

**Meaningful Use Workgroup
Subgroup 3: Improving Care Coordination
Transcript
April 30, 2013**

Presentation

Operator

Ms. Robertson, all lines are bridged.

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

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

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

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

Thanks Charlene. George Hripcsak?

George Hripcsak, MD, MS, FACMI – Columbia University

Here.

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

Thanks George. David Bates? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Here.

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

Thanks Leslie. Mark Overhage? Paul Tang? Larry Wolf? I believe Larry's on the line. And if there are any Meaningful Use Workgroup members on the line, if you could identify yourself.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul Egerman.

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

Great. Thanks Paul.

**Joseph Francis, MD, MPH – Veterans Health Administration – Chief Quality and Performance
Officer**

Joe Francis.

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

Thanks Joe. And we have Art Davidson as well. And, are there any ONC staff members on the line?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

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

Thanks Michelle. With that, I'll turn the agenda back to you, Charlene.

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

Thank you very much. Okay. Thank you, workgroup. We actually are in the middle of the process of responding to the feedback that we've got on Stage 3. And as those of you who have been participating, it's been a two-part process. First part of the process has been to look at how we can potentially overall restructure Stage 3 to be more focused toward outcome. So we've done that in two ways. We've looked at consolidating the requirements, so where there's potential to meet one requirement with another objective, we've consolidated from that perspective. So there's concurrent work going on there. The other part of the process is as an optional process, to look at achieving certain outcomes and by achieving those outcomes, be it both – the focus has really been in the EP world right now, the ability to be able to actually deem the achievement of certain requirements. But again, the intent of Stage 3 was to recognize that both EPs as well as eligible hospitals had been through Stage 1 and Stage 2 had the bulk of the infrastructure in place to be able to do some more advanced type of improvement in terms of care. And we wanted to really start to stimulate that in Stage 3.

We're now in the part of the process where we're actually looking at the feedback that was provided by the public when we put out our RFI earlier this year, what is it, May and it was in like January. So that's what we're going to be doing today. Our workgroup we've got it broken it up into like two parts for feedback. Today we're going to be looking at, and I don't – can you move the slide to the objectives, the next page please? Today we're actually not going to look at reconciliation, 302. I've deferred that, because I wanted to include Paul in that conversation, but I'm not quite sure how we're going to do that, so we might have to regroup a little when Paul's available. But today we're going to look at the referral loop, at notifications, interdisciplinary problem list and prescription writing capability. A lot of our requirements you will see, are dependent on an infrastructure for information exchange. So as part – I think it's of the next week, is that Michelle, on the May 8?

Michelle Consolazio Nelson – Office of the National Coordinator

Well, it will depend on Paul's schedule now, but we were planning on May 24 doing a combined call with the IE Workgroup.

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

Yeah. So, I think, the Information Exchange Workgroup has concurrently done quite a bit of work in terms of looking at the requirements, so I think a combined workgroup will make sense. So we'll have to determine what's the best sequence to have them kind of come, and I would...I think we're going to determine at the end of today, we're going to need some updates relative to where some of the processes are. So it may work to do that on May 8 and then come back with reconciliation, care planning, and care summary on May 24, if Paul's available then. So, we have to kind of work that out.

The reason I moved reconciliation was because there was a lot of feedback from the Standards Committee group that we weren't ready to reconcile some of those data elements. But, there's some dependencies between what's in the care plan as well as what's in reconciliation, so I thought it might be better to have a holistic discussion around those topics in one session. So, that was one of the reasons I moved it. The other framework, I'm doing to lay out just a couple of principles as we kind of do this, and Leslie's going to notice, one of the things we've been trying to do in care coordination is to recognize that it's a process.

And so when we step back and looked at a vision for care coordination, we said, there is some key functionality that really has to happen here. And again, we recognize moving toward new platforms of care that are going to support shared care plans, care collaboration and some of those are emerging. We don't want to constrain that in any way, what we want to do is to enable that. So you've got to have some basic infrastructure in place. And again, meaningful use is intended to be the floor and not the ceiling. So that was kind of our focus in here. So as we go through these requirements and the feedback today, kind of take that in mind, as the purpose of what we were trying to do was to set a framework.

There were three key functionalities that we identified at the highest level when we were trying to envision what this future state might be. One would be communication, so the ability to enable communication, not only within an institution, but across institutions and primarily to move to the patient-center – putting the patient again in center of this process. And that's where we recognized some of the infrastructure that we need to actually get there, is not necessarily in place. But we didn't want to say; well we can't do anything until it's there, because we need both sides of the process. The other thing we recognized that in addition to communication, you need some tracking capability. So, you want to communicate that something needs to be done, and then you want to actually track that it gets done, you want to start to close some loops. And again, this is over time and space, right. And the third part of the process is, again, as you're communicating and you're getting information in, you need some robust capability to reconcile the information that's coming in. So all of this framework is dependent on a pretty robust infrastructure to be able to support those three capabilities.

So that's kind of the context we're working in. The one that has been – an important input to this process has been the work that Larry Wolf has been engaged with in terms of how to...even though long-term care...post-acute care facilities aren't incented by meaningful use, clearly as we look at transforming healthcare, the ability to be able to connect with – connect the continuum is a requirement. So there's been a lot of work done by that community in terms of what their future state needs to be, and advocacy around the need for shared care planning and coordination with those facilities. And again, because those facilities think in longitudinal ways, they're bringing a lot of requirements to the table. So that will be more the focus of what we really talk about on May 8. And again, what we're trying to build in Meaningful Use is a stepping-stone to enable this process, recognizing that not one entity can do this all. So, you'll see in the thought process we're trying to enable some steps.

So, with that said, I know we've got a couple of new people on the call. Are there any – and, Leslie, I know Leslie was on the first process with me, and George. Any additional comments or considerations you want to discuss or put on the table.

George Hripcsak, MD, MS, FACMI – Columbia University

Sounds good.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right, sounds good to me. I did meet with the care planning team last week and I think our whole message is we've got to walk before we can run.

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

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think you've laid out a good program here.

