

**HIT Policy Committee
Meaningful Use Workgroup
Subgroup #3: Improving Care Coordination
and Information Exchange Workgroup
Transcript
May 24, 2013**

Presentation

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

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

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

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

Thanks Charlene. David Bates? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Thanks Leslie. Marc Overhage? Paul Tang?

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

Here.

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

Thanks Paul. Larry Wolf?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Here.

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

Thanks Larry. From the IE Workgroup we have Larry Garber. Larry is here. And David Kendrick?

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

Yup, yup.

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

Okay, great. Any other IE Workgroup members on the line? Okay. That was a weird echo. Meaningful Use Workgroup members, we have George Hripcsak?

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

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

Thanks George. Any other workgroup members? And any ONC staff members on the line.

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

Michelle Consolazio Nelson.

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

Thanks Michelle. Okay, with that, I'll turn the agenda back to you Charlene. Are you logged in?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
I am logged in.

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

Okay. Perfect.

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

Okay, great. Next slide please. Okay, just – Paul, I want to welcome you to our call, we have had two calls of this workgroup and I'll review some of the content from our last call. I'll also do just a little bit of leveling the field as we get started. So if you could, next slide. So just as a little bit of backup for this call, again, this has been an ongoing workgroup and we started out with a vision where we would really – moving toward a model of more collaborative shared care. But we also recognized in that process, that we had to make that a stepwise process, to facilitate that happening in the future.

So, that said, we spent, in our last call, we had the IE Workgroup join us and we spent some time actually reviewing the feedback from the referral workgroup as well as notification. And in that workgroup, the IE Workgroup presented some of their work that they had done in the analysis of transitions of care in support of care coordination. And so I'll just touch on a couple of those comments, for some clarity. Today the focus of the call is going to be on continuing our discussion around the care summary objective, as well as the care plan. If we get to reconciliation, the intent is to get to reconciliation, again, just as a reminder, our focus has been on really trying to bring forward three key capabilities in coordination. One of those is the ability to communicate what's happening. Again, lots of gaps in care occur because there's a lack of communication of the current patient status, etcetera. Second is the ability for robust reconciliation when information is shared and the third is the ability to track care over the continuum. So those three elements are key in our thinking about this particular capability.

So, with that, I'm just going to touch on a couple of the framing topics from our last call and then I'm going to move on to actually reviewing the detailed content of the care summary. Next slide please. Oh and on that lastly, we have one more call scheduled for June 4 and I think, is there a report out Paul to the Policy Workgroup in June or not?

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

No.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
No. So what is our target date for the final – for the report out on this again?

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

So, well –

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

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Go ahead.

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

The June meeting, sorry Paul, the June Meaningful Use Workgroup meeting, I think – I'm just looking up the date, I think it's the week of the 10th, so the week following your meeting on June 4.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Okay. All right. Okay. So we are – so it would be June 10 then, right, would be the report out of this workgroup.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
I think I have the 12th – Wednesday.

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

Yup. Thank you George.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Okay. All right. And again, David you're on the call, Larry – is Larry on the call?

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

Yes.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Okay. So I do want to commend the work of the IE Workgroup in thinking through the various use cases in support of longitudinal care coordination. I'm going to touch on a few of the slides, but then I'll stop and add a few – ask if you want to add any additional input to that. But I just wanted to frame where we were last week, just to get us all on the same page. Okay. I didn't pull all the slides and I consolidated a little. Next slide please.

Again, what this slide again depicts is the work of the workgroup to look at the need for longitudinal care coordination based on pretty extensive research. And again, this is just for framing. Again, one of the items that we identified the last time that we spoke was the need for an understanding of the respective data elements that we are starting to share as we build a more robust infrastructure to support care across these transitions. So again, this picture depicts again the current status of the CCD data elements, not all of them certainly standardized at this point, in fact, a small set, as well as those need for the various types of basic transition needs as well as more robust transition needs. And I'll reflect on those a little bit more in the next slide. The good news is that many of these data elements can be mapped to current constructs; however, there are also some that are missing. Next slide please.

Twenty percent have no appropriate construct. A key step in the process of understanding care transition is the development of use cases and what this work did was, as it looked at the data sets, it looked at the various – and this is the real strong piece. Again, there's a lot of different use cases in there, office visits to EDs, dah, dah, dah, referrals to consultants, and again, more site-specific transitions of care. And again, what this work did was looked at how each of these key data sets could support these various transitions, again trying to normalize it a little bit, so we can use, if you will, a shared document type to handle multiple types of transitions. Again, filling that document type with the appropriate data for each of those transition types. There are five that were looked at and the three that we were focused on – the group focused on were the last three, looking at the data necessary for the shared care encounter summaries as well as consultation requests. Again, when you respond to a consultation, there's information you provide back and lastly, the more robust site transitions of care, when you're moving patients from facility to facility, for more robust care in each of those cases. Next slide please.

So what this slide depicts then was the three cases that were focused on and the representative data sets, again where it shows there is continuity among those data sets as you move and as different levels – different amounts of data elements, to support each of those types of transitions. And that aligns certainly with what we're trying to do in Meaningful Use is incrementally add to the data that we're sharing to support the practice of care. And there's also depiction of an overlap of the care plan and the associated data that's contained in the care plan. And, I don't – I think that's what this – maybe this is on the next slide. Yeah, it's on the next slide. So again, there's a reflection in this particular case is the data in the care plan is kind of still considered to be, if you will, a separate document type concept here, but a separate use case. Next slide please.

That – actually, back up. I was – so again, this just again reflected the corresponding scenarios, the – really just kind of visits that kind of associated to each data set. Again it's the kind of visits or the kind of referrals or the kinds of activities, the transitions that actually were supported by each set of data. Next slide please.

And then, the also positive news here is one of the key requirements, in terms of meaningful use, and accepting new requirements as we look at trying to define the types of meaningful use requirements is again, the status of the standards that are able to support that. And again, this pretty robust effort on the part of the community to put the requirements and standards in place to support care coordination. And so this just reflects the activities. Again, there's testing of those concepts actually in practice, as well as there are updates to the HL7 standards to be able to support the definition of the data required as well as the use cases – and so this, by the particular standard. So, this slide just depicts the current timeline where by the end of 2013, the intention is to go to a ballot publication, and this just reflects the ballot is intended to address updates to the continuity of care document as well as a new referral – a new transfer summary and a new care plan type document. So, it's a pretty aggressive schedule, but that's the current plan for the definition of standards. And again, we will just have to track how that process proceeds.

So, I just wanted to stop, just for a moment before I move to our – the actually walking through the content of – the content and feedback that we received from public comment, to ask if David or Larry wanted to clarify or add any additional comments.

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

This is Larry. That was a great job. The only thing that I would add is that as part of the opening of the Consolidated CDA to add these new document types and to update the consult note, the other thing that's happening is the ability to add a digital signature. That's something that's also going to be incorporated into the September ballot cycle for HL7. And the importance of that was to support the home health plan of care, the CMS-45, so that digital signatures could be attached by the physician, as well as electronic signatures. So basically the ability to support both of those.

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

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And can I add to that, this is Leslie. We also have in the same approval with the – in the Consolidated CDA the first attempt on patient-generated health data. So we have all of these things coming forward in harmonization and I think that it's been really great work.

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

So Leslie, where's the update of patient-generated health data going to – put?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's going to be in the same timeline in that it's part of the Consolidated CDA ballot coming forward. So –

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

Oh it's – number 1.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah.

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

Okay. All right. I'm not quite sure what to do with that, but I'll let the other workgroup think about that.

Okay. And the reason this is important is in our last call we talked about – we're really trying to track referrals and the fact that we're actually creating a standard to send back the referral note. We've always looked at the activity of actually creating the response as what we want to measure. I think that's important to our thinking about how we – about our referral objective. All right, next slide please.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Hi, it's Larry Wolf, just want to jump in with my sense from our last call, when we reviewed this.

