of the challenges in the rural area is not using Meaningful Use dollars to pay for Stage 2 and the things you need to do. Not enough staff, technical staff in the rural areas and a lack of fundamental understanding among leadership and a lack of total funds that's been committed to these projects. They typically want to put it to operations and not look at the complexity. So again, I think more education and everything's possible, but we're excited about it at this point. Thank you very much.

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

Thank you very much. And our next speaker is Amy Feaster.

Amy Feaster – Vice President, Information Technology – Centura Health

Hi, my name is Amy Feaster. I'm Vice President of IT for Centura Health. Centura is the largest healthcare organization in Colorado and so we're a large IDN. We are lucky that we are on a single standard system in both our inpatient and ambulatory and home care. We are hoping to start our attestation period April 1, what might prevent us from doing that is the transition of care though. We had an ambulatory portal, which – and with that, we had really good adoption, but our vendor's Meaningful Use portal came with our Meaningful Use 2014 upgrade that we did at the end of October. So we have now really been working hard to get that new portal implemented and then get it rolled out to both our ambulatory sites and our hospital sites. And so we currently have one clinic on that portal right now and we are doing the rest of our organization next Tuesday.

One of the challenges we're having with this new portal, we have changed how we're engaging patients, and how patients actually sign up for it. And to do it, we're using email addresses and in doing such, we have found that we are not very good at collecting patient's email addresses. In fact, for our hospitals, we're only getting 24 percent of patients we're getting email addresses for and for our clinics, 46 percent. So, we have a campaign going to really work with the registrars and the front desk people to make sure that we are capturing email addresses for our patients. And that patients understand why we're doing that, we're not doing it to send them junk mail; we're doing that so that they can sign up for the portal.

We are able to view and download through our portal. We are currently working to get the transmit function working, and I was hoping that it would be working before this call, but it will be working tomorrow. But that has been a bit of a challenge because we have a lot of groups involved, it's not just our EHR vendor that's involved, we're looking at going through our state HIE and then – so we have our state HIE involved plus their vendor. And so coordinating among all those groups has been a bit of a challenge. We are a large organization so I feel like we've had an advantage there in that we do tend to have a little more clout than maybe a smaller organization might have when working with those kind of large organizations.

I think challenges though that our patients will have for the transmit portion will be trying to figure out if they have a Dr. Smith, which Dr. Smith is their Dr. Smith. And another challenge we have is that most providers in Colorado don't yet have Direct addresses. We do have a huge – all of our hospitals are connected to our HIE now, many of our – many practices within Colorado are connected to the HIE, yet most of the providers do not have Direct addresses set up. In fact, our HIE just told me that we only have a handful of providers who have Direct addresses. So that means, as – because we are a larger organization, we are preparing to do a large campaign with the providers in Colorado to help get them set up with Direct addresses.

We do not have any fee – as long as we go through our HIE we don't have any fees for our transmit transactions. And I think I'll – the last thing I'll say is, we have 8 affiliate hospitals, they are critical access hospitals and they do have challenges mostly in that they don't have a lot of staff or resources, so many of those affiliated hospitals have reached out to us for help. So, I'll end there.

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

Thank you Amy and thank you to all of our panelists, we greatly appreciate you taking the time. We'll now open it up to the workgroup for questions. Please raise your hand if you have any questions and a reminder to our panelists, as you are asked questions, if you could just state your name for the record. Larry Garber, you don't have any questions.

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

Actually, I do, but I got booted off the network, so if you'll let me ask one, I'll do that.

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

Okay, go ahead.

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

So what I heard was sort of an interesting revelation and conundrum. I hear that for the transmit piece, the groups are thinking about connecting to HISPs that are – whether it's the state or other HISPs that are already connecting to a lot of providers, to give them the ability to – for patients to make connections and send documents to providers. Yet on the flip side, I'm hearing well, we're already taking care of their needs through the transitions of care. In other words, if we're able to get connected to those providers, then we're already sending the document for the patient so that the patients don't really need a transmit piece to send to providers. What they actually need it for is to transmit to their PHRs and they could have done that with just downloading a CDA document and uploading it to their PHR. So, do you guys as panelists think that maybe the smart thing for us to do is to get rid of the letter "T" from VDT?