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

Yeah, so again, we want to set the framework for it, and that's – it's like, you can't define all the requirements, but that's what we're trying to do. So, if we want – what I wanted to do then was to review 305, 308, 127 and 125 this morning. I don't think it's going to take us the whole time, which I think will be fine. And then we'll go back to reconciliation, care plan and care summary, maybe when we can Paul engaged, which may be May 24, and then maybe we'll use May 8 to actually engage with the IE Workgroup, if that makes sense. We'll have to think about that. All right, if you could move to the slide on referral loops.

Okay. So let me give you a little bit of background here. And I think you'll see the context of some of the comments that we got. When we started out with this requirement, and first defined it, we actually kind of had defined it assuming, again, coming out from the ordering process, because under care quality, there's a requirement that you can actually request a referral, right. And so what we're really – and I know it's a little bit confusing here, so people don't necessarily see the pieces are intended to tie together, but I think the IE Workgroup does. The intent here was to put an infrastructure in place to start to close the loop. We know statistically that about 25 percent of referrals do not occur and if we want to connect the continuum of care, we need to do that. We also know that there's really no tracking whether they occur or not. In some of the Beacon Communities, they're actually tracking these and they're actually able to reduce the number – a gap in care there, but that's kind of the problem we're trying to solve.

So, the way we wrote it to get it off the ground, and this is – and know that we kind of modified it at the end, so I think this could have been one of our issues, was – the objective was the receiving provider, and we had the hospital included in here. But the EPs, if you think about referrals, to whom a patient is referred acknowledges the receipt of an external information and provides referral results to the requesting provider, thereby beginning to close the loop. And the measure that we put in place was for patients referred during a reporting period, the referral results generated from the EHR, 50 percent are returned to the requestor and 10 percent of those are returned electronically. So again, this would require some accounting on the part of the sender that they acknowledged and complied with this request that was our intent. The certification requirements, I think this was the S&I Longitudinal Care Coordination Framework, I think is still open for discussion be – I think some of the standards are being defined. But again, the standards for – and again, some of the feedback were referral requests that require authorization for precertification, surgery, etcetera. So, there are some, I think, open questions about what is actually really meant. What counts as a referral basically? Questions on the objective and its intent?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is Larry Wolf, just jumping in with a thought that may actually be in some of the responses. A 50 percent threshold for a response back has me thinking about all of the reasons why the referral never happened. So, we were allowing didn't happen as a legitimate response, right?

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

Yeah. And again, this is, I think one of the – and I know Michelle, one of the philosophies, and George, you can speak in here too in terms of when we actually – I think we assumed this would be core. We didn't even debate whether it was core or menu, but it was to get the infrastructure in place and off the ground, that's what we were trying to really get in place here, because we think it's important. So, we can debate whether it should be core or menu, but I don't think we even spoke to that.

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

Yeah, I agree. I agree.

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

Nex – the other just – I'll make the other comment, you'll see it on the next slide. We actually changed this objective to be more of an "and" objective, we had it both – and you'll see a comment that's about consideration of hospitals. So if we go to the next slide, you'll see some of the feedback. I think we may have forgotten to make a change when we actually were writing the final one. So, the number one was, be clearer in defining referrals, especially what it means for EH. So the question was, because this was really – in our thought process I think we really had thought it was more EP, but because we changed the original objective to exclude – I think we actually had the loop being completed by the receiver, which could have been the hospital in this case. I'm not sure that we want to include hospital anymore. So are there use cases where we should be including the hospital or should it just be an EP measure?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

This is Les and I think the issue is what do we want to have acknowledge in a transition in care to long-term post-acute care and areas we're further incenting transitions being useful and meaningful so that we could include hospitals. But we're asking for...that they receive an acknowledgment at the long-term post-acute care or can we do nothing because they're not being incented? Larry, what are your thoughts?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, there's a question about sort of flow from one care setting to another.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, there is a flow from acute care hospital, incentivized, to one of the post-acute settings not incentivized. But those are generally not referrals; those are generally actual transfer of care.

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

They're orders, they are orders right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Someone is discharged from the hospital and now they're in a post-acute setting. So, it's not the referral model, if you will. It's not tell me what you think, more like, I give you control.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So we can handle that under the order section.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, that's a separate piece, I think altogether from referrals, but I think there is use by the post-acute care settings of referrals, where someone is sent out to see outpatient doc of various kinds, might be to have a specific procedure done, might be for an assessment. And they might even send someone to the emergency department for an emergency assessment. So, waiver's a referral, but then the loop back is to a non-incentivized provider, so outside the scope really of what we're trying to define. So, I think ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But if we ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

... the purpose of 305, I don't think this speaks to post-acute care or long-term care.

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

But Larry, in the case they would send – the post-acute care would send the referral, it doesn't have to be just from the hospital, it just – they would still be accountable under the measure as we defined it, that they complete the referral. Because it doesn't say, it has to come from a hospital or, it can come from anywhere, right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. So we're asking – so, I guess there are two players. In the referral loop, there are two players, right.

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

Um hmm.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

There's the organization, first an organization that's making the referral, and then there's the folks doing the consult and responding to the referral, right. So a sender – and Act 1 and an Act 2, right, so two parts, I think. So if what we're saying is we want Act 2, that you should always respond electronically, if you can, and you should certainly respond even if you can't respond electronically, you should certainly respond back. I think that's true. But we're looking to measure the sending side of this relationship, right.

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

Umm, the response side, we're the close the loop side we're trying to measure.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But that's measured by the person who sends it, who is incented to receive the closed loop, right. Because you can't measure long-term post-acute care, they're not incented.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, but ...

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

Yeah but ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, clarify for me. Are we measuring, are we saying, if you receive the consult, so now you're the second half of this, right, you receive the consult, we want to put a measure for you to respond, is that what we're looking to do?

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

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It's really not on the, okay. So I misunderstood. It's not – we're not measuring the initiator of the referral.

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

No.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We're measuring the person fulfilling the referral.

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

Yeah, because when we originally defined it, I think we had it a tighter loop. When we finished it, because the order's coming out of the ordering section, we just started – we've got to see baseline. You're going to be counted that you actually do your response and we want you to do it electronically, that's kind of where we started. So really ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. So this is accounting by the person doing the – completing the referral.

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

Exactly. So they know they're going to be accountable, right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So in that case, I think we should include anyone who sent the referral should count in the denominator.