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

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Which is, as part of our go forward work, and I'm not proposing we do this today, I just want to make sure it's in our work plan, is that we should reconcile the language around these five use cases that Larry Garber's group has developed with the existing Stage 1, Stage 2 language that the rest of the world has gotten used to using. Because I think that this model that we're putting forward is really very clean, but since it's a new model, we've been using language that wasn't developed in the context of this model and we have, I think, some homework to do to help people through the transition.

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

Right. And you'll see I kind of put that note, I put consider on the next slide –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Oh, okay. Thank you.

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

I didn't do the work – I just – I said consider defining types of transition in terms that reference these data sets and corresponding use cases. So I started some thoughts there, but I didn't actually do the work. So I did that. The other item we had last week, which I started down the path doing, was a little bit of work on – thinking through the term, but that was a pretty big leap, so I kind of had to step back a little bit on that one. So, any other comments? So anyway, what I wanted to do, again, just to kind of review for this group, and again, what actually was said, what was the requirement that we put forward in our RFI for the care summary? I kind of just put some discussion topics down on the – in terms of preparing for our discussion today. But again, we'll kind of work through it.

So again, if we look at what the current objective is for Stage 2 again, it's again for transitions of patients from one setting of care to – or one's transition of care or referring a patient to another provider, to provide a summary care record for each transition or referral. So, as Larry said, in that case we were trying to define more broadly for transition of care, again, more of a site transition and/or a referral, and we kept that case separate because there's a little less data needed in that case, and that's kind of how we structured our Stage 2 objective. And then, we had measures where, in this particular case, we asked for, in those cases where there's a transition or a referral from one setting to another, we wanted a summary of care record sent 50% of the time, and then we wanted that sent 10% of the time in electronic form. And we were flexible in terms of whether that was sent directly or through an NwHIN exchange., again recognizing that both those kinds of facilities to exchange data.

And then there were some additional requirements that there was – you had to satisfy the definition of an electronic exchange of a summary document, one or more for eligible hospitals, as well as for – let's go back. So number 3, again, this gets really complex. You must satisfy criteria where you conduct one or more successful electronic exchanges so that – of at least one document, as well as the eligible hospital can measure. Okay, forget that one. That's too complex to talk about here, unless Michelle you want to explain that one. But I don't think it's as pertinent today, we can try and move on. These are the challenges of this workgroup.

So basically that was where we started for objective 3, for Stage 3, here's how we thought about it. Again, we used the same paradigm of site transitions as well as referrals and then we looked at the addition of four additional data elements – types of data, for these transitions based on the feedback that we received. And again, we broke out the concept of transitions of site of care as well as referrals. And again, we also said – we also reflected that again there's going to be variations in these transitions and there's going to be appropriate data that's sent for each type of those transitions. So the 4 data elements that we asked for were concise narrative in support of care transition, and again, in this place we were trying to provide for the case where again, there's the intention of the transition that's communicated. And we were really clear, we wanted this to be free text so that it would be possible for providers again to make that transition information specific to the transition was happening. We accepted the fact we could not predict everything and every use case out there. So we said, okay, put this free text field in there.

And then we also put placehol – we also asked for the definition of setting specific goals, what are the goals for this transition, instructions of care during the transition and 48 hours afterwards, as well as a definition of the care team members. Again, one of the elements that was added was using the DECAF standard as defining these care team members, as the requirement. And then in this particular case, and we talked a lot about it, we actually increased the number of – we increased the measure to 65 of transitions with – being done, that the summary had to be provided and then 30% electronically. And then there are some pretty specific certification criteria that were also added to support this. And criteria one was the ability for that concise narrative, number two was the ability to populate a referral form from the data that was included in the electronic health record, including a referral to a smoking quit line. And then number three was actually inclusion of the data sets that were being worked on by the SI Longitudinal Care Coordination Workgroup. So again, those were three of the criteria that were added.

Specifically the consultation request that we just looked at, as well as the larger transfer of care document. So again, it was a pretty significant ask because of the amount of data that we're talking about sharing kind of in the time frame.

So anyway, as a next step I just – is there any – we had really – I actually just want to open this up for some feedback. We had identified some specific talking points in terms of looking at the – number 2, 3 and 4 and maybe consider these concepts, whether we should say they can be free text or if they need to be coded. We did kind of question DECAF reference a little bit, because we're actually specifying a standard here, where that's really the domain space of the Standards Committee. So, I just want to kind of open the current state of 303 kind of open for discussion at this point.

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

This is Larry Garber and I do want to point out that we've discovered, which is no surprise, is that a lot of these do not have well established standard vocabularies, and so I think we would – we really do need to permit free text for much of these new data elements, certainly at this phase.

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

This is Paul. My guess is the same, I'd probably second that and say, it probably applies to all 4. We don't even really have a way of transmitting TCP, except for NPI, for example. But at any rate, so I think right now these are just placeholders for content that is useful during transitions and we're just asking them to start the process of making sure that the fields for this are defined in EHR systems, so when one asks another, they would get the free text field. Is that – that's the assumption.

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

Yes.

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

Prob – if that is, then we ought to, just to try to reduce the angst, put that in paren, which it would be free text.

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

Right. We're trying to make sure there are buckets to put everything and to encourage them to be populated when they're important. But, I think to ask that they be codified with a specific vocabulary and terms at this point, I agree is not – is probably unreasonable and excessive angst will be caused.

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

So if we just make it explicit, like a paren (free text), that would help reduce the questions and angst.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So this is Larry Wolf and it seems like, I don't want to get us off of, yes, let's move forward and we should allow free text here, but there's been a fair amount of discussion about the need for and possible approaches to provider directories. And so it would be great if somewhere in our recommendations out of this effort we could highlight the importance of that work and indicate this would be a place it could be used.

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

Absolutely. Yeah. So, we'll put – I don't know where we put that, but –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It could also be – this is Leslie. And I think building on that, the work is being done in the direct standard I think for this, provider directory, so we could also build on that standard for care coordination.

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

You raised the question, Charlene, about DECAF. I don't know that the DECAF is a well understood – there may be some standard behind that terminology, but if providers don't understand that it won't be populated correctly, so, this might – as you said, this is probably something not for us to say in policy point of view.

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

Right. So, if we can – we'll just – the recommendation is just remove its reference at this point –

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

Yeah.

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

– and put free text, we put, you can use – permissible to use free text, right, so we would just change that. So, number 4, we would remove the reference to DECAF and we would just say free text permissible.

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

Well for all of them free text is permissible.

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

Yup, for all of them.

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

We might in our preamble describe – refer to what Larry brought up, the NPI, but that's something that ONC can decide in its certification process, the Standards Committee can incorporate it and ONC can include that in their certification process.

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

This is George. For some of these, the long-term goal is coding, but for others, the goal is always free text. So care team members, of course I'm going to want to use provider – uniquely identify the provider, I'm talking about, although the caregiver, I don't know that I'll ever have that in codified form. But I'm thinking like the goal I'm going to want in the distant future when we have coding standards, yes I want like a problem list encoding, but I also want some sentences that say what the patient's goals are. So I'm always going to want – so I don't want to phrase it that it will be free text until we have standards, there are some of these fields that will always have free text, in addition to the coding perhaps.

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

Right – want it and/or, right?

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

Well, I'm saying for now, at least free text, that's what I'm saying, but in the future it'll pro – some of these fields would be both free text and the coding, like the first two. Well, it depends, I don't know, I have to think about it.

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

Well just to be clear, the Consolidated CDA or any CDA templates are designed such that even if you have coded data, there's also associated human-readable free text that's generated from it. So there will always be, just by using a CDA, there will always be human-readable free text. So I think the key thing is to say that free text is permissible, but not at all, number one, I don't think you have to say that its required because it's just inherent in the CDA that it'll be there.