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

Yeah, John Berneike, St. Mark's Family Medicine. I think I would tend to agree with that and I'm certainly one of the panelists that talked about the difficulty in engaging patients to do the transmit or even the need for transmit. I do think the exchanging data with the PHR is an interesting idea and some of you on the panel may have been part of the discussion with local REC folks here in Utah, Healthinsight. Where they're doing a project to exchange data between Microsoft HealthVault and the EHR and I was a clinic that worked with them on that and not just exchanging CCDs both directions, which we've tested and played with in a proof of concept. But also done a test – pilot test of having a patient using a glucometer that can upload data to HealthVault, upload their data to HealthVault and then transmit that data from their HealthVault to our EHR via attached to a Direct message.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Yeah, you don't – this is Greg. One of the things, just to kind of piggyback on that, I do agree and I think what I'm hearing from the patient, or at least in speaking to them, that it's almost like when we were – when we were using the ATMs 20 years ago. People are becoming more comfortable with these online transactions and they're not as cautious as what they used to be. We're seeing more non-Direct, which is really not what we want to do – than being encrypted and Direct transmitted. So, I really think that the patients are looking to get their information, but again, I do agree, I think that it's for the PHR as opposed to any transition of care.

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

This is Fred Brodsky in Seattle and I agree. I think that the workflow around this, in terms of how patients are going to interact with clinics in a meaningful way is just – I just can't quite grasp that right now. I think that there are some other really exciting uses; I mean I can imagine a world where researchers would recruit patients and patients who were potentially candidates for experimental therapies or what not could transmit a summary of care document and to be assessed for candidacy for research protocols and things like that.

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

Michelle, this is Amy, can I ask a question?

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

Sure, and then we'll go to Paul Egerman.

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

Do you want to go to him to answer it first and then I'll ask?

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

Either way, it doesn't matter. Go ahead. Amy.

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

I was – I might have missed this if you said this, I apologize. Do any of you know what percentage of your patient populations have a PHR separate from the patient portal that you have where the VDT would be associated with?

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

This –

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

John Berneike, and I actually have no idea, but with this Microsoft HealthVault pilot test that we did, we actually identified patients that we thought would be good patients to do this test and we actually had to walk through helping them set up their HealthVault account just to get them to participate in this test.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

This is Jeff Hatcher. Ours is – the PHR is with the portal through NoMoreClipboard, so all of our patients are on the same PHR as our portal.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

This is Greg. Ours is exactly the same way, so when they do that, they're able to download it to and consume it, at least create a CCD or even anything that's readable at all and can either download it themselves or transmit it as well. So, but it is all self-contained.

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

Yeah, so part of the reason I was asking is because we're sort of using patient portals separate from PHR and then we're talking about VDT and I think it's just a challenge to think about what's the same and what's different, that's why I'm asking the question.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

John Berneike. I agree with the comments there that just because they practice or a delivery system has a portal doesn't mean that the patients are necessarily using it as their PHR. And it's certainly possible that patients would be getting care, depending on the healthcare system in the area, they may be getting care from other providers outside of the delivery system. And therefore outside of what the provider might be thinking is the PHR, and again, perhaps having incomplete data in that PHR or altogether using a different one.

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

Exactly my point. So thank you for answering that question, I think we have to be careful with semantics as we talk about this. Thank you.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

And I do agree with that as well. One of the things that we have in a rural area is, I'm looking at it from a rural perspective, there ain't nobody else around, so we kind of tend to think that we're the only ones that they would use, so that's a very good point.

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

Paul Egerman.