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

That's right. So whether it's long-term care or anyone will count. The question is, I think the question's valid, what does it mean for the EH, because typically – the focus here was really to the EP. So the recommendation was making this only an EP measure, which I think was the intent; we just lost it in the translation when we modified the measure.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

You know, listening to this, this is Leslie again. I think it might just be an EP measure and that we use – we had the CPOEs for core needs in transition in – not a care coordination measure, but in a CPOE measure, and with that, with an acknowledgement there and we could maybe beef that one up and keep this just EP.

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

Yeah. Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. So I know this will make the EDs nuts, emergency department's nuts, but they're often used by post-acute care to do, essentially as a referral.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, if someone is in a post-acute setting, something emergent is happening, they're sent to the emergency department to basically do an assessment or to do an emergency procedure. And then potentially send the individual back to their post-acute or long-term care setting. It doesn't have to be ED to admission, it could be ED, send them back.

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

So might that count in the case where at discharge to wherever, they have to create that transition of care summary? Wouldn't we capture ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah, if they create a transition of care summary and send that – if they create a summary of what happened in the ED and send that, that would certainly be sufficient, yes.

Joseph Francis, MD, MPH – Veterans Health Administration – Chief Quality and Performance Officer

This is Joe Francis and I have to say that I'm thankful that in my world in VA, things are a little bit simpler. But, recalling my days in the private sector, particularly as a nursing home physician, and also recalling the Medicare Demonstration Project from a few years ago where in fact, it was shown that you could manage many of those acute problems in the nursing home if the payment mechanisms were appropriate. I just worry that we don't enshrine in meaningful use computer code that locks us into essentially an artifact of an old payment process, which we hope will be evolving over time. And that might be one reason to sort of exercise caution and a more limited scope here, and focus on the – maybe the EP focus is more appropriate. I mean, all of these things are real and they actually happen, but they're not ideal in terms of how they're structured.

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

That's a good get.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I'm fine if we limit this to just the EPs, it simplifies the whole mindset as well. We're not pushing a paradigm change as well, there's a reporting issue.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Me too.

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

Okay. So we're going to change this to EP. So then, the next one then would be, consultations should be excluded from the measure. So, I could see where consultations in the case of the hospital happen all the time, you wouldn't want to include it in the measure. But are consultations then valid in the case of an EP? I mean, typically isn't that why you do a referral, because you want a consultation on some topic?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah, I think this is getting at the doctor-to-doctor communication, to determine whether a referral was necessary versus a patient exam and patient consultation, I think that's what this was.

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

So, I guess my question was, and maybe this is a question we could ask the IE Workgroup, are there...is there some mechanism around identifying kinds of referrals. I mean, I think in the practice world we know what a referral is, but, and I know in the financial world they know what a referral is. So, it would seem like we would want to be under that definition as opposed to if they request a consult, they request...that should be valid. So is there anyone that's got any intelligence on that piece?

Joseph Francis, MD, MPH – Veterans Health Administration – Chief Quality and Performance Officer

So I guess I'll, given the language, I'll assume that consult means you're in a hospital and you're on a different service and you've come to provide your advice.

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

Joseph Francis, MD, MPH – Veterans Health Administration – Chief Quality and Performance Officer

And if we make this EP only – right.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But if we drop then ...

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

I think we take care of that by dropping EH. All right. The next comment was means of counting referrals should not add a counting burden. So, here was the thought process, and this is a little bit of a challenge if there was – we've got the order that's for the referral. If they've got an – most systems have this in place, if you get an order for a referral, then you know if you close the loop, then you count, so by definition they will know that they've received a referral. Can we count on that as the denominator?

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

Could you say that again?

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

So again, we're placing a request for a referral via an order, right. They receive an order and they will know how many referral orders they have, and that's kind of the denominator, right. And then based on that, they know if they sent the response back in paper or electronically, and that would be the denominator.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think here's the infrastructure problem.

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

Yeah, I know.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Today it's not uncommon for a patient to be handed a piece of paper that is essentially the order to go for their referral, right. I don't know that there is a reliable electronic analog today where we send a message from the PCP to the specialist, for example, or from one specialist to another specialist. I don't know that there's a reliable messaging model currently in place to do that.

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

Well what you're saying Charlene, is just that if you receive a meaningful use referral, then that's when you get counted for closing the loop.

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

Well that's one option or the other option is to assume that there's – most of the time you go to the doctor, they're going to put your order in, because they at least have to bill for it or account for it, and then that would create the denominator. This makes the assumption that the systems have the capability to create the request for the referral as the basis for their denominator, whether it's automatically set or whether the patient walks in with a script.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, but you don't know that you're billing that it came from – that it was a referral or a new visit or something, right. See, you can't just go to your billing records and know that answer.

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

I was going to.

George Hripcsak, MD, MS, FACMI – Columbia University

Sorry, go ahead.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So what happens if we're really perverse and we say, we don't really care about whether or not this showed up as an order, we care whether or not you told someone what you did.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And that you supply...if you send your summary to the PCP...

George Hripcsak, MD, MS, FACMI – Columbia University

Right, then what's the denominator?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Encounters generated by a referral will have some percentage of encounters generated by a referral will have a response to the referring physician.

George Hripcsak, MD, MS, FACMI – Columbia University

How do you know the encounter was generated by a referral?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

You're going to have that in your billing system, are you not?

George Hripcsak, MD, MS, FACMI – Columbia University

No.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

You know it was a new patient or a referral.

George Hripcsak, MD, MS, FACMI – Columbia University

Nahh, I don't know. Not necessarily.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, the new patient could be a referral or the new patient could be someone random walking in off the street.

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

So the question to the standards workgroup is, is there – do we have some identification that this request is a referral?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

If you have a system that can accept an order from a foreign system, you do. But in general, that's still not happening between unaffiliated physicians, it will happen from a physician and a lab or a physician and a radiology group, but today it doesn't exist there. I mean we're hoping to – that with the direct standard, to at least give secure email from one to another, but that's not going to tick-off that a referral happened. So they would be attesting to a referral, and we may not have any electronic evidence of that referral, is that acceptable?