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

Okay. All right. Then the other point, and maybe we can just – one of the feedbacks that we get consistently, and you'll see that in the comments that follow, is can you define transitions. So, just that comes to Larry's point that getting – first of all, defining transitions in terms of being able to know what they are so they can be measured and be in the denominator is always a challenge, but we get consistently can you define transition? So, I took a shot at kind – because we're policy I didn't want to say – I'm trying to use words that relate to what we're trying to manage.

So, I just, and I'm trying to come up with, we call them site transitions and referrals in our definition and I was trying to just come up with some different nomenclature that kind of at a high level defined...would start to break down those types of transitions. And then we can refer to the specific one, so that was kind of this next concept, in terms of trying to step back a little bit and break down these transitions in terms of some of the use cases they're supporting, rather than list all the use cases, all these kinds of transitions, which maybe I need to do. I broke them down to three categories. So, any comments on that thought process in terms of moving – I'm trying to move our objectives from these site transitions and referral concepts to maybe a breakdown of three types of transitions we're talking about. It's more – go ahead.

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

I think two of them make sense to clinicians, consultation requests and transfer of care. I don't know that shared encounter summary is as easy to understand.

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

And so I just called it transitions, I didn't know what else to call that. So, we could do a consult request rather than referral request. That's good. And transfer of the care, but what do I call this other category, which is office visit to PHR, consultant, to PC, ED to PC, I don't know, this – that level. Again, it's not as robust of a data set.

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

Well office visit to PHR is not, I don't think it's the same thing here because that's part of –

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

I did –

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

– VDT. The other things, consultant to PCP is sort of part of closing the referral loop.

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

Yeah, but it's a subset of the data, it's less of the data.

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

So right now in the Consolidated CDA, it's called the consult note, and we thought that that worked, with the exception that the data set that we had also would be a way of reporting. What a – the office visit to PHR, I guess, was one of the cases we thought about where it sort of wasn't just a consult note, it was summary of a visit, where there's really not necessarily a transition.

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

Yah, that's covered under VDT though.

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

Yeah.

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

So maybe a consult note is the way to do it.

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

Yeah, maybe the consult –

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

Consult note is understood, of course, and then it's of the type results, right. I mean, you can consider that, and that's useful because results – results trigger other things and lack of results trigger other things. So those are – if we consider a consult request a “order,” then –

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

Yeah.

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

– a consult note is a “result,” and there's lots of benefits of those, I mean, they inherit the properties of order and results, which are good to use.

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

Um hmm.

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

So I –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think the re – this is Larry Wolf. I think the reason that Larry Garber's example, his use cases distinguish between the order/result piece and the sort of more robust what I would call consult piece, is that the order – he's separated the complexity of the information that you're communicating. So to do a lab test, you mostly just need the presence of the patient to obtain a specimen, you run the specimen through machines generally, sometimes humans have to view slides and things, and you get a very focused report, even if it's a narrative report from a pathologist, it's pretty focused. As opposed to, and the pathology report actually might bleed into the second case, which I guess is why some of this is great.

As opposed to, there's something unusual going on with this patient, PCP is asking for a specialist to look at it, they want to communicate some history. They want to communicate their thinking, they want to communicate some of the plans or actions they've already taken so that the consultation can happen in context, but not necessarily send the entire record. And then when they get back, the commentary from the consultant, they want more than a yeah, go ahead kind of response, right, they want support for their logic, they want insights that they didn't have, they want collaboration, whatever it is they're looking for. And so I think that there's an intention to try to create a distinction here.

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

But I think – this is George. I think we're confusing a label for a collection of fields with the title of the note. I think what you guys are saying, the IE group is saying that shared encounter – shared care encounter summary is just a collection of fields and there are several different kinds of documentation that would partake in that, including an office visit note, a consultation summary, which is the referral back from the transition. But that, we don't want to call it a shared care encounter summary to the clinicians, they won't know what that is, that just defines what fields will be in each of those notes and they happen to be very similar so we lump them together. Isn't that how it's working?

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

Yes.

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

That's exactly right. And that's why I think – since 90% of the use case is actually the consult note; I'd be fine with calling it the consult note and recognizing that it can also be used for other purposes. I just think it's immediately understood when you say that.

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

Exactly right. So I get the fact that it's very different from other types of like lab results, but the nice part of calling it another kind of result is the rest of the infrastructure we're building – it can take advantage of the rest of the infrastructure we're building. Everything from tracking, because we're tracking procedure results and this is just a type of proce – we're tracking results, when are they going out, what's the turnaround time for them getting acted on. What's the turnaround time for them getting acknowledged and sent to the patient? There's all kinds of infrastructure that's built in for that. If we include this in that, then we can measure all those things, and that helps us with the "close the loop" measurement and measure. See what I'm saying.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah. This is Larry. So I guess what I'm hearing is on the workflow side, they're very, very similar; on the content side, they are some probably important differences.

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

But that's okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, yeah, yeah.

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

It can be fine with differences.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah. So what we're saying is the – if you will, the payload of the message is different but the –

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

Right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

– some of the structure is going to be the same; maybe all the structure's going to be the same.

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

Well and the time – the metrics that we're building around that, which are important to both the clinician and the patients, we re-leverage.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yup.

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

Okay, so are we – in terms of the types, again, I'm trying not to put the standard in the requirement, but do we say – are we agreed it's consult note, consult request and transfers of care?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

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

– as the 3 types we want to categorize here.

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

That sounds great.

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

Okay. Let's leave that kind of as our go-forward and then look at all the comments that we have and make sure they hold.

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

Let me get – let me figure out whether consult note, which is well understood, but you couldn't put ED to PCP in that bucket and people would easily understand that. Is there another term –

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

Right. That was – I struggled with –

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

Is there another adjective to note that we could lump consult note in? It's – I mean, okay, I'll throw out one but it – I'm not sure that works either, like transfer note – that doesn't – it's not – maybe there's a bucket and we list all these things, consult note, ER note –

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

Well maybe I could call them transfer notes and then list them or something, right.

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

That's what I was suggesting, as long as we do list them so that we – so that people understand.

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

I mean, this would be hugely valuable for people to understand because there's a lot of confusion. So transfer note and then list the kinds of notes, consult note, ED note that type of thing?

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

But the problem with a transfer note, the term transfer implies sort of a hand-off, it's sort of a one-way –

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

Yeah.

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

– I’m transferring the patient, and that’s really why we have the transfer of care – whereas these are really shared care, in other words, the patient still was owned by both these people, the consultant or the emergency room along with the PCP, and that – so there’s no transfer. The note’s being transferred but the patient isn’t being transferred, per se.

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

Right.

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

And that’s where we came up with this shared care encounter summary, as much as it’s being maligned, it actually is exactly what it was.

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

This is Amy, and I joined a little late, I’m sorry. But what about either assessments, maybe that doesn’t connote a result information, but when you go – in all these cases you are doing an assessment and giving feedback or just report.

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

Well you know, let me – so consult note, everybody understands a consult note. So let’s figure out what’s not covered. Actually, ED to PCP could either be considered a consultation request or a transfer of care, so the ED is transferring back to PCP or it’s their consultation notes.

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

Well the vast majority of the patients that go to the ED are intended to be coming back home, it’s just 15% or whatever that actually end up staying there, so, from my perspective, it’s always been that when someone goes to the emergency room, it’s really just that they’re being evaluated because they’re sicker than average.

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

Right. Which is why a “consult note,” as long as we list it. So if consult note people can get it, as long as when they see the paren (ED to PCP), oh, I get that, and they’re considering that a consult. We just need to help people understand what we mean by these terms. If consult note is just much more comfortable, which it can be, then we just make sure other things that are like consult notes are included for the purpose of definition and certification, etcetera.

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

Agreed.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And this is Leslie, and I think that term is good because it can work for whether the patient’s generating it or the physician. I mean, it would look forward for future use of this document that would be patient generated. Are we going to just leave that for a later time?

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

I think patient generated notes are going to have their own document type.

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

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay. And not be a part of the shared care plan?