Paul Egerman – Businessman/Software Entrepreneur

Yes, thank you. It's Paul Egerman. And first, I want to thank all the panelists, this is very interesting, extremely interesting and very helpful. I have like two questions; the first is sort of an arithmetic question. The first speaker, Fred Brodsky said that 5 percent of your patients were visiting the download area and a tiny fraction were actually doing downloads. But when you said 5 percent I was unclear, was that 5 percent of the total population or 5 percent of the people using VDT?

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

So – this is Fred – so this is not the key part. So we have –

Paul Egerman – Businessman/Software Entrepreneur

– yeah the download part –

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

– download. We have something like 300,000 patient – unique patients who were active during – over the past 18 months and, I can't remember the exact number. But I think it was like 1200 unique patients visited the download page at least once and actually, I couldn't get the exact number of the number who actually hit the download button, but it's very small. And so they're just – and to be fair, we did not put that link in a prominent place on that portal page, but I think it does speak to the fact that there doesn't seem to be a huge appetite for it. Because as long as the patient has access to the portal, and in our particular healthcare organization, a multispecialty group practice that's kind of Kaiser-like in its organization, most people's care, their healthcare data really is sort of within our portal. So for us the use case for the download piece just isn't that great. We offer it because we need to comply with Meaningful Use.

Paul Egerman – Businessman/Software Entrepreneur

Well that makes sense and I have to tell you, I'm familiar with both Kaiser and Group Health Cooperative. In my opinion, Kaiser is Group Health Cooperative-like as opposed to the other way around.

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

Thank you.

Paul Egerman – Businessman/Software Entrepreneur

But I was also really very interested in I think it was Greg Wolverton's comments about training, I think it was training physicians about how the VDT process works. I'm curious if the other panelists could tell us to what extent and how you handle training. Do you have to train them on download and transmit? Has Stage 2 caused some additional training that you didn't have to do in Stage 1?

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

And I'm sorry, was your question educating physicians or educating patients?

Paul Egerman – Businessman/Software Entrepreneur

Educating physicians.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark’s Family Medicine

Okay. John Berneike. In my opinion, again like has been discussed earlier, that if properly implemented, at least the VDT part of it, from a provider point of view, shouldn’t really matter. Other than the provider informing the patient that yeah, you can go to our website, log in, create an account and you can access your record and download it and transmit it if you’d like. But at least in GE’s implementation, from a provider workflow, there is no additional work, it all happens automatically behind the scenes.

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

I –

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

This is Greg – I’m sorry, go ahead. Apologize.

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

I’ve – this is Fred in Seattle. I was just going to say the extent to which providers are involved is that all of a sudden they get this CC – this random CCD document from a patient in their in-basket. And in the absence of any context, it’s hard to know what they’re supposed to do with that, because the patient may not be able to attach any kind of contextual message explaining why they sent it.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Well part of the reason that we – this is Greg again, and to comment on that. The reason why we train providers and everybody from a systems approach was that again, it takes a team, if you will, to run things, but because of the patient messaging that we have back and forth, we needed to engage the providers because we also do patient messaging to the providers as well as a part of our portal. So we wanted to make sure that the providers and everybody understood the whole workflow, in case they were hit up with a patient to say, how do I do this exactly. And we didn’t go into the technical details; again, it just took only about 30 minutes, which is not a whole lot of training, comparatively speaking.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark’s Family Medicine

Yeah, and that’s a good point. Certainly in terms of secure messaging and Direct messaging, whichever the case is, in that case there’s definitely some provider training involved. But, and then again, in terms of if a patient sends us a – transmits to us, then obviously we know how – have to know how to incorporate it, but I – as a primary care clinic for us it’s usually the other way around.

Paul Egerman – Businessman/Software Entrepreneur

And if I’m hearing correctly, none of you are using the transmit function currently. In other words, another way of saying it, none of you have patients who are using the transmit function, did I hear that right?