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

So would they – I mean so the options would be, they've got a – when they – this denominator, I can't figure the denominator out here, without having a...I think in the original requirement, we created a structure to create the denominator, but we've kind of lost that so.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well I think we also assumed they were all meaningful users, this is Leslie. So, if we said that any patient, any referral, any encounter generated by a referral from a covered or from a meaningful user electronically, you expect a reply. And we've reduced the number dramatically and could keep it as a core item as a result, and then move it to a higher threshold the following meaningful use phase.

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

Okay. So should we – this might be one where we can get some more content from the IE Workgroup, because they've probably been thinking this through, I would think. So maybe we want to leave this as an open question right now and get some input from the IE Workgroup on that, would that make sense?

Michelle Consolazio Nelson – Office of the National Coordinator

Hey Charlene, this is Michelle. I think it might make sense, because there's a piece of this that also relates to the transitions of care item, because we moved ...

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

Yeah, I know.

Michelle Consolazio Nelson – Office of the National Coordinator

... the CPOE for referral there, so I think it all is connected and we probably need to defer until our next conversation.

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

I agree.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

Because this is one where we don't know how to capture the basis for our denominator because we don't know what to count on for infrastructure basically. Otherwise, because I don't know how I'm going to quite get that denominator. All right. The next one was threshold recommendations to increase or decrease. So, they seem to be comfortable with 5-to-10 percent electronically and they were ranging between 30-80 percent for at least submitting it back in non-electronic form. Any – what's in our policy Michelle on that? The first time we introduced it, is it 30 percent? We kind of went 50 percent because we thought it was important, that was what our rationale was.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. So we, yeah we have pretty much done 30, 50 or topped out. There is one that's 65, but ...

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

So are there any thoughts whether we keep it – I don't think we wanted to go higher, especially for the first time, than 50, even though we would certainly like this close the loop, but we felt like it was more important than 30 is kind of where we were. So, we took a middle ground, that's why we suggested 50.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

My sense is that in some ways it's all arbitrary, even at 30 percent, you've got to bake this into your process.

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

You have to bake it into your process, that's what we want to do, is bake it into their process, and then it'll just go up, right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That's the thought. I mean, that seems to be what's happening with all the other measures, so far, is, if people commit to doing them, the percentage is very, very high.

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

So ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

They do build it into their process, otherwise, if you're at 30 percent and you're not paying attention, you run the risk of only being at 5 percent at the end of the year.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

If you actually want to get 30 percent, you have to assume you're going to try to do it all the time.

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

So, any thoughts on keeping the number, lowering them, increasing them?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think for something new starting ...

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

Here would be my – I would like to leave it at 50 and 10, because this potentially might become a menu item and then we'll get some of those early adopters out front, really getting this to work. I mean right now it's not a menu item, and then if they would say, okay, make it core, maybe we'd lower it, but I think there's a lot of possibility this could become menu.

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

It's hard to set the threshold until you know what the denominator is.

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

Okay.

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

If the denominator is all electronic orders, then 50 is fine, if the denominator is all visits you have, then it's got to be instead of 50, 10 or something. So, I think leave it as is and then see what happens with the denominator.

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

Okay. Good one. All right, the other comment was, and we didn't really discuss this, in other measures you have to respond within a period of time. We didn't put that requirement on the table here. Do we want to table that until we kind of really understand what the denominator looks like too, and what the infrastructure looks like?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And do we really want to mandate that, because it will be based upon the care and the outcome of that particular referral, which might not be, based upon the patient's health or status, more – I guess I defer to the doctors on that one.

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

Yeah, would agree with you Leslie.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It also could be a multi-visit situation, right.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

You're referred to a specialist, they see you, they talk to you, and they invite you back to do a second visit. They do some labs, they do a procedure, they see how it goes, and you heal up. It could be six weeks before they actually have something definitive to report back as, this is what we did and here's what we learned.

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

Yeah, so that's the case, when we talk about denominator, you know sometimes they refer you for six visits, right, so. All right, so we need to get a little bit – because if they refer you for multiple visits, it's not one for each, it's kind of a referral for the process, right. So, we're not going to do timing, but we have to be sensitive then, I think, in terms of counting referrals then, because it's not going to then be each visit, it's going to be for the order, right? So that's what our gap is. So, the next point was measure language needs refinement, as it's confusing as to what is to be completed then measured. So I think as we, in the objective, and Michelle, why don't you read the objective again. I think the measure was clear, but the

objective was ...

Michelle Consolazio Nelson – Office of the National Coordinator

So if we take out the – so the EP to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby beginning to close the loop. Do you want me to read the measure?

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

For patients referred during an EHR reporting period, referral results generated from the EHR, 50 percent are returned to the requestor and 10 percent of those are returned electronically.

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

Okay. So, um, I think, again, I think this one is one where the IE Workgroup could provide us a consult. I think what happened was is we modified the objective, we may have left acknowledgment there.

Because really the intent of this measure is that they close the loop. So, to assume that – it would be really nice when they get it that they actually acknowledge it; I tell someone so that I've got the receipt, but that even puts more infrastructure in place. So I think it's really that they actually consult ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Charlene, I think – this is Leslie – sorry about the noise. I think the acknowledgement issue was in this current April 7 model, you send an order, you send a lab, and we have an automatic acknowledgement that goes back to the system that says we've got it. There's no – and so it's just a system-to-system communication.

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

So, I don't know if we need – do we need to inc – I totally support all that, we've got to assume that infrastructure's in place that we sent something. It actually – I mean, but this would require them, when they got the referral if it was on paper, that they would, that they would enter the referral and then it would send it back and acknowledgement that they received it. And I don't think that was our intent, I mean it would be nice, but I don't think that was our intent.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

No, it was really around the electronic.

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

So I think the acknowledgement word probably could, I mean, it's like – so we need to assume that infrastructure, but it was not to imply that when they – because we're not counting it. When they receive the order, that they actually acknowledge that I've got one and I send a, by the way, I've got your patient here, I'm taking care of them. So I think that one we could probably delete that word. And then, I think we make the assumption that there's an electronic infrastructure such that if an order is – if they receive the electronic order and/or we send it back, the HL7 capability has the acknowledgement to actually indicate that it's accepted or not.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right, so we want to make sure that the standard is like that, that's all, it doesn't have to be in the measure, but it has to be in the standard.