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

Well, there will be a specific – I believe there – my understanding from the discussions right now for the Consolidated CDA is that they're making a new header and thus presumably new body for a CDA document that's generated by patients. Because there's so much – it's important to note where the information came from when it came from a patient versus from a provider, and so that it will be within the Consolidated CDA, but it'll have its own, so say its own document type, I think, in the end. It'll be reusing template –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think it'll be document templates underneath the common header, which has been constrained, but we don't need to get into that now. I think we're fine, I think, but think.

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

Okay. So I think we are – for this we're going to use for where I've got transitions listed, we're going to use consult note and list the different types and see if that holds. I had referral requests, but we want to make those consultation requests, is that what you want to use, and transfers of care.

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

I'm good with either, in terms of the referral or a consultation. Referral does have this connotation of getting insurance permission, so maybe consultation request is a better term.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, I'll echo that on the hospital side. Whenever we've used referral in the past, we've had to distinguish it as an outpatient referral or an inpatient referral, because inpatient referral really is the initiating step in the transfer of care, so I think calling it consult request avoids that confusion.

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

Okay. So, if we're good with that we'll move on and I will make those two changes in terms of just – I'll figure out how to put those in the context of the objective, but we'll use those three categories to better define the transition of care concept. All right, we'll move forward and look at comments now. Next slide please.

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

Cons – what's category 1 labeled now, consult req – consult note, is that it?

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

Consult note we're going to leave it as, then consult request and transfers of care.

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

Right. Thanks.

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

Okay, again, just for framing. One of the items that we – from our last call was again an understanding of the current state of the data elements and one thing Paul reinforces again is that we're trying to not boil the ocean in terms of incrementally add those required fields. So this is just to kind of ground people, ground the team in terms of understanding the current state of Stage 2 care summary items. Again, dependent upon – those being fulfilled depended upon the knowledge of the caregiver in terms of knowing it or capturing it as part of the care processes. However, there are a list of fields at the bottom, again, that must be included in all summary care documents, which include the problem list, the medication list and the medication allergy list. And there is a requirement that they must verify these fields, and this is important, because we've had this conversation, for currency of that data and that they're not blank before they're actually exchanged. So there's a pretty deep requirement in there that their integrity is as good as it can be.

We do have some – what's listed in the right hand column again are the Stage 3 additions, family history, and I'll – Michelle, I'm going to let you walk that one because I think that was one that came out of the consolidation.

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

Yeah.

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

Another we had talked about was the inclusion of a pending referral or a pending consult, including the status of that, because that's coming from another workgroup, as well as the concept of this indication of advanced directives. So those are kind of open items for consideration, and then what we just listed was the four additions that we identified in the previous page. So, if you want to add clarity to the first three, what would be helpful.

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

Sure. So, in the consolidation work, originally the objective for high priority family history was consolidated into the care summary and view, download, transmit. During the last subgroup 1 meeting, though, it was decided to keep family history its own objective. So that being said, do you still want to include family history as an element within the care summary, not necessarily being required because it is an objective somewhere else.

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

Yeah, and again, these are – the struggle is we're trying – those predictors of the need for care is what we're trying to capture in that family history concept.

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

So I don't know if you want to talk about that one first, before moving –

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

Go through them all and we can come back to this. But again, I think they're just open items that we're going to have to resolve through this process.

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

Yeah. So as far as advanced directives goes, so there is – we're all planning a listening session and we're going to talk about that actually during the next full workgroup meeting next week. But the idea was that we wouldn't be removing the advanced directive objective, but an indication of if there was an advanced directive should be on the care summary. And then the next – I'm sorry, I skipped status of pending referrals. So that came from originally there was an objective proposed for Stage 3 that was for CPOE of referrals, and again in the consolidation work, it was decided that it should get consolidated here. I think that we resolved that by adding there is this reference on the other slide, there's a test tracking objective currently, but we talked about making that procedures and so referrals would be a procedure, so it – the order piece of it would get included into that objective. So again, the question is, do you want the status of the referral in the summary here, though. So, I know that's a little confusing, but hopefully people followed it.

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

Yeah.

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

This is David. Can you clarify it just real quickly again, the status of the referral included in –

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

So –

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

Okay. Go ahead Michelle.

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

Oh, I'm sorry Charlene. So the idea here would be that the status of the referral would get included in the care summary as an element, who they're being referred to, for example. Well actually, that's not right either. I don't know, Charlene, maybe you can speak to it better than I can explain it.

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

In terms of trying to track one of the requirements that had come up for – in the other workgroup around quality, was knowing when there's an overdue date for a specific – and again, it can be – it doesn't have to be every test, but like for, I'm looking for the results back from this microbiology test or whatever, this culture I'm running. And we said, we have that same need in terms of understanding the tracking around referrals. When I refer out and I'm looking back for my consult report to come back, I can put an overdue date in there so the provider can just know when either they're expected back and the systems can flag you that these that are overdue, the patient never did them, that type of thing, and they can better manage that. So, the request we were putting in place was the ability to be able to capture that and track that, it's just the regular part of process in terms of caring for patients under managing and improving quality.

So the question to this workgroup is, do we care about communicating on that shared summary about a referral request out with a due date. And it may be less pertinent in this case because we've kind of got a different approach to manage that process, we're kind of putting it back on the provider, if you will.

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

So this is David, I forgot to mention my name a minute ago. But that – so I was – this is the first, I mean to me, this is probably the most important thing to have on one of these forms is the current status. But I would hesitate to restrict it to just when do I expect something back. I mean, there are a lot of statuses that are important in a transition of any kind and I wonder is that in scope here or is – are we really limiting it just to the status of, okay, this is a tickler, so I'll be sure and look for this thing?

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

I think – this is Paul. I think this might be in the what steps do we want to take. This is a huge step we're taking, even here. And I think we don't know – to know what referral is pertinent to this care summary might get a little complex –

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

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

– put that – what are the things that should go with every one. And let's just start that process instead of, the more we add – when we add complexity, you really deter – there's a lot of resources on the vendors point of view, going towards that and the providers of having to specify it, then subsequently the providers having to enter that information in, potentially. So, I think if we focus in this major change for this document in Stage 3, on the core things that are going to fly everywhere and everybody understands. I think that's the most important, that everybody understands, we'll make better progress.

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

Yeah, this is David. I totally agree that we don't want put in the provider's lap the need to manually track a status here, but I thought I just heard it said that the CPOE of the referral was put into this – work list and – is that right.

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

I think the CPOE part was put into a different objective.

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

Oh is it?

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

It originally was a test tracking referral to kind of close the loop on tests, but we decided that we could change that to procedures as well, a referral being a procedure, so then we could get the tracking mechanism in place.

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

Okay, good.

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

It's a different objective.

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

I will be quiet. That's where it belongs, I agree.

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

Hello?

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

Are you on mute Charlene?

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

No, I'm sorry, my line dropped. I just got back on, so I'm sorry. So, where are we at? I'm sorry, I lost – Paul, you were making your comment about just focusing on those go-forward data elements that are consistent across most of the transitions and that's where I dropped.

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

Yeah, and I think David agreed that having it in the test – the procedure tracking would be appropriate.

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

Okay. All right. Next slide please. Okay, so Paul, one of the things you had asked for, and then Larry and David maybe you can add clarity. So what this is, and one of the questions, and I have not done all this mapping yet, because to find this stuff has been really hard for me, is to start and understand again, as we looked at what were those required fields as part of the current Stage 2 care summary, start to get an understanding of the trajectory around the addition of additional data fields in support of some of the other – of those three datasets that we're looking at. Again, the first being the shared encounter summary, the second being the referral note and the third being the transfers of care, because there are a significant amount of data elements. So this slide just reflected, in my understanding, the current status of the CDA relative to what fields are considered optional and what fields are considered required. And so I was using it kind of as a template to move forward with, so really this is to kind of ask the standards group, is there a different mechanism that we can actually start – this group – the request is that this group kind of understands at a little bit more of a granular level, the kinds of data that's required around the different datasets.