Amy Feaster – Vice President, Information Technology – Centura Health

This is Amy, that’s correct.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark’s Family Medicine

Yeah, and John Berneike, that’s true for us too, because we don’t have the software for transmit yet.

Paul Egerman – Businessman/Software Entrepreneur

Okay, so that’s very true for you. Perfect. Thank you, you’ve answered my questions, I appreciate it.

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

This is Michelle; I don’t see any other workgroup member questions in the queue. I’ll do one more quick check to see if anybody has additional questions.

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

This is Larry. I have one more question. If CMS were to reinterpret VDT such that the physician could do the transmit on behalf of the patient, say from their request, would that be – would you consider that to be more meaningful or useful or more likely to be usable?

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

So how would that be different than a transition of care?

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

It would be outside of the context of a transition of care, in other words, it's based on a patient request. It might be to their own HealthVault account.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

John Berneike, I think it overlaps quite a bit with transition of care but it's a transition that's been initiated by the patient – by a patient request. We will frequently have patients who self-refer to a specialist, which as their primary care doctor, I'd prefer that they come see me first, but that's a different issue. But if they do self-refer to a specialist, they'll frequently call us and say, hey, because of my insurance reasons or whatever else, I need you to send a referral. And that's a use case where I could see the patient asking us to do the transition of care as a substitute for the patient doing the "T" part of VDT.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Well – this is Greg. I agree with that as well and part of that is that if we initiate an outgoing message, it would be for the purposes of referrals, consults and things like this. Again, you're talking outside the transition of care; certainly we would do that on our end with the patients. With the provider doing it on behalf of the patient, we – frankly, we would want the patient to do it if it's outside of a mechanism of care.

Amy Feaster – Vice President, Information Technology – Centura Health

And this is Amy, I agree with that, too.

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

Thank you.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Can I say that, what we're trying to do with what we've done in ARcare and Kentucky Care is to keep – push everything to the lowest level possible, but at that lowest level or any level, keep things in a workflow, keep things as automated as possible and keep things from being hazardously disruptive.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

So – this is Micky. Michelle, can I ask a question?

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

Of course.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

So from what I'm hearing, and I don't want to overgeneralize, but from what I'm hearing, given that the provider attestation requirement is view, download or transmit, while there may be issues with sort of adoption of the transmit function and the need for better infrastructure – infrastructure before people can really use it. But getting to meeting the 5 percent for the VD or T, I'm not hearing from any of the panelists that you see that as being a significant issue. So first off, wanted to make sure that that's right and then second, do you think that you are representative of the provider communities that – at large – the larger provider community that you are a part of?

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Well this is Greg, I would like to jump right on that and say to your last question, no we do not feel like we're part of a larger because the larger part of the community are still getting involved. But I think one of the things that we were able to do is jump on this heads on and read it – and put the monies right now in it, and go ahead and get it done and over with. Secondly, with regard to the view or the download, what we've done is we encourage all of our patients to sign in at least once a year to meet that threshold, so up to and including our goal of putting kiosks in our facilities to where we can take care of that.

Amy Feaster – Vice President, Information Technology – Centura Health

And this is Amy, I think patients want portals, so if somebody has a portal, I really feel like patients are going to use it. I do think some organizations, the smaller practices in particular, will struggle with getting a portal.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark’s Family Medicine

Yeah, John Berneike. As a small practice I think that is generally true and like the other panelists today, I am the physician champion in our clinic, coming from an IT background myself. But the average small, private practice clinic is very often lacking a champion who’s going to push this kind of stuff. So I think that outside of these ONC type panel circles, I think it’s a much bigger issue.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

Yeah, this s Jeff Hatcher, I agree. We’re so far ahead of anyone in our area in Southeast Indiana and there’s still a large proportion of independently owned practices, I think it’s really hard for them to grasp something like this and get it off the ground.