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

So you got that, I mean, I think that's – we've been doing that for years. Okay, for reviewed, yes, this is what we agreed on, the last, isn't it sufficient to prove the consultant reviewed it and sent the data, so I think that's what we're agreeing, right. We're agreeing that just receipt. So I think we agreed with what the third comment is.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

This is Marty Rice. What are we agreeing upon again?

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

That just, what we're trying – the intent of this measure is that the report is actually sent back. So we don't want the provider to have to go and say, we'll I acknowledged it – to take extra steps to say that I actually sent it back, and that's what they're saying. So some of the language that we have in there starts to imply that they have to acknowledge that they received it and acknowledge that they sent it back; the intent of the measure was they actually sent it back. And we're assuming that the standard supports the infrastructure to actually ensure that the electronic communication was sent. We're not going to make them do extra work. Does that make sense?

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

It makes sense, I'm just trying – are you saying also for reviewed? You're saying that the infrastructure's there and we're just making sure that it can be sent back saying reviewed.

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

Okay. So where's the reviewed word Michelle?

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

It says, "What does acknowledgment mean? Received, reviewed or signed?" So my question is that we're building measures, or we're utilizing measures for actions and if those actions are not avai – if they don't do those actions, what's the – is there a negative – is there anything negative that could come out of that?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, in this case, the model that we were thinking about was practice 1 sends request, sends an order for practice 2 to do a consult, and we wanted practice 2 to say, I got the request. Right, that's what we're talking about. And it sounds like today's discussion, we're saying, well it's less about acknowledging the request than it is about actually doing the consult and telling me what you did.

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

Right. So our focus is simply on that last – they get it in some form and they send it back, that's the loop we're trying to close. We're not asking them to acknowledge that they received it. We're just – so any language that pertains to reviewing it, receiving it, we just want it back – this measure, sent back, and we want the work done.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Okay.

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

So Michelle, I can't see the reviewed, I can't see the original, because I don't have my papers out, where is reviewed in the language of the objective or the measure?

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

It says when a patient is referred, acknowledges receipt of external information and provides referral results to the requesting provider.

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

So I think we just want to say, upon receipt of it, provides the results, right? We're skipping that acknowledgement.

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yup.

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

Yeah. And I mean, if infrastructure gets in place that we could do that, on the receipt of an order, that's wonderful, but we're not making that assumption right up front, unless the IE Workgroup says it's all going to be there.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, going back to slide 7, where the recommendation and the future stage and questions/comments ...

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

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It looks like when we first wrote this, we were really focusing on that initial "just tell me you got it," and now we're much more concerned with "tell me you did it."

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

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think it actually make – so, we're shifting our emphasis here from we're just being mechanistic about putting in infrastructure to we actually want to know the consult happened and what was learned.

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

Yes.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

So, if somebody is sending back a result, they're actually acknowledging that they got something too, and it doesn't even matter if they've acknowledged it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. Exactly.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Okay.

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

And it think the future stage is still, like we'd like to know when an order's sent, then you can track it and get the denominator, and you close the loop, right. That's really what we're trying to get to, but we don't know quite what's in the middle to do all that yet. Okay, back to slide ...

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, back to, just based upon the last comment, so are we taking out the "acknowledges receipt of external information" or leaving it in?

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

In the description of the objective, yes, well, the future state's fine. We're – let us focus for this stage is actually that the work gets done and it gets sent back, that's what we want to measure. So, we changed our focus.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

But it might be adequate just to simply say, this is Leslie, it's been, never mind. I think you're right, focus on the end game and have the standards group focus on what the steps are to get there.

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

Yeah, yeah. And, okay, and so then the last question was, does this item address, address referral loops between primary care providers and public health providers? So, I would think that the answer should be yes, but do public health providers, are they, let's see, yeah, they receive incentive money. So community health center falls under an EP, right.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yes.

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

So, I think we're fine.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

A community health center, yes, the providers would be – the community health doesn't fall under an EP, the providers that work at that health center do.

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

Okay. Yes.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Health centers aren't eligible for any incentive program.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So I guess the question though, my concern here is, when they say public health providers, do they actually mean a service that the public health department is doing? Or do they mean community care centers?

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Yeah, it's kind of a confusing verbiage.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

So, this is Art, maybe I'll make a comment here. So this is actually what happens in my county, that we are the public health TB service, actually for seven counties. And we receive patients, they're cared for, for TB in our clinics and then sent back to primary care providers, whether they be from a community health center, which they often are, but they're referred to a TB clinic for their care. The same way that, I know that Tom Frieden has made pitch for referring patients from a primary care provider to the Quit Line. And then to have that referral process go back and inform the primary care provider that the patient needed a ride, was treated, did this and this, didn't complete, never showed up, all those sorts of outcomes. So, I think that this should apply to that as well, it's a referral, and that referral should result in a bit of information flowing back to the referrer.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Yeah, the key term is health provider.

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

Yeah.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Whether it be, public could be anything, whether it be a community health center, Ryan White Clinic, doesn't matter, it's a health provider.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. So Art, in your example, the docs doing that care are there as EPs and that practice counts as part of their EP activity.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Yeah, I mean the referrer is an EP, that's – and that EP should expect that there would be a referral back. If everybody's trying to play in this market, not saying that public health has all these things worked out, but where feasible, the public health provider should be sending back an HL7 message ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

... with the results of the referral.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay.

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

Yup. So, as long as the...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So we may not be counting those, we may not be counting those because the public health provider...I doubt it's scoped for meaningful use, but we want to in general, encourage that behavior.

M

Yes.

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

So, do the EPs in the clinic, in the public health clinic, are they included in the Program was my question?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I thought they were.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Well it depends on which clinics you're talking about. I mean, there aren't really EPs at a Quit Line, which could be considered a clinic. If you're talking about the TB clinic, where I work, or in my building, they are indeed EPs, yes.

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

Okay, great. So I think we'll get some and we probably will miss some, but the intent was to get them.

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

Well I would just say, yeah, I would leave the phrasing the same and insofar as they come under this program, yes, and if not, no. It's not an...

