

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
June 24, 2013**

Presentation

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

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. This is a public call and there is time for public comment on the agenda. The call is also being recorded, so please make sure you identify yourself for the transcript. I'll now go through the roll call. Paul Tang? Are you there Paul? No?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
He'll be here a little late.

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

Okay. 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

Thanks George. David Bates?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Here.

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

Thanks David. Christine Bechtel? Neil Calman? Art Davidson?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Art. Paul Eggerman? Marty Fattig?

Marty Fattig, MHA – Nemaha County Hospital

Here.

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

Thanks Marty. Leslie Kelly-Hall?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Here.

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

Thanks Leslie. David Lansky? Deven McGraw? Marc Overhage?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Present.

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

Thanks Marc. Charlene Underwood?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Charlene. Mike Zaroukian? Amy Zimmerman? Tim Cromwell? Joe Francis? Greg Pace?

Greg Pace – Deputy CIO – Social Security Administration

Here.

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

Thanks Greg. Marty Rice?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Marty. And Robert Tagalico? And any ONC staff members on the line.

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

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

Hey Michelle.

Michelle Consolazio Nelson – Office of the National Coordinator

Is Elise on?

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

Is –

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator

Hi, yes, I'm here. Elise Anthony, new to ONC. Happy to be part of the ONC team.

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

Thanks.

Michelle Consolazio Nelson – Office of the National Coordinator

So MacKenzie, when we open up, can I quickly introduce her?

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

Sure, we're open, so do you just want to do it now before I turn it to George.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, if you don't mind.

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

– is on also.

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

Sorry, who was that?

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

Terrie Reed.

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

Terrie Reed, okay.

Terrie Reed – Food & Drug Administration

Yes, I'm here.

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

Okay, thanks. Go ahead Michelle.

Michelle Consolazio Nelson – Office of the National Coordinator

So I just wanted to introduce the Meaningful Use Workgroup to Elise Sweeney-Anthony. If you all remember, Josh Seidman, she is taking over his former position, but we may change that role a little bit, but she is going to be the Meaningful Use senior advisor, and I'm not sure if that's a correct title. But she'll be working with us and you'll hear her on the calls, so I just wanted to let you all know that you'll start to see her name and at future meetings, you'll probably see her. So, be on the lookout and I look forward to being able to work with her and all of you.

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator

Thanks Michelle. Thanks everyone, wonderful to meet you.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And MacKenzie, it's Christine Bechtel, I joined.

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

Great, thanks Christine. Okay George, I'll turn it back to you.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Hi, it's Neil Calman. I just joined.

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

Oh, very good Neil.

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

Thanks Neil.

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

All right. Well, good morning, thank you everyone for joining us this morning. We're going to – first of all – so today we're going to cover a little bit left over from subgroup 1 and then go over – spend most of the time on subgroup 3. And then Michelle or MacKenzie, after this, our next call, just so I have it straight here is July 2nd.

Michelle Consolazio Nelson – Office of the National Coordinator

Correct. On the July 2nd call, subgroup 2 will review their recommendations with the group.

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

Okay, and then that's it?

Michelle Consolazio Nelson – Office of the National Coordinator

Yup. We are actually working on scheduling a meeting for July 16 to do one final review with everyone's recommendations, just to kind of make sure, once we put them all together, everything aligns, but that is to be scheduled.

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

Very good. Thank you Michelle. Okay, so let's see, we can – let me see, what do we have here – we have our agenda. We can go forward a slide and – so that's our agenda, which I just described. And we can go forward to the next slide, and David, would you lead the discussion on the device identifiers.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yes, I'd be happy to. Can you hear me okay?

M

Yes.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Yup. Okay. So the backdrop here is there's a new standard for device identifiers and it would be very helpful, for a variety of reasons, to – if that standard gets used in a broad way. Currently, people have devices implanted all the time and it's often hard to tell exactly which device was implanted and to find people who have had devices implanted. And therefore, we proposed as a meaningful use objective that providers would be asked to record a unique device identifier whenever an implant is placed in a patient that would be both for eligible hospitals and EPs. The measure would be that the unique device identifier, or UDI, and its core attributes, which include things like MRI safety, should be available for each implant from the implantation on. And there would also be an ask in terms of certification criteria, which would be that all EHRs should include a place to record the UDIs and core attributes for all of a patient's implants, which would allow a query of what implants the patient has. So that's really a short summary. Terrie did I – is that reasonably accurate?

Terrie Reed – Food & Drug Administration

Yes, that's fine.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

And there's some question about whether we could handle this with just certification, I think it would be very, very helpful to have a specific objective. We know that today these things just do not get done and here what we would be asking for, again, is that anybody who puts a device in would record the device identifier. It might not be the doctors themselves who would be doing it; it might be somebody else on the team.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

David, this is Marc Overhage, just a couple of questions/friendly amendments. One, I think you're suggesting here permanently implanted devices, because even intravenous catheters, for example, will have a UDI, and I don't think you're suggesting that everything that's implanted in the patient for a short period get recorded. I know it's not – goal, but I don't think that's what you're –

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

That's correct – go ahead Terrie.

Terrie Reed – Food & Drug Administration

I'm sorry. Marc, there's an FDA regulatory definition associated with UDI rules that talks about what a medical device implant is, it's over 30 days implanted in the patient.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yes. So, I just wanted to make sure we were all thinking the same thing there, because it's easy to leap. So, for example, this would include things like central catheters that are left in for chemotherapy, but not central catheters that are placed for short-term intravenous antibiotics.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Exactly.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And the other thing I would question is, you were suggesting, I think, that the attributes get stored in the EHR and I'm not sure that would be the cleanest answer in the sense that there will be databases of attributes of these devices maintained by the FDA as part of the effort. So I'm not sure why you would retain the data in the EHR, it would make more sense that that would be referential once you have the UDI. And then I think there are some discussions we've got to get into about the specifics of what we mean when we say the UDI, because of course, that's a multipart identifier and so on.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

So I guess the question is, and you know more about this than I do, about whether there might be some key attributes that would be good to keep a little closer than the FDA, because you're probably not going to want to hit an FDA database every time someone goes for an MRI.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

That's fine, I guess I was questioning whether we want to be so directive as to suggest that it's going to be – there's a whole variety of ways they might attack that.

9:14

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

The other think that I have discovered in going to hospitals is the inventory systems often have this information. Hospitals are using catalog number now to reference their inventory systems to actually charge patients for devices and so that the attributes associated with the UDI could also be stored locally in these systems that already are at the hospital. So, it's a matter of working out what works in a particular hospital, I guess. I'm not sure how that fits with the EHR certification criteria. There needs to be a linkage so that those attributes are available, but where they're stored, probably needs some discussion.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie –

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

I agree that the language – yeah, sorry. I agree the language should support a variety of use cases.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie. And one of the concerns is that the ease of putting this in will largely be based upon bar code or some automated way and the attributes might already be bundled with the UDID, so it might actually be more efficient to take that entire bundle of information than to require it to split up. What are your thoughts on that?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

I think either – that's likely going to be how it will work practically.

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

So David, this is George. We – this is usually a stepwise approach and what would you – so we can envision what would be the perfect system that it goes in and then as soon as you have a question, it pops up in the EHR the properties of all the patient's devices. But that doesn't mean we can achieve it in the first stage that we put it into. So, what would be the first stage, say if it's a measure, what would be the proportion, the threshold and that kind of thing?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

I think we would pick some threshold, which would be a pretty high threshold, like 80 percent or something.

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

Well we didn't pick 80 percent for most of our other things that are also critical because it was the first stage and we weren't sure what was going to go wrong. So usually, what we would do is have a first – in the first stage, a fairly low threshold.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Here we're putting in permanent devices. I don't really see the need for a low threshold.

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

Well, I don't see a need for a low threshold on any of the things we're collecting, in all our – I mean, it's a matter of how to implement it, not what the goal – the goal is always 100 percent, whether –

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

I actually disagree with that. I don't think the goal is always 100 percent. This is different than a lot of other things in my mind.

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

Except that we're not sure what's going to – we're not even sure what we're going to be putting in yet and I don't see how we can know – we don't even know what's practical – what fields are practical to put in yet, so then how can we say well, we'll achieve 80 percent.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Well the UDI is definitely practical, I mean, that is supposed to be recorded all the time.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

So if the HER – this is Neil. If the EHRs are going to have to have a field for it, what would be an excuse for somebody not putting it in?

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

That it was done elsewhere, now the patient came – the way it's phrased now, providers should record the device identifier when patients have implanted devices. It doesn't say –

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

No, that's not what it says. No, the objective is, when the implant is placed, which means when its put in for the first time.

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

So we need to rephrase the objective, because on the screen it says when they have implanted devices, not when they're implanted.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

I'm sorry, I'm looking at – I'm not looking at the screen.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

The other thing that's a little confusing about this then is many, not all certainly, of these implants are done in a surgical setting and often in a separate surgical information system rather than in the – so things are being recorded in an SIS rather than in the EHR directly. So do we really mean the – so we get into that game as well.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Well if it's – I mean the whole idea here is so that it's retrievable. So, is that going to be accessible in that system?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

No, exactly, that was where I was going is, it sort of makes complete sense to say, okay somebody is in fact – they're putting the sticker from the device in the patient's paper record or whatever, to say at the time of implantation to have somehow the circulating nurse or somebody record this data electronically in the system that they're using in the OR – a no-brainer. As soon as you say, well wait a minute, now you want to do it in the EHR that may or may not be connected to that, and certainly, we don't have authority in terms of certification over surgical information systems, I don't think.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Well I mean, I think we're saying here that it has to be in the patient's electronic record. I mean I think it's a cop-out to say that it could exist in some surgical system that doesn't connect, that would not be enough.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

I was just sort of responding to the question about sort of why wouldn't somebody do it and where would it be; if it's already done, people are – I think it makes it harder.

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

So this is Charlene. It does seem like – I think David you mentioned that we needed to like scope out some use cases of this? I mean the minimum bar would be for certification, right, in Stage 3 and then in terms of Meaningful Use, then again, I think the level's probably dependent on what use cases get scoped. So the standards so that they do that or – I'm not sure it makes – it's useful to argue over a percentage right now until we kind of know what use cases we're going to handle, because we talked about a couple of them.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

This is Christine. I agree this is so important to have an objective around and since we're not the final authority, it might be helpful to think about choosing either a 50 or an 80 percent threshold. And then there will be a public comment process and ONC and CMS can take in public comments about the threshold at that time, rather than making – obviously we're not making the decision now.

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

This is Art. I have a question about where this information – I mean, Marc's pointed out that there's a system in the hospital that may be separate, we're trying to figure out how to get it into the EHR. I'm interested in knowing how would this UDI get transmitted in a transition of care document or summary? Is that where it would – how would you know that someone had it in one place and then you're now taking care of them, like David said, you have MRI contraindications. Would that flow in the transition of care document?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I think also, I'll add to that, it's Christine again. I have a similar question about patients being able to have access to their UDI for the future, so that if they're able to access data or use an app that trends their data over time that would be very helpful. So I agree with the concept of making it available in the EHR, but also in some output that perhaps a patient could see.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

So I think both of those things, would be desirable. Whether or not it would go in somebody's continuity of care document depends on what's included in the CCD and that is likely to evolve over time.

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

I – this is Charlene. Just from the vendor perspective, I know there are vendors that actually do this already and are certainly thinking about doing it, so, it's just – but in general, and it's not on people's roadmaps yet. And again, just now we've talked about a couple of different scenarios that we'd want the process to support. It seems like we've got to get it in the database first, in the appropriate form. So, I hesitate to endorse all these different – I hesitate to endorse 50 or 80 percent in Stage 3 when we don't even really know kind of what we're doing yet, and it's really not in product yet.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

So this is Leslie and I think that one idea would be to look at what's happening in the operative note because I think today there's a considerable amount recorded. But back to I think it was Art's point, how do we make sure that gets transitioned to – for transition of care and then also in the view, download and transmit for a patient to have access to that. Could we do a certification requirement and some – and a menu item at a high threshold to begin with, followed up by then a requirement. Because we're still talking about a small population and there is a habit today, in the OR, you have the supply chain information that's brought into the operating room. That information can be bar-coded and scanned, just like the UDI, into the operative note, and then from there, transitioning through our standards into a transition of care document and view, download and transmit would be important. So we could set the stage with certification and a menu item at a high threshold for use.

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

And that would be a reasonable approach from my perspective.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

This is Christine. I agree I'd like to do a menu item. I might think about – the only thing – the only question I would have is that if it's a high threshold, like too high, 80 percent, does it make the menu item less attractive? Because I know, we had that problem in some of the patient and family engagement objectives in Stage 1, so I don't know if that means maybe, we should think about 50 percent, because we know that people – it's the objective, particularly at 50 percent, when they're doing the objective.

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

So this is George. I agree with you Christine, but if we say 50, you can't go to 80, if you say 80; you can drop to 50 in the process. So, it might be wise to – although, I'm always on the low threshold side, it might be better to say 80 at this stage, knowing we might have to drop to 50, especially if it's a menu item, we're a little bit safer. So –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

That makes sense George.

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

So to summarize I'd say, we have to change the phrasing of the objective, providers should record their device identifier when patients have devices implanted, so just flipping those two words, number one. Number two, we should just do the device – I think we should just do the device identifier for now at this first stage, that's the first stage part of it. Figuring out what fields to show, whether to get them from the FDA or your own database or your operating surgical system is probably something that won't be able to be done in time for our suggestions to the Policy Committee and then to CMS. So I think it should be specifically the device identifier for now. I think menu objective makes sense because otherwise we'll have mostly exclusions; we might as well make it a menu objective for now. And there's a question of whether that field needs to be added to other lists like transitions of care, right, if available. Is that a summary?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, transitions and view, download and transmit I would say.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Yeah. Right.

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

Well but what about the – well, we'll be talking about in a moment we're going to be talking about the referrals and so forth, too. Okay. Does that sound reasonable David?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

It does.

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

Okay. Any other questions about this one? Very good. Then we'll move on, next slide, to subgroup 3, and the next slide, good, that's the agenda. Charlene, do you want to take over here?

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

I can do that.

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

Thank you.

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

Okay, so just – I want to give a little bit of a framework in terms of going into improving care coordination. From the get go there are two important points. We recognized that our future state vision for this is certainly a model of data shared across care venues and care settings, as well as providers with significant patient and family engagement as part of the process, but we also recognized that as part of Stage 3, our intent was to set the framework for that. And we focused fundamentally on three key areas, the ability to provide communication, to share some data; the ability to be able to reconcile that data when it's provided and the third is to be able to provide tracking capabilities. And to that end, we – and we recognize that what we're trying to do in Stage 3 is to set the framework for this more advanced function into future stages.

The other thing that as we reviewed the input, and we got a lot of input from the Standards Workgroup, the Interoperability and Exchange Workgroup, and this process which was very helpful. So we worked pretty hard to align with the research they'd done in this particular space as well as the research on the long-term care initiatives. So again, we did that homework as we did through the process. The other piece here is we were sensitive to try and minimize the number of new objectives, and we consolidated where possible. So you will note, and again, this is the result of the work that we did. We – I'll give you our feedback on reconciliation.

In care summary, what we did to align with the work going on in the standards, we actually consolidated the referral requirement. Care plans again we have looked deeply at the capability of care plans, and again see that as a placeholder for the future stage. So in the context of that, again we included elements in the care summary, which will move us toward the care plan. And then on the notification piece, again which is another important piece in terms of tracking – walk through these couple of pieces. All right, next slide please.

So, the reconciliation objective, the intent – so let me give the background on this one. In Stage 2, the measure is around again, for providers to be able to reconcile 50 percent of transitions of care, their medication. So again, we are working towards increasing on a regular basis, the reconciliation process for medications. The vendors for Stage 2 are required to also support a broader clinical reconciliation capability for certification, and that's noted at the bottom, and that includes not only medications, but medication allergies as well as problems. So, our proposed initial recommendation for Stage 3, because the vendors would be already certified to that, was to support a use objective at varying levels of providers actually doing medication reconciliation as well as reconciliation with med allergies as well as problems.

And again, we varied the percentages, we left 50 percent for medications, but we put 10 percent down there for the other two field types. We got very significant feedback relative to the readiness and the process standards even around people being able to reconcile medication allergies and problems. So we made the decision, as part of the workgroup for Stage 3 to keep the focus maintained on medications, but we deferred advancing medication allergies and problems in Stage 3. One of the key areas that we thought was important to focus on, and this comes back to David's workgroup. We talked a lot about again, in the reconciliation process, what's important is about getting this information right, so we wanted to make sure that we got it right that the problem list was accurate, that the medication list was accurate and the allergies were accurate.

So we did add...I think there's an addition of a requirement in clinical decision support that's in David's area, to actually support the improvement of the problem list, in terms of the ability to be able to look at a patient's labs and perhaps detect a problem that wasn't there. So we really fundamentally wanted to make sure that if we're going to do this reconciliation process, we help the providers do that and we make sure that at the end of the day, we improve the accuracy of the process. So we're taking a little bit of change in direction. So with that, I'll kind of open this to the broader Meaningful Use Workgroup for your feedback. And again, we're trying to move up the capabilities, but also to do it in a way that was sensitive to not overburdening providers and doing it in a way that results in good quality data.

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

Charlene, I'm sorry to be dense, but I wasn't on the call. You're saying that we're going to add in – I mean, I'm looking at the slide which says get rid of allergies and problems.

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

That's right.

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

So you're saying to – that we should no longer put that in –

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

Yes.

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

– just leave it in certification.

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

Yes. We got pretty significant feedback that in the comments that there weren't – the standards were not reconciled sufficiently in terms of reconciling allergies. Again because there are different types of ingredients that have to be evaluated, as well as certainly reconciling problems and being in the transitions between, ICD-9, ICD-10, SNOMED, made it a really complicated time to be able to do that.

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

So the question to the group is it okay to get rid of those two things?

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

Um hmm.

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

Okay.

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

And then the recommendation was to refocus around trying to assure – using clinical decision support to assure the integrity of those data fields.

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

Yeah but that's – and so that's what's called certification criteria number two, that's more or less – with what's on the – what will be on the next slide from CDS, right?

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

Well, the CDS piece actually was included in the clinical decision support section, whatever that objective is, and I should have referenced it.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle. So, George, the next slide is the CDS slide, if you want to see how it's integrated there.

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

Okay.

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

Right.

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

Great. All right, so if we look at the red items in – under the objective, improving the accuracy and completeness of the problem list for one or more chronic conditions.

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

This is Art. I think I get the idea that you could maybe use clinical decision support and lab and pharmacy to figure out a problem, but how would you do that for allergies? And I don't see allergies on this 113 slide.

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

No, I think we just focused on – I misspoke, this is Charlene. It was focused on the problems was what we ended up with.

Michelle Consolazio Nelson – Office of the National Coordinator

So this is Michelle. So, just to clarify. In subgroup 1, there was certification criteria suggested for problems, meds and allergies. In the subgroup 1 discussion, it was decided to put in the problem list as a use case, so as you can see on the slide. But in the yellow box for 113, I'm suggesting that the criteria that was originally suggested, we put back in, which covers all of them, problems, meds and allergies, the clinical decision support. So the language is there from before, from the RFC. I know it's a little bit confusing, but –

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

Michelle Consolazio Nelson – Office of the National Coordinator

– and as we all know, for allergies it will be a little bit more difficult, because there is some standards work that needs to happen.

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

So it's not – .

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

It was a little less about standards I was asking, but more about what sort of logic you could use –

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

I think it would be hard – I agree with you Art, it would be hard. I mean it's the kind of thing I think where you get a medication and then there's some kind of rescue procedure which is standard when you have an allergic – you get, I don't know, steroids and epi and this and that. Could you suggest that – and then the medications get started, then you get rescue medications and the medication is stopped. That would be a scenario where we would say, is the person allergic to this med? But I don't know that that would ever be reliable enough to use, but I think that was the kind of thing they were thinking of.

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

And this is Paul. In the unusual case where someone does code, come in with an allergic reaction to a med, there are codes for that, it's not very reliable that people do use that coding, but that's another trigger essentially.

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

So if there's another part of the record – I mean the big thing is, what if in the structured note, you ask for allergies and it goes there, it has to go on the allergy list also. I guess you shouldn't be doing that.

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

So now my question to you Michelle is, now we have kind of the same thing in three places, right? We have it in the previous slide, in 302 as certification criteria number 2. And then we have it under the kind of use cases at the top and then we have number 6 below. So, where will these actually end up?

Michelle Consolazio Nelson – Office of the National Coordinator

So my suggestion is to remove it from 302 and put it in the CDS objective. There are pieces that aren't the same though, so I think you still need a certification criteria and the use case part of it in 113.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

But that's just my suggestion.

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

So Charlene, we could – I'm sorry, go ahead.

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

No it's just – you said you included allergy in this 113 somewhere and I can't see it right now.

Michelle Consolazio Nelson – Office of the National Coordinator

It's in the orange box.

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

It's in the yellow box at the bottom.

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

Oh, sorry.

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

So we weren't going to put it as a use case at the top because it's kind of unusual for this to work, we're just saying certification, it should be possible if you have structured information that's relevant to allergies, to also affect the allergy list. Although it would be much less common, that says a problem. Okay so Charlene, on the previous slide, 302, what you're looking for is input is it okay –

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

Yes –

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

– so is there any disagreement with changing allergy and problems, and then we can go to – and separate that.

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

That's right.

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

Are there further comments about allergies and problems?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie and I just had one question. I think Michelle we had talked about allergies more broadly like food allergies or intolerances that the patients might have and also might report in patient-generated health data in the future. Do we have that captured then in the other sections under allergies?

Michelle Consolazio Nelson – Office of the National Coordinator

Nope.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Okay.

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

So Leslie, this is Charlene. How would you – I think it's standing out – it seems like the whole area between allergies and contraindications needed a framework around it, I think that's what we were really trying to have that discussion for future stages –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Yeah.

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

– and it would make sense that we expanded the allergies in that context, don't you think?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Yeah, I thought we had talked about that for certification to make sure that we have the standards to include allergies more broadly.

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

So maybe we could put that under proposed for future stages and make sure that we don't – we put contraindications in there, but maybe we list that, because we wanted that to be considered in that process.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Yeah, we did. So I just wasn't sure where it ended up.

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

So Christine would it – and I wasn't part of that subgroup, so I may not have all the context, but would it make sense to think about in the patient/family engagement priority area, we have like a patient-generated health data objective. And I wonder if we should add some – the ability for the patient to submit, here's my list of allergies, which could be broader than medication or other, but food, etcetera. Is that what you're trying to get at Leslie?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Yeah, because it's one of the areas that we've heard testimony on the patient-generated health data when a patient can provide information like, my allergies, my intolerances, contr – things that I know about myself is a really great area for patient-generated health data. So making sure we're aligning the needed standards in the EHR with the patient-generated health data work would be important. So I would just advocate that when we look – we make sure we're synchronizing those things. I'd be happy to take that on in the standards area for the certification, but I just don't want to lose those ideas that we had –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well we could potentially put at least the ability for a patient to say, here are my allergies and intolerances. I think then the question is how do we link up the area where they're showing – where they're submitting that information with the care summary, because it does make sense for those things to go site-to-site. So, can we think about an approach where if that – if there is a field for patients self-submitted allergies and intolerances, that they do through view, download, transmit. And it becomes, and there's a pointer to it in the record or it lives in the record, once the provider's accepted the data in, then if that field is populated, it should also show up on the – in these other areas, on the care summary, something like that.

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

And I think when we've talked about – this is Charlene, the patient-generated data, that was where if we could understand what the standards framework is, certainly in the terms of expanding allergies, then that would give that linkage – that it would give you the possibility of making that linkage. So I do think we need to add it as reconcil – as another element that we want to propose for a future stage, so that's considered in the standards work, in the context of both contraindications as well as expansion of the medicat – the allergy field because –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Yeah, that works.

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

And then, whatever that framework is should be the mechanism that ultimately links in a more user-friendly way the patient data, adds to, subtracts – okay. So we'll make an adjustment on our propose for future stages with some standards work in that area.

Michelle Consolazio Nelson – Office of the National Coordinator

I'm sorry Charlene, this is Michelle. Can we go to slide 6, because I think it's already there? I'm sorry, I said no, so I'm sorry.

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

Is it there? I didn't see it – I know we talked –

Michelle Consolazio Nelson – Office of the National Coordinator

I had it under the future stage; it is there, standards work needs to be done to support the valuing and coding of contraindications. So maybe we would just expand upon that a little bit.

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

Yeah, that's where I wanted it at, and I want – and allergies beyond medications, and let them think through what this means.

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

So should that be including both allergies and intolerances or is that implied in the contraindications?

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

I'm not sure Art, should we include it? I mean, it's important.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Yes.

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

I think it should be – we should be specific here –

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

Okay.

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

– because this is about figuring out how to get from patient-generated data in –

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

And again –

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

– I mean the contraindications –

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

– some of those – some of it will overlap at the end of the day, that's why we've got to get it straightened out.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Right, but the intolerances are what the patient says and the contraindications are generally what the provider says, so –

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

Right.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

– we just want to make sure we had captured both those thoughts.

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

Um hmm, um hmm.

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

Michelle, this is – let me just – is this the logical place to put this, under the reconciliation objective or is there some other objective where we should be asking the standards questions and similar? Like we used to have –

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

And sort of a –

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

– go ahead.

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

– related question is, have we in the past talked about certification criteria for intolerance versus allergic reactions? Intolerance is not something – I mean, it's something a patient reports but the provider would also like to use that concept rather than putting everything in the allergies. Have we dealt with this already in Stage 1 or 2?

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

No, we haven't and I think the assumption is, it would be – it's more – it's free text, it's not obviously structured data, so there is definitely some work to be done.

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

So med problems and allergies got moved into –

Michelle Consolazio Nelson – Office of the National Coordinator

Clinical decision support and the care plan.

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

Well, to –

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

And what?

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

The care summary is where they are –

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

To VDT or summary or what?

Michelle Consolazio Nelson – Office of the National Coordinator

The care summary.

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

The care summary, okay. I don't know if the contraindication/tolerance question goes into reconciliation or the care summary, but it goes into one of those two objectives. It doesn't have its own objective, so whatever makes the most sense is where we should put it.

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

Yeah. And again, we felt we – from reconciliation, we couldn't reconcile without some structure behind these things, so, that's what we were thinking.

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

It's just a little – it got moved into care summary, even though we have a lot of work to do in all three areas, problems, meds and allergies. And this is just another example, we had to make – up to date, this one is on allerg – I'm a little surprised, we must have just forgot to have an intolerance field, the capability to record that. Because that's an important –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Well we had put it here, Paul, for Stage 4