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark’s Family Medicine

John Berneike again, not directly to this question, but kind of a related question and going back to the discussion about PHR versus portal terminology. One thing that I see that the larger hospital systems here in Salt Lake that are now some of them on EPIC, they have EPIC MyChart functionality they advertise it to the patient that you can log in and view your record. But they don’t make it clear to the patients that it’s only the portion of your record that’s maintained by that hospital. And again, within a large integrated system, it may be less of an issue, but here in my community, where we’re a not integrated network, that can be a very confusing issue from the patient’s point of view.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

I can speak to that as well. We’ve had several patients that have been in Cincinnati using EPIC and tried to access records through that and then come back through our portal and access records and if they’re in certain organizations, they feed back into directly their portal chart that we hold. But it becomes a very clunky, cluttered type of navigation for patients and its disjointed, just like if they didn’t have access at all.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Great. Thank you.

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

Larry, can I do a follow on to that, do we have time?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Yes.

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

Umm, sure.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Oh, I’m sorry, Michelle, you’re the timekeeper, you tell us.

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

Well I – so go ahead Larry, but Charlene Underwood has a quick question and I think we need to wrap up after that.

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

Okay, I'll ask this very quickly. So you're bringing up a great point where – as we all start growing out these tethered portals to our EHRs, now patients are going to have multiple different portals to have to deal with and what do you foresee is going to be the patient's solution to dealing with multiple portals?

John Berneike, MD – President – Utah HealthCare Institute; Program Director – St. Mark's Family Medicine

John Berneike. The state HIE here in Utah, we have discussed, though not implemented yet, having a patient portal as part of the EHR so it would be an integrated record from all the separate providers that are supplying data to the HIE. So, I think that's a good ultimate solution. And again, we haven't gotten that far here in Utah, but other areas may have, I'll listen intently.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

This is Greg. I know in Kentucky, the Kentucky HIE has just – a contract I believe for a state portal, Arkansas may be working on it. Again, we do the Blue Button, so we're trying to get involved in the national effort with the Blue Button that we put on our website to allow people to have that one-stop shop if you will.

Jeff Hatcher, MD – Medical Staff Liaison - Margaret Mary Community Hospital

Yeah this is Jeff again at Margaret Mary. Our portal is not a tethered portal so we're kind of working directly towards what you're speaking to, trying to integrate the systems where we have patients that interact with the various facilities. And at least in the early goings, it's working well with the hospitals that we have agreements with. I think the hard part is getting the interest to get all the providers and all the organizations to collaborate through the HIE and we're hopeful that the Governor's Board at HealthBridge, our main HIE, will help break down some of those barriers that we've encountered.

Fred Brodsky, MD – Assistant Medical Director, Informatics – Group Health Cooperative

This is Fred.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Sorry, one of the things we're seeing in Arkansas, real quick, and we're seeing in other places is hospital systems wanting to do their HIE, they've now found out that it's good to have so rather than participating in one main state HIE, they're choosing to do their own. Which now for us is leading us to where we're going to end up with different – five or six different HIEs to connect to, and that's not financially conducive and for a lot of cases, not for a lot of places either.

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

Thank you.

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

Charlene, do you have a quick question?

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

Yes and mine was on the same topic. So I just wanted, from the Meaningful Use Workgroup we did not want to preclude providers in their implementation of Stage 2 from doing exactly what you're talking about, because we envisioned a patient having to go to seven different portals rather than a unified one and wanted to encourage that. Is there anything in the current regulation that is preventative of that? One of the areas that we were concerned about was attribution, so – and would guidance help if something were a barrier there? And maybe that's to detailed of a question – interpretation of regulation is often a challenge.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

Well this is Greg; I think the less is more at this point in the game.

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

It was really, you had to – certain thresholds such that if you for instance said your information about the patient, the transition of care document – state portal, then the patients looked it up on the state portal and they'd look at all the information – that you get your 5 percent or whatever it was question.