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

Yeah.

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

This is not intended to close the loop with public health departments, which is a very good idea, but that's not what this intent was.

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

This is ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So I think this is a good example of, we don't want to exclude good behavior, right; we don't want to discourage good behavior. If a public health department says that they want to build the infrastructure so care that they provide can be reported back to EPs, the EHs and anybody else who sent someone to them, that we want to encourage that to happen, but it's really out of scope of the meaningful use requirements.

George Hripcsak, MD, MS, FACMI – Columbia University

Right. Charlene, I realize that we're out of most of our time at this point, so, just as far as pacing us.

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

We're going until 12, so ...

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

Oh, 12, yes, it's not 11:30, 12, but I'm just saying, that's two-thirds done.

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

Yes. All right, so I think we – our changes we've made is EP only, we're going to take the word acknowledgment out of the objective and we're going to ask for guidance in our discussion with the IE Workgroup relative to the development of establishing the denominator, that's an open item for us. And we're going to also as we talk with them, make the assumption that acknowledgement received, all that is a part of system function and the real intent of this is to make the completion of the work the proof that it was actually done, so I think that's where we ended up. And it's inclusive of all EPs and hopefully therefore extends both to public health providers and those studies and that type of thing. And we're still open relative to what our threshold is relative to our discussion with the IE Workgroup. That's – is that it? Okay. Next one. I think we have a referral from – I think we have an input from, actually the Standards Workgroup. Next slide. Okay, so I think we left open the time window to respond to the last request, some results critical, otherwise it's minimally useful. So, I think we recognize the fact that there can be referrals from multiple orders. And so we need to leave the flexibility there, that when they...we've got to put it in their hands, when they complete the workflow or the test is back, we can't make it visit dependent or anything, we'll have to have that discussion when we have the denominator discussion. Any other comments on this slide?

Okay. Next slide. Okay, so this is actually one that the IE Workgroup actually brought forward and recommended, and this is an EH or a critical access hospital requirement. It's a new one, but it's...the old requirement that when there is a significant healthcare event, and there's some question about what that is, and they had defined 5 of them in their definition. So I think that they have got arrival in the emergency department, admission to a hospital, discharge from an ED or hospital, or death. That's 4 of them, and if they need us to clarify those, we'll do that. But it was to send just a simple notification in a timely manner to "key members of the patient care team." And again, we were trying to be real flexible and recognizing that it's going to potentially require patient consent. So again, there are a lot of caveats here relative to including all of those measures. We recognized – just put 10 percent there because, and we gave it a requirement of two hours, that it happened. But we used a very low threshold because again in this case, our intent is to get that infrastructure set up for this process, because, I know people actually in the field are actually using this process, and it's been deemed valuable. Any comments or questions on that? All right.

Next slide. So again, this is all about communication. Okay, so the comments. Some comments thought a 2-hour window was too short and selected lengthening the time frame. And I thought that there were – it might be too burdensome, there just may be cases that, again, we kept the threshold really low, but again, there's a lot of pushback that two hours may not be realistic. I'm definitely open to that, I think it's – again, I think what Larry says, we're just trying to get this piece based into the process is really what we're trying to do. And what we're trying to do is that there's a notification that goes back to patients here, in appropriate cases. So, we're trying to get the infrastructure in place, that's the intention of this one. Any comments on that, the timeframe? Thoughts?

George Hripcsak, MD, MS, FACMI – Columbia University

I'm okay with four hours instead of two. Although if we're thinking that this is going to be hard and two hours is too short, I'm not sure why we're also increase – I wouldn't increase the threshold then. The two recommendations, this one and the next one, seem opposite.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Charlene?

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

Yes.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Yeah, this is Marty.

W

Hi Marty.

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

Yeah you live this, so what do you recommend?

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

How does this notification occur?

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

Okay. So when a – I would think it would probably be a process, I'll make this up. But I know some systems have this in place today, and I think there are some gaps here in care, when the patient's admitted to the emergency room, or one of these events come up, that the system knows that this is a significant event, so we know that this is a significant event. And you would be prompted to say, do you want to communicate the even to a caregiver, right, and if so, who would that be? And then notification, again, we had a dependency on infrastructure here; we would be able to send that information via email to the primary care physician and/or the caregiver. So it either implies that we've got that information stored in our system and/or there's an IHE in town that you can send it to and it routes it to that appropriate system. So ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

So today – this is Leslie. So today, we're, in the ED or in the hospital, you're asked if you have a primary caregiver and if you want your records shared. And so today, that might go by FAX or it might be sent inside a closed system. That's one part of it. And then the other of notify is having a system that has the capability to see that his ADT has been an admit, discharge or transfer has been done at the hospital and that that sends out an alert function automatically to the eligible provider who's on the care team list, so it goes out. They're doing this at Rhode Island, out of the health data exchange and many, many hospitals have the ability to send an alert. So I think we need to just expand on that idea. So it's detect and notify, as well as send a copy of the record once that discharge takes place.

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

Well, I think this was just – the notification I think we just the alert piece, we weren't even thinking of sending the record yet, right. This was more timely than ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right. This is just the alert that says this has occurred.

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

Yeah.

M

If this has happened automatically, electronically, two hours is fine. If I have to intervene in some way to notify a practitioner, two hours is not nearly enough. You're providers are tied up in a busy – treating ER patients, they're not going to have time to go notify a provider.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

No, if you – you might get an alert in your inbox that says this patient has been admitted to the hospital, but not a, there's no anticipation of, there's no action item for you to take.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

That's assuming the provider is a meaningful user.

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

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Correct.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

What if they're not?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

They're not attesting and they're not part of the denominator.

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

Hey Marty, this is MacKenzie. We're just having some trouble hearing you, it sounds really, really quiet. So I don't know if you're on a speakerphone, if you could just move a little bit closer.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Okay, I'll move closer, sorry about that. Thanks.

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

The flow was a patient in a hospital, either is admitted to the emergency room or dies someplace in the hospital and it's simply an alert to some other person on the care team that this even happened. And so the question is, how – again we kind of wanted to leave it open how that process might happen. But the assumption was that this – either the fact – it could be, then we start to get it could be genera – it doesn't have information about, again, other systems will be, they were admitted for this purpose, I mean, people will get more sophisticated with this. But the intent was just that the event occurred and not to necessarily have to get any other data about it, was the intent of what we were trying to accomplish here. And then people can get wiser and smarter over time in terms of what they communicate, but just simply an alert that the event occurred. So the question was, if it's coming from – again, I think it could come from an admission to an emergency room, but if a patient dies, that's in there, too. So, is two hours ...?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

It would be at any admit, discharge or transfer, which includes death.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Yes, if only notifications to those providers who are meaningful users occur are counted in the denominator, I don't have a problem with it.

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

Well, it could go to, the way it's written, it could go to, of their care team. You won't know that. It's just going to – it's going to simply count that when you have one of these events, they'll be a percentage of those that you send out. So, you won't know if they got it, I mean, you'll have to put the infrastructure in place so that they can receive it though, so it's 10 percent.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And it could use a direct message, which is what they're going to do in Rhode Island.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. And I don't think we need to qualify anything about the receiver at this point, right?

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

No.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Then we send it.

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

We're just, the, so, we're still kind of wrestling with the question of the time period, we can extend it or do we drop the concept of a time period or do we say the function is that this will be – there are two pieces of this one. To what extent does it have to get patient – you've got a patient coming in the emergency room and you have to get patient consent that you send the alert, because that definitely slows things down on who you send it to, right?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Well the topic today is they ask who the members of the care team are by the patient at the admit.

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

So Kelly, what was your recommendation there? Leslie, I'm sorry.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think that we – I think that the infrastructure can be expanded pretty easily, if that's your concern.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So we could look at examples where this is happening today. I know of at least a couple of managed care organizations heading towards ACOs that are connected to an HIE. And when an admit is registered in the HIE for one of their – is communicated to an HIE for one of their patients, there's logic in the HIE that notifies them that one of their patients has been admitted to an ED or has been admitted to a hospital or has been seen by another provider.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah and ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

But it's all automation in the infrastructure. The providers themselves are not specifically choosing to send a notification.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

It's automatic, but it's one of the big things that any organization that's going in an ACO wants, because they don't have a way to intervene when a patient is at a different facility otherwise, they don't know it exists.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, so I guess what I'm saying is I don't know that this is sort of a cognitive burden activity for the providers. I think this is built into the registration process or built in to the discharge, into the technology of the registration, the technology of the discharge.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right, we're just asking them to attest that they're doing it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And presumably their systems have the stats and they can say, yes, we did notify for these admissions or we did notify for these discharges.

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

Right. And therefore, do we want to leave that two-hour period in place then? Or do we expand it to four hours? That's kind of what I'm hearing is maybe we just expand it to four hours.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah, I think it's fine to expand to four hours. I think, again, if this is actually baked into the infrastructure, it's going to all depend on knowing who to notify ...

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

Yeah, I agree.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

... and, and/or sort of contracting it to a third party, who's doing this on your behalf.

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

Yes. And then I think like for purposes of – again, if it's baked into the infrastructure, it would strike me that for at least purposes of what we're trying to get done, 10 percent, it's maybe too low, but because this is a new piece of the infrastructure, we just kind of need to leave it there, right, and once it's baked in, it'll happen, right.

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

If I ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It'll happen.

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

I agree with the 10.

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

And then concern about the privacy implications and the patient role in consent, I mean, won't the process that we want baked in is, when the patient gets registered, you find out who their care team members are, you – someplace you're going to have to define consent in your process, right? You're not going to document consent in your system, or do you have to document consent in your system? I don't think...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

You don't have to, it's already – you're asking the patient who their care team is, or the doctor is and who do they want their information sent to, and that's already built into the process of registration.

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

All right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We're going to need some narrative to explain this to folks.

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

Yes, we're going to have to. And then significantly in the previous slide, I think we had defined four categories of significant events, and I think we need to just make sure that we're aligned with the IE Workgroup in terms of those definitions. I know they originally recommended five, but we just need to get clarity and just to clarify those events with the IE Workgroup. Michelle, do you have that? Because I know they had categorized them.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

All right, so we'll just nail that. And then again, I think the last point that's open here is this inefficient technology infrastructure to support this measure. I feel – we're trying to do with this measure is to call the question of that. So, this may end up a menu item rather than a core item for that purpose, but where they can do it, we want to get this infrastructure in place. So we might have to make it core, because it's just not all over the place or menu. Thoughts on that?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think if we want this to be standards based, then we – I don't remember what the standards guy said, is what are we leveraging for notification technology.

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

Right. So again, I think Michelle, the question we'd want with the IE Workgroup is clarification on that, what assumptions should we make? Because I think what we're trying to do with this particular measure, which I support, is pushing getting the infrastructure in place. Not make it a burden on hospitals and just take the current process and make an automated through whatever HIE infrastructure has evolved by then. We just want it to be an add-on. Any other comments on that?

So we changed it to four hours, we left it at 10 percent, we need to describe the fact of the privacy implications for the patient role in consent as we this as an automated process where defining whom the patient will communicate to and getting permission will be part of that registration process. We're going to clarify significant with the IE Workgroup, I think they're defined under the certification criteria, but we might have to pull that – meaningful use. And we want to discuss with them what they mean by this inefficient technology infrastructure, and what that means to us in Stage 3. And I don't think we'll know yet, but. Any other comments?

Okay. Next slide. Okay, so this was the inpatient admission, so, Michelle, go back two slides. I thought we defined these. I know in the original work, I don't have them in front of me, okay, it says, we specified arrival in the emergency department, admission to a hospital, discharge from an ED or a hospital or death. And again, I think this, with some overlap, when you do a discharge from a hospital, do you also do a notification as well as the transition of care summary, so there could be some overlap there, I guess. We have four significant events defined. So, we just want to clarify those with the IE Workgroup. I know we changed this to be four hours. Okay. All right. Leslie, you said on the transfer, so that might get included, we just have to clarify if we want transfers included, okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I meant internal transfers, I'm sorry, I'm under the internal transfer in the hospital, I get transferred into rehab or I get transferred from ICU down, or up. So the notifications were admit, discharge and internal transfers inside the hospital.

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

That's what we've got to talk about. And you know what, to get feedback of the providers wanting opt in and opt out of this on the other side of it.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Right.

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

It's always complex, you need these two sides working together. They want to know which ones, the provider wants to know, which, of these, which ones do they want to be notified of, on the other side of it, right.

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

I'm not sure.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And sometimes that's based on risk, right. If I'm in an ACO and this patient's being admitted in the ED, I want to know if they're being held for observation or they're being transferred to the ICU versus transferred to the short stay unit.

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

Okay.

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

Yeah, but I don't – I mean, this is George. I think we may bog down this new objective if we start putting transfers, because some transfers yes, some no, I mean sometimes more important than a transfer is whether I'm going to have a surgery, right, or whether I'm going to be on some medication, or whether I'm having a chest tube placed. There's an endless list of things that I might want to know, but I don't want to be sending out a barrage of notifications. So, I would really stick with the big ones like admit, discharge, ED visit.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah. I agree with you, I think the market will, as I think someone said earlier, once you put the infrastructure down, it'll go beyond that.

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

Yeah, people will get ... to what ...

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yeah, I need ...

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

And we need the other side of it to, so they can select in and out, so we're not defining that, so, what's important to them. So, we're just getting the one piece in. Okay. Next slide. Let's see where we're at, what's the next one after this one please. We're done with that. Done. Okay, we can – this was one that was kind of added late in the process. This is part of med reconciliation. So let's kind of start with this one because we're going to come back to med reconciliation. Create the ability to accept a data feed from a PBM to receive external medication fill history for medication adherence monitoring. So I know some systems do that today, right. Was this for EPs and EHs, or just EHs, do you know that Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

I think it was for both.

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

So we need clarification. Yeah. And then there were some additional req – so this is proposed for a future stage, okay, so this really – so, let's look at the comments on this one. And again, we certainly see the – streamline access to prescription monitoring. This is really starting to actually get into some of the drug management. So this was kind of a future stage, it's not a Stage – this is not Stage 3, right?

Michelle Consolazio Nelson – Office of the National Coordinator

This is all future stage.

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

Okay. Next slide. I'm not sure we need to – we'll just look at the next, the comments and think about them.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So you're right, so this is focused on feedback from PBMs, but it could come from the pharmacies, right?

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

Yeah, I think they're just trying ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We're making a process.

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

... source of getting a complete medication list, right? And the PBMs are one source of that, and they have to reconcile that in. So why don't we just, as we go back through med reconciliation, which is kind of, we'll talk about that on the next call. I don't think we should exclude data coming in from multiple sources, but again, they added some additional requirements where we've got to be smart about what that data is and what the implications might be.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well and there's a dollar cost in here as well.

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

Yeah, there is a dollar.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

The PBMs typically charge for supplying this data and they charge the pharmacies for processing the messages on the fill side, but they're billing for that.

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

You're – yeah, I've talked to doctors and they don't do it, because of the charge. It's not that they don't want to close the loop, but they just don't do it, because of the cost.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

However, the cost that we have right now, at least at the eligible hospital of reconciling the brown bag at the emergency room and then the lack of knowledge of what's happening outside the hospital. I think it's just – there are huge cost in the system, so maybe this is something where we look at it as an eligible hospital requirement first, because they are getting the burden of the cost of just simply trying to find out what the drugs are. And they have the burden of risk when a drug is selected that's not part of the formulary as the payer dictates.

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

Yup. Okay. So let's keep this under consideration, it might be EH only to start, we might want to look at it as part of the med reconciliation process. This would be something again; I think the IE Workgroup might be able to comment on. Is there another slide on it from standards? Let's see what standards says.

Support of – oh, they want to move it to Stage 3. Okay, well let's keep open-minded on this one, and we could restrict it maybe just to EH, too. But we have to – next slide. Okay, so that's, HITSC said, helpful tools, but should not be mandated. It doesn't seem like this was the problem we were solving though, we were trying to help with the reconciliation process to get a complete list of medications, I thought what we were trying to solve was that one. And again, they wanted to – this supports some of the clinical decision support around it, right. Okay, so we're going to leave it as a future stage, but as we move through the med reconciliation discussion, we're just going to potentially keep it on the table for EHS, but what we really care is just the infrastructure to do that is in place.

Okay, so we're close to the witching hour. Michelle, I think we had one more, which was – is it interdisciplinary problem list? And again, I think we could merge – we could put that on the table when we discuss care plans, care summary and reconciliation. Okay, we'll put that one on that schedule.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

All right.

Michelle Consolazio Nelson – Office of the National Coordinator

I'm sorry; I was muted when I said it before. This is for a future stage as well, too. So, yeah, we'll put it – we'll move it though.

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

Right. Because again, we've got a coup – we've got two future stage ones and you would think there's potential overlap, in my view, of this one with the shared care plan, right, because you've got to have an interdisciplinary problem list to have a shared care plan. So I kind of made that assumption, I didn't think it was a carve-out item. But maybe we have to carve it out so it can be the basis of a shared care plan. So, anyway, I was – all right. So, the next call is May 24. I think we keep that one and we invite the IE Workgroup to join us and we talk about notification and referral, the notification and referral loop, and if they can bring some content to the table relative to the current state of the work, if they've got any input on the PBM connection, that would be great. So I think we leave that one in place and then maybe if Paul's available for the following call, we do the reconciliation and the care plan piece. So Michelle, you're just going ...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Paul was May 8, to May 24, did you mean May 8?

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

So Charlene, I will follow up with you offline, I just want to, because there are a few other pieces that I want to make sure we have together, so ...

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

That's fine.

Michelle Consolazio Nelson – Office of the National Coordinator

I'll send you an email.

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

Yes, so see when Paul's available. But I think we can go ahead with the IE Workgroup and work through what we did today as a step, if Paul's not available. And then we'll just have to find out when he's available to go through those other pieces.

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

Program Lead

Are we ready to open line for public comment Charlene?

Public Comment

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

Program Lead

Okay, operator, can you please open the line?

Rebecca Armendariz – Altarum Institute

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

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

Program Lead

Okay.

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

I guess our meeting is adjourned and thank you everyone.

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

Program Lead

Thanks everybody.