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

So, this is Larry. We're aware of this grid and while we're adding a lot more data elements to these documents, we're thinking that we're probably not going to add a lot more required fields in that. So for instance, while the consult note is going to probably stay with the same required fields, the consult request will probably have fields similar to the CCD and the transfer summary, that will probably have a few more required fields. But we're not – we don't want to expand it so much that people are going to say, oh my God, I can't possibly send this. So, we were leaning more on keeping it closer to the existing required and optionality that you see here, than starting to check everything off as required.

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

Okay. So, and then just to clarify for me, as I look at these different columns, again, they're reflective of different CDA types, is that how I read this?

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

So what this is, so the Consolidated CDA is a library of I think it's 9 or 11, I forgot the number, documents. And so each of those documents, one's the CCD, one's the consult note, one's the diagnostic imaging report, but each of those is a different document that's made up of a bunch of templates, and the template library is the Consolidated CDA template library. So there – it's sort of – so the Consolidated CDA is actually defining all these – each of these as different documents and within those documents it's telling you that that for the CCD it's required that you – that's the only document that requires that you put in allergies. Well, okay, I don't actually understand why allergies are listed there twice but – so, it's talking about the different template sections, which are what are listed on the left, and it's telling which ones are required to be populated. And so what happens is, in a lot of these that are required, but there are no allergies, they you have to specify no known allergies, or if there are no problems, you have to specify no problems. But each of these is a different document type and so we'll be building on 3 or 4 more document types to this list.

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

This is David. Can I ask a clarifying question?

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

Yes.

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

Sure.

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

If there's a – if it's blank, does that imply that it's not possible to put that data in that template or that it's always optional to have something in that slot in that template?

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

So these are in the Consolidated CDA, these are – all these documents are considered what they call "open documents," which means that you can always add another, any one of these sections, if you so choose. So, it's okay to always add one of these other sections. If you wanted to add a hospital course inside of a CCD, you could do that.

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

And so in that model then, does the – should all these cells just have O's in them then?

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

While technically that would be true, but when these were set up, the idea was to try to encourage people to focus on these, and so as a receiver, you focus on expecting these for the particular document types. But in technicality, yes, you could have put O's in everything.

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

Yeah. So O is –

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

And for that matter, technically you could have just had one document type.

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

Yeah, O is – say definitely if you've got it, put it here, but if you don't have it, you can go without it.

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

Right.

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

So, from the perspective of the vendors then does this basically mean that they have to – they're no longer focusing on documents, they're focusing on these sections. So when they take something in and they need to parse it and process it, they just need to recognize the section header and process it, whatever the document type is.

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

That's – it depends on how the vendor implemented it, but that's – that is the desire, that the right way to do this is to focus on the different sections and to recognize that if this section comes in, this is how I'm supposed to handle it. So that is the ideal way to do that, now whether every vendor did it that way, it's hard to know.

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

I got you. And then for presentation purposes, they would do a grouping like, this is a diagnostic imaging report, even though it has a bunch of other sections in it.

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

Right. And there's a – and all of these can be viewed with one, it's called a style sheet. There's a standard CDA style sheet that comes with the Consolidated CDA and no matter what sections you send, it can display it. And it actually is pretty nice, it actually has like a table of contents that you can click on and it jumps you to the right section of the document. So, it works remarkably well.

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

Right. My experience with the same thing in CCDs has been that the human-readable, that is the clickable, navigable sec – portion of the document is often done well, but the coded section is a disaster, usually –

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

Right

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

– and that seems to be where the vendors really fall down. So I just was curious.

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

Well hopefully Stage 2 will do a better job.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, this is Leslie and there's a great program out there a lot of people can test their Consolidated CDA and see how good it is, right up front. So, they tried to address that in MU2.

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

Is that a NIST – at NIST or where is that?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I believe that's under ONC – no, I'm sorry, it's under one of the certification tools and maybe we can get ONC to send us a link.

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

That would be great.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It is a test script that says, how good is your CDA, basically.

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

Can I ask a question on how do the Consolidated CDA sections relate to the data elements, the 483 data elements?

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

So, within each section, there are –

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

Okay.

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

– entry-level templates. So each section may have multiple subsections essentially, and so the 483 is – and the 175 are based on those subsections.

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

Okay. Thank you.

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

And just to be clear, some of those – a lot of those 483 can be represented in the existing subsections that are in here. But, that they are not constrained to be required or encouraged to be put in. So for instance, as an example, when you've got someone with congestive heart failure, we want the ejection fraction to be conveyed in the document, if it's known. And so there is a – there's always been a place to put ejection fraction, but it's never been encouraged to put that specifically in the case of some of the congestive heart failure; so those constraints are added to the definitions, and that's where some of these elements come from. Or if someone's on warfarin, you want to make sure that you're supplying the last 3 INR values. Again, you could always put an INR in, but you never – it was always just completely optional, now it's a should when someone's on warfarin.

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

And I – this is Charlene. I just have one – so in terms of what's expected, Consolidated CDA is kind of what the requirement is the vendors have to support and this matri..this table, if you will. But in terms of achieving Meaningful Use, is tha – are all of these data types required or note – CDA types required or is it just a subset of them? Do you know what that answer is?

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

I believe that you can send – I guess I'm not 100% sure. I guess I'm not sure.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well the language, so maybe Michelle can help us with the language – says where appropriate. So the structure of the Consolidated CDA allows for many fields, but there's optionality based upon clinical relevance.

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

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right but for vendor certification –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

For vendor certification, they have to do the Consolidated CDA header and, I believe, the – several of the templates defined by measure. Like, Michelle do you know the specific answer on that?

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

No, I'm sorry, I don't.

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

Okay, well, let me bring it back up. So what we're trying to do is just get a sense, kind of where Paul is, like, if we ask for the expansion of certification to cover those three document types. That's quite a few data elements that either people are going to have to capture and/or – I mean, and certainly putting down certification is one-step, but it's a big step, so we're trying to get our arms a little bit around that, in terms of understanding what the data requirements would look like, even if they're optional. Do we still want to pursue that course and if so, is there a better means of doing that?

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

I mean I can say that this is some of the work that's being done in the S&I Framework, I mean, over the next month, that's what we'll be working on. So I don't know if you want us to report back to you in a month or so or four to six weeks, to let you know what we've come up with. Basically we're analyzing the surveys that we had done through the Impact Project, my Impact Project up in Massachusetts, where we asked people, what is required when you receive a patient. So, we could give you some sort of evidence-based feedback and what we came up with.

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

Yeah, I – go ahead.

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

Part of what we want to assess for us is the level of adoption, a fresh – there's a lot of necessary but not sufficient kinds of things before we get into recommending a regulation essentially.

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

Yeah.

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

The clinicians have to understand what it is we're referring to, sort of has a little bit of that talk in the vernacular of consult note and things like that. So people have to understand it, people have to agree on the professional side that this is a good thing to transmit, require, whatever it is. Then there needs to be a standard that both humans and computers can understand and then it's got to be transmitted. We have to make sure a lot of that line – a lot of that chain is mature before we force everybody to do it, we wouldn't want to have something that's new, but not fully tested and understand the wrinkles and yet required of everyone. It doesn't mean – it's just timing it's a matter of is all I'm saying. So, when we've put it into one of our recommendations, it really should be fairly mature and understood, for that matter.

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

That's also in part why we, in terms of putting in required fields, we wanted to stick largely to the fields that are already being required so that the additional data elements would fall mostly into the optional ones.

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

So most – so what you're thinking is, of the 483 data elements and the CCD sections, you'd be looking for the ones that are known to be required and there's a level of maturity in terms of adoption. Is that what you're saying?

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

Right. We figured what's already being required is likely – most likely to have been adopted already and that those would be the ones that we would, for the most part, keep as required. And try to limit the newly required ones, based on the maturity.

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

Right. So when you say required, it's required and in use.

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

Right.

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

Do you know what percent of the 483 that is?

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

Well, we actually – it’s interesting, we did – we analyzed this on paper. We had 16 organizations, nursing homes, home health agencies, LTACs and hospitals and we exchanged on paper these data elements and found that 90 some odd percent of the time, they were able to find the information because they were already recording it, they just weren’t typically sending it. So most of the data elements are typically being collected in some place, it’s just being able to pull it together to be sent is the tricky part.

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

So Paul, do you think the best approach is just to wait and have them report back at this point, and leave this just kind of an open question around that certification requirement?

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

Yeah. But I think, knowing a bit more of the distinction between finding it somewhere and being able to report it, we need to probably understand that, too, that’s part of the “maturity” in terms of the products in the market and as I said, we can’t force people to go from 0 to 60 in one stage.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But – this is Leslie. Don’t we have some assumptions that since this already being collected in the EHR, this is a question of developing the feature to assemble it and send, not an intervention required by the provider to do so. Right. I mean, Larry, we’re assuming that this is going to be an automated process to bring this information in.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

(Indiscernible)

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

Well – I mean one of the things – this is Larry. Oh, I’m sorry.

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

Go ahead Larry.

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

Just one of the things that we did discover as we were going through this is that while they were able – when we did this on paper, while they were able to find the information, sometime it was not in a discrete field, so it was lumped in with other maybe a textual note. And so, just because we found 90 some odd percent of these, that doesn’t mean that an EHR could easily pull it out discretely and send it...so, in the right bucket. So, I agree with what Paul’s saying, is that we need to be conservative, certainly at this stage in terms of what’s required and I don’t see us advancing that much further than what is currently required. But the key thing is, that for certification we’ll be making buckets so that going forward these can start to be collected discretely and that for Stage 6 or 7 of Meaningful Use, we can get closer to nirvana.

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

No, I think that’s exactly right. So we can start introducing signals of where we’re headed and here’s the assessment of where the – where standards exist, but we have to move on – we have to somewhat gait our recommendations for both the certification requirement as well as certainly the use, based on market maturity. But no, I think what Larry’s saying is right. So, let’s just be conservative in how we make them – require them to be used, but be strong in our signals.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Is there – this is Leslie again. Is there any advantage of taking a look at these areas by field and say moving any of the O’s – optional to required in this stepwise approach that you’re indicating then, do we want to be explicit?

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

I think there have been – I'm sensing that they've been judicious in what's required versus what's optional because it's really hard to set some kind of generic template and say, oh, for every case, this is required. There are very few things that you can say are required for every case. It sounds like that's what they've tried to do in this matrix.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That makes sense. Thanks.

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

And then they spent a lot of time when they made this to figure out, okay, if something's required by there really is no answer or it's not relevant, how can you specify that it's not applicable or we weren't able to get this information, the patient doesn't have any allergies. So they have a whole bunch of different ways of saying no for the required fields.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, and to that end, that's why we have some things on here twice, so like allergies are here twice and encounters are here twice, and hospital discharge meds are here twice, immunizations are here twice. So a bunch of things are here twice, I assume because of the different levels or saying no, I don't know, it's – I don't have the data, I couldn't find the data.

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

Yeah. That's probably right. Okay, do I need to do any – this is just kind of for information purposes in terms of just understanding the data types. So, is the next step on this one – again, we're kind of – adding the certification requirement is still an open item for us, so maybe we just want to leave that as an open item right now and wait until we get some additional feedback. Paul, is that how you want to handle that?

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

Ah yeah, that sounds good.

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

Okay. So, we'll check point back with you what, in about six weeks or so?

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

Check back in four weeks.

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

Okay. All right.

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

Yeah. I mean, they're going to make some progress, but then I think there's some thought about what's truly required for essentially core for this particular objective –

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

Right.

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

Right, then an iss – distinction that they could help us with.

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

Okay, that would be great input, too, as you're thinking it through, you saw the four data elements that we're requiring for Stage 3 or data types, data elements.

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

Okay.

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

Okay. All right. Next slide please, I think it's a continuation. Yup. So this is, again, you saw this in the handout in terms of what's required, so again you can see in Stage 3, again you see the requirements for medications, for problems, you saw earlier for allergies. And then there's a requirement for result entries in this particular one, and the care plan, as its currently defined is an optional field. So, next slide please. Okay. Kind of – we discussed a lot, so again, we've got probably some answers on these slides already. There were 119 comments that we received. Again, there are – again, it was an expansive one and one of the key comments was we really need to understand, and you'll see this feedback later, the ability to be able to execute the Stage 2 Meaningful Use requirement, where we're actually starting to exchange these documents and getting them to work.

So one of the key points was, definition of DECAF. I think our decision earlier was to actually remove that and let that be a Standards Committee decision, in terms of them coming back to us. Are we okay with that? Point two was clarification requested on the details of the four required elements. And what we made the change was to make free text permissible at this point. And again, I think we're going to have to depend on standards to put – do we need to write the intent of each of those required data elements in our overview material, Paul? Hello?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I hear you.

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

I can hear you. Paul, are you still there?

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

Yeah, I had to make a transition, so –

W

– I know – so no, this was just –

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

We need to check, was that a transition, that was the transfer or a consult request?

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

This was just – we have the four required data elements and again, what's meant by setting specific goals, instructions. Again, well, the change we made was just to say free text was permissible.

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

Well I ju – sorry, actually, this is Larry. I was making a joke. But – however, in terms of your setting specific goals, that's not necessarily a term that we've been using. We have spoken about different types of goals that fall into generally two categories. There's the overarching patient goals, these are their broad goals about what's important to them in life. And then there are the more sort of the problem-specific goals that are related to the individual problems, their cholesterol, their sugar, whatever. And so, I don't know if – I mean we, at least in S&I, haven't defined what a setting specific goal is.

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

So let me do a clarification here. I don't think we ever put – this workgroup every puts any specific goals in, I think that got translated in the process. I think our intent and Leslie, you can clarify – you can change this if I'm wrong, was to make it patient goals and free text would be fine. They'd want to go home to be with their in-law – their family or whatever it was – so we actually – I think our intent in terms of goals was patient goals, it was higher level goals.

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

So could we call it sort of overarching patient goals? Does that work for you guys?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That works. That is what we discussed.

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

That's what we discussed. I don't know where we got it translated to spec – I never understood setting specific either, so.

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

Sold.

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

Sold. Okay, do you want to make it overarching or just patient – I would – one of the things from the vendor community is there's so much lack of standardization around patient goals. If there could be – we could set that focus so ultimately there's some common nomenclature we could use there, I think it would be really powerful for advancing this cause. We've got standards for medications and problems, but we don't have then for patient goals yet, so.

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

Well one of the advantages of using the term overarching is because it distinguishes it from the goal of being able to quit smoking cigarettes, which is a patient goal. I mean, they do want to quit smoking, but it's not that high level, overarching goal, which sort of, well as you know, overrides all the other things that we do. So that's why we were using the term overarching patient goal.

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

Well how about –

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

Or high-level patient goal is probably okay as well.

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

– patient goals and then we use that in the definition. And then I'll look at maybe some of the nomenclature you've used in your definitions as part of that process, in making that transition.

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

Okay.

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

Okay. And Paul, are you back on? Okay, we might not have –

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

I am. I am.

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

I was just saying then things like – how did we handle this before, instructions, I mean, I'll put patient goals – do we do a lot of definition in our preamble?

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

We didn't and that's a problem.

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

Okay. So I'll do a little bit of work to do some definition – again, it'll be more in the text as opposed to in the objective, right.

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

Right.

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

Okay. So just clarification. Um, there was a concept – there was a concern over the prescriptive nature of them, considering their relevance, but – and we required all of these as mandatory fields, but free text permissible. So are we still – so the question is, are these really all core, these four fields? Again the core fields being that overarching patient goals is. Instructions for the next 48 hours, that may not be always relevant, right, instructions, but I do think we said –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think there's an opportunity, perhaps, and – with looking trying to define what an after visit summary might need as a – and potentially even a way to align there – so that we get more for the – more out of this and harmonization. Paul, what do you think about that idea?

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

The idea was have after visit summary in there?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

No, to – I'm just getting to more of the standards, the four elements required, we started to look at what are the four elements required for transitions, even for patients, so that the patient's getting elements in their after visit summary. Do we need to have harmonization between a care summary and the after visit summary is my question?

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

We don't – there isn't today.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay, thanks Michelle.

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

I'm on that workgroup, I'll raise that with Christine, too, all right? Christine and my intent was trying to harmonize that as much as possible, too. That was I think the intention is there, we may not have gotten there yet. I just wanted to bring this workgroup, again, so we're going to switch to this new language. So, in the case of referral request being made, the referral request, that particular case or the consult request, we're going to call it a consult request, what we said was, okay, the only thing that you really needed was that first field, which was the purpose of the request, the purpose of the transition. For the other cases, the only cases that we required those additional three fields would be the transfer of care, the more robust document.

So I think maybe it ma – maybe for what we are now calling consult note and consult request, we only deferentially required the first field, in the case of the transfer of care, we required all three fields. So let me look back through that and make sure that that whole – but I get it in this new framework, I've got to make sure that's consistent. But again, we tried to be pretty clear as we made these requirements that we didn't require those additional fields in the case they were not relevant, patient goals, instructions and the instructions field and the care team members. Okay.

The last comment here, potential administrative and cost burden on the transferring provider and the burden should be placed on the EHR and data should be reused from other sources such as clinical summary, care plans or progress notes. I'm really – we weren't really clear what that concept meant. I don't know if anyone wants to comment on that. Okay, and then the last concept was, suggested adding additional fields as required, and these were some of the additional fields that were suggested as adding, in terms of additional core fields being added. So, any comments on that? And I think being cognizant of the fact that Larry and his team will bring back a recommendation or two from their work.

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

Right. These are all well covered in the transfer of care summary.

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

Yes, okay. But we're not calling them out as required right now.

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

Probably not.

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

Okay. Next slide please. We had a lot of feedback on the threshold, both ways. Some felt that – their concern was increasing the threshold from 10 to 30%, and again, it's been just a – we kind of have an informal policy in the group that if we're going raise a threshold, we go from 10 to 30 to 50 and then either we top out, because it goes to 80 automatically, or not. The other requirement was completely the other way, 80% have the summary of care records as well as 65% electronically. And I think we got very similar feedback from other people on this one. So any comments on this threshold requirement. And again, we either table it and wait until we get Stage 2 experience, I'm okay with that, or we can – and leave it as is, or discuss it.

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

I think one of the, sorry about being in the car. One of the ways we look at the threshold is, depends on how much it should be in every action. So for example, a problem list you expect to have on every patient, that's why we went up as high as 80 before we top out. There's a lot of them where definition of the denominator is very either unclear or it's not likely that such an action or such a data requirement would be true of every – it's hard to – what the word is – every instance. So in the case of transitions, because there are so many different kinds of transitions and there are different settings, it's not likely that we're shooting for 100%, even in an ideal world. So that's why I think moving it beyond 50 may get us into more trouble. Because every time...the reason we try to have one number, and that numbers adjusted by how many “exceptions or exclusions” there are for that. Here I think there probably are going to be more exclusions than for example problem lists, so that's why keeping a lower one will try to get it away from being too close to where there are a lot of legitimate exclusions. Does that make any sense?

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

Yeah. Again, and one of the exclusions they indicated was a lot the transitions happen in areas that are outside of the incentive program, like nursing homes. So again, as well as the possibility to – referral patterns and those types of things, so –

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

We also – this is Larry. We also, as we looked through this, we found that there were a whole slew of people that we're referring patients to that – like chiropractors, who aren't going to be able to receive anything electronically, and that was problematic for us. And then the other thing is, we were thinking that for Stage 3, we're talking about expanding the data elements that they're sending, so that in itself was a step and would be a reason to sort of keep the percentage low.

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

Right.

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

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So this is Larry Wolf. I wanted to respond to the comment about getting some feedback on Stage 2 usage. I'm very – I'm both encouraged and a little bit, well, I won't talk about the down sides. I'm basically encouraged that this week I got my first unsolicited request from a partner of Kindred to start discussions with them about our receiving CCDs, Consolidated CDA documents, when their patients are transferred to us.

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

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It's beginning to happen.

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

So is your point, we should wait for that experience or hold –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So I think in terms of the setting thresholds, I suspect in the next six to nine months we'll start to get some really, really good anecdotes, and we may even get some really good data.

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

So I guess I'm saying, the only thing that data would bring is likely to go down rather than up. I wouldn't suggest us going up at any rate.

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

All right. So right now, we would not go – okay, so we're at 30% right now electronic, that's the one they're pushing on. So, we –

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

Well I'm saying go back – don't go from 10 to 30.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Stay at 10.

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

Stay at 10.

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

Stay at 10, okay, I mean, all right. We're good.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think actually, I think 10% is enough to actually be a driver.

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

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It's going to get people to put some infrastructure in place and start doing it. And then the question's going to be, will that naturally grow and how fast?

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

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

The thing, okay, to add one wrinkle, the thing we might want to think about is the out of network stuff, right, because right now that's at one, one document needs to be sent outside of your network.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So maybe getting to more adoption is really about the number of entities that you're connecting to versus more of the 10%...

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– because if it's 10%, you're going to do 50 if you have the connectivity.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But if you don't have the connectivity, you're not going to move your threshold beyond what's comfortable, so you can support 10% probably on an internal transfer, from inpatient to rehab, inside your facility. So, having the movement, I think it's really important to say, how many entities outside of your organization would move this agenda further.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right –

M

I'd agree, I –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

– depending on where you are and how the referral patterns work that could be easy or hard. But you would think abo – you could get above one.

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

Isn't the one to a different EHR vendor?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes.

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

Yeah, that's right. It was – I think it was too. Because like I don't recall that it was in or out of network as long as it was to – but we're being, from the vendor view ask, it's certainly not within the context of an organization, it's external to the organization, right, and if you're within the same system it doesn't count.

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

Correct, it's just –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But now we have –

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

(Indiscernible)

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– whether you're

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

– another system and to a different vendor and/or a CMS test system.

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

Right, exactly.

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

This is David –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Now that we have direct and – requirement in Meaningful Use 2 as a requirement, then that gets rid of a lot of the interoperability or interfacing issues – this document can be sent as a direct message to any number of organizations. So, with that constraint being lifted, could we ask that this be number of organizations or entities versus number of EMRs?

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

This is David, I would think so, but in any case, I would also remind you that there's sometimes health information exchanges and others in the middle, not just direct.

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

Right. So, I think the point was being made, do we want to make sure that we're – that this – want to add a component to go to an external network. I think that's there in Stage 2, as well as ability to exchange with some different kind of system or health information exchange or other entity. So I think that's – Stage 2, I think we've got it. It's just – and I don't – and when you – if we leave the threshold the same, it will still be that 10% to that – network, whether that be an HIE or to another provider in the marketplace. I think we've got that covered. Okay.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Let's just confirm that though – let's confirm that Charlene, because if we get down this path and we're no further on getting transitions of care managed to external sites, we won't have met a lot of the objectives.

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

Yeah, but I think that's what this is all about. So I will confirm it –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

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

– I really think this is kind of at the heart of this objective as – .next slide please. Okay. Again, these were some of the feedback from HITSC. Again, there were a couple of issues related on the threshold to 65%, as well as the increase from electronically from 10 to 30%. And in Stage 3, and this is relevant to our last comment, we did eliminate that CMS-designated test site as a requirement, because we felt that would be covered in Stage 2. So, I think the – we kind of moved the – we addressed Stage 3 by moving the threshold back to 10%. Point one, in terms of the overall threshold to 65%, I think we moved it from 50 to 65, and this is just the creation of a summary, but not necessarily the electronic transmission of that. Any comments on that? I mean, we could leave it at 50 and then leave it at 50 and 10 for Stage 3, as one alternative.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, this may be a noise question, but I'll ask it because maybe it'll help us trying to set thresholds. Do we have any – I know HHS has said they're not going to be issuing Stage 3 requirements this year, have they put out any guidance on when they think they will be issuing Stage 3?

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

Michelle or Paul, do you have that answer?

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

No, no further guidance.

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

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And the reason I was thinking that is we would have opportunity to get more feedback from actual use with more time, and also we might consider tweaking things because there is more time and it won't be perceived as a slamming it down, a big change through the reg process.

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

So Larry is your recommendation just leave as is until we get more input or –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well I guess what I'm trying to think through and maybe this analogy should have occurred to me sooner, but it hasn't, software goes through point releases and major releases and I kind of feel like from Stage 1 to Stage 2 – from nothing to Stage 1 and Stage 1 to Stage 2, was a major release. And I'm wondering if with the delay that's been announced, if we could be looking at Stage 3 as another major release. Or if we're looking at more as a point release that we're making minor adjustments to Stage 2 or actually trying to lead in a few focused areas, where we're actually looking to introduce new things and make a big difference.

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

Paul –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

It's more a philosophical question maybe for the broader Meaningful Use Workgroup to kick around.

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

All right. I mean, because of the timelines being really tight, it feels to me like it's more incremental, but we're taking smaller incremental steps as opposed to large jumps at this point. But again, I think it's a broader question.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, that's why I was asking. Because if the timeline isn't tight, let's say they said, you know what, we think we actually want to delay three years until – so that Stage 2 becomes a 4-year Stage instead of a 2-year Stage.

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

Oh yeah, that would change the parameters.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That would change the thinking a lot, right?

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

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right, that's where I was going with that.

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

Okay.

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

So at this point we don't have any guidance. We're working towards the September final recommendations from Policy Committee –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

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

And we haven't had any – I mean, we've had –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's fine Paul. That's plenty, that's exactly what I was looking for, but maybe the broader question should be asked back to HHS as well.

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

Okay. And there were – and then the following points were – there was just general comment, all information should be shared when a patient is transferred, and we walked through those different document types where we're actually showing the potential of being able to do that. So it seems like if the data's available, at least it has a spot to go at this point in time and with the advancement of the work done by the Longitudinal Care Workgroup, provisions for additional data will be identified. So I think we've got a handle on that one. We don't know what the answer is, but we've got a handle on it. Then there are two questions about numerators and denominators at this point, in terms of whether – again, it's like how is it counted for; I'm not sure at this point it makes sense to – again, there are different complexity of calculating them.

I'd actually like to put those on hold until we kind of get through the higher level decision making and come back then and look at our numerators and denominators, we're really kind of looking our threshold numbers at this point. But, I would just recommend we hold and going into detailed analysis of that, because we'd get stuck in terms of figuring out how to actually calculate the denominator in many of these cases. I'm just going to – next slide please.

All right, and then again, and if there are any comments on this – again, some of the certification requirements – in the first certification requirement, it was the ability to be able to – in the narrative certification, clarify that allows the provider to prioritize clinically relevant information. Again, the intent of this narrative, and I can go back and relook at how the certification requirement was done, was to provide – the provision for the clinician to put in relevant information. We do not want to be prescriptive here. So, maybe we just need to clarify – what they recommended was focus on the need for additional clarity on the question being asked of the provider, like suspect gastric ulcer, performed – please perform EGD. Again, those were all things that we felt could go in the narrative, but we didn't want to be prescriptive in terms of it, so maybe we need to go back and look at the language around that one. So I can take that as a "to do." Are we okay with that? Any comments on that?

All right, the second – hearing nothing, I'll move on. Auto populate certification criteria. Again, this was – and specifically it was the ability – we had talked about the ability to refer to quit-lines and that type of thing, and we were pretty specific in that criteria. So, again, these were some of the criteria that actually ONC wrote after the fact and included in this objective. So are there any comments on that? They're generally supportive of it, in terms of the feedback.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sounds like we're all saturated for today.

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

All right. Well I'm trying to – we're going to get to the care plan. Okay, last one then, I think we've covered in terms of the support for adding that criteria. Again, we're going to leave that as an open item and wait back until we get some additional feedback from the Longitudinal Care Workgroup...Coordination Workgroup. Okay, next slide. Okay, given the time, 10:47, I think that we should probably break now, because to get into care plans is a complex issue. Certainly we've heard the feedback on two fronts of it, again, it's a very broad initiative and complex and we're way ahead of the curve. We've also heard the other one that people would like to accelerate this one. So I would suggest that we actually make this the first topic of discussion for our next workgroup meeting, and continue on this one. So if that's alright with the rest of the workgroup, we won't start on it at this call. Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Fine with me.

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

Yeah, that sounds reasonable.

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

Okay. So, I will try and be more timely on the next call and if we could open the – open for public comment, that would be great.

Public Comment

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

Operator, can you please open the lines for public comment?

Caitlin Collins – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

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

Okay. Well I want to thank the workgroup members for working through the work that we did today, this is very complex territory that we're navigating at this point, but I appreciate all your help in terms of sorting out how to establish an objective that will support us moving forward in this area. Thank you. So, our call is adjourned and we'll talk on the next call.

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

Thanks everybody.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Thanks, it was a really good call today.

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

Thanks Charlene.

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

You're welcome.

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

Thank you.

Public Comment Received During the Meeting

1. Charlene: The current MU2 regulation allows ANY of the document types shown in the grid, as long as they use the section templates (rows) that include all the MU2-required data elements (which are called "entries"). So Larry's earlier comment about consuming documents at the section levels was correct. Certain doc types are "better fits" than others for MU2, but the regulation allows for any of those shown on the grid.
2. As for which of the doc types are used the most by vendors, my guess is that it's the CCD, because it was already required in MU1, and is a good (if not perfect) fit for MU2 data. As Larry said, the consult note looks like a better fit for MU3 if the data set continues growing.
3. Cait, I'll try to make the following comment verbally on the phone if time permits. I'm copying here to assist in the public record. "There was a survey about 2 years ago of many EHR vendors conducted by the EHR-HIE Interoperability Workgroup led by NyCE. It asked which CCD data elements were captured in the EHR and whether they were in discrete fields and if so, whether they used the vocabularies required by MU. Finally, it asked whether the data were not only captured but also assembled into the CCD. The purpose was to understand vendor readiness. If an EHR had the discrete codified data, even if it didn't currently put it into the CCD, it would not be hard to add it to CCD. But if it didn't have the data at all, or it was not in the right format or vocabulary, then it would be more challenging. ONC recently announced a partnership with that EHR-HIE WG. Perhaps the MUWG could ask them to do a similar survey to indicate the state of data readiness of EHR systems."

4. Cait, if I make the public comment, it's been revised, so the following replaces what I sent you previously. "Regarding how big a lift it would be to add data elements for transitions, there was a survey about 2 years ago of many EHR vendors conducted by the EHR-HIE Interoperability Workgroup led by NyEC. It asked which CCD data elements were captured in the EHR and whether they were in discrete fields and if so, whether they used the vocabularies required by MU. Finally, it asked whether the data were not only captured but also assembled into the CCD. The purpose was to understand vendor readiness. If an EHR had the discrete codified data, even if it didn't currently put it into the CCD, it would not be hard to add it to CCD. But if it didn't have the data at all, or it was not in the right format or vocabulary, then it would be more challenging. ONC recently announced a partnership with that EHR-HIE Interop WG. Perhaps you could ask them to do a similar readiness survey regarding your potential MU3 elements

5. Sorry, I dialed in a few seconds too late to press *1. Anyway, I'll appreciate your adding the comment to the public record. Thanks

6. The comments show some confusion about care plans. The core difference between care plans and care summary is that care plans are looking forward - to goals and how to achieve them. Care summary is reporting history