Greg L. Wolverton, FHIMSS – Chief Information Officer – ARcare

This is Greg again, I would much prefer one spot to do it and the state portal is the best place. However, I don't think we're going to stop these people from having their own proprietary portals because it's in their best interest to do it. To make a point – and do things and also a lot of people use those portals for a large – and things like that for influenza and different things like that that we're doing for those that are on the problem list and comply with patient-centered medical home on notifications. I think that if the patient was able to get one view, that would be a whole lot better and I think it would be easier for the patient and so –

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

Yeah, okay. That's a good point that it's going to be complimentary. Thank you.

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

Thank you and thank you again to all of our panelists. I think I'll turn it over to Micky to see if there are any final remarks that you'd like to make Micky before we open up for public comment.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

No, other than to thank the members of the workgroup as well as the Meaningful Use Workgroup for your active participation and especially the members of both panels, I know the first panel may have dropped off by now, but the second panel as well. It was incredibly thoughtful presentations and discussion and we really appreciate your giving us the benefit of your experience and your expertise. So, let me turn it back to you Michelle.

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

Thanks Micky. And again, thank you to all of our panelists and thank you to all of the workgroup members who helped us identify panelists. We greatly appreciate your help. And thank you to Kory Mertz and Kim Wilson for really planning the hearing and getting everyone gathered. We appreciate that. So with that, I'm going to open it up to public comment. Operator, if you could please open the lines?

Public Comment

Caitlin Collins – Project Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-6006 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment please press *1 at this time. We do have a comment, David, please proceed.

David Tao – Technical Advisor - ICSA Labs

Thank you. Hi, this is David Tao from ICSA labs. I really appreciated the candor of the ToC panelists, wanted to comment on two things they mentioned. Their remarks about the limited value of the summary of care record by itself are similar to recommendations that were made in the ONC Transition of Care Initiative that I participated in. We pointed out that MU2 requirements are a floor but that providers should be flexible to be able to send what is relevant to help the recipient care for the patient, so that might include additional data in the summary document or attachment of other documents, etcetera. And the regulation also does encourage senders to include more than the minimum data set as needed. Some EHRs may offer the capability to customize the C-CDA to meet those needs while others may not.

And regarding lack of status tracking for referrals in Direct, that's currently true, but I suggest that someone inquire whether the ONC 360X Closed Loop Referrals Project has made recommendations to address these gaps in tracking using Direct. They did a presentation in 2013 saying they were defining metadata elements such as workflow states and statuses to support closer coordination of referrals and I looked on their Wiki site and they do have a referral state diagram there, so I think some things to address those problems are in the works. Thank you.

Caitlin Collins – Project Coordinator – Altarum Institute

We have no additional comment at this time.

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

Okay, well thank you everyone and we greatly appreciate all of your remarks.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Right. Michelle and Kory, thank you.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yes, thank you. Bye everybody.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Bye.

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

Bye, thank you.

Public Comment Received

1. Part 1 of comment I will make on phone: This is David Tao from ICSA Labs. I really appreciate the candor of the ToC panelists. Their remarks about the limited value of the Summary of Care Record by itself are similar to recommendations made in the ONC ToC Initiative that I participated in. We pointed out that the MU2 requirements are a floor but that providers should be flexible to send what is relevant to help the recipient care for the patient, that might include additional data in the summary document, or attachment of other documents, etc. The regulation DOES encourage senders to include more than the minimum data set as needed. Some EHRs may offer the capability to customize the CCDA to meet these needs, while others may not.

2. Part 2 of my public comment: Regarding lack of status tracking in DIRECT, that's currently true. I suggest that someone inquire whether the ONC 360X Closed Loop Referrals project made recommendations to address these gaps in tracking using Direct. In July 2013, they published an update saying they were "Defining meta-data elements, such as workflow states/statuses to support closer coordination of referrals" but I don't know what they've done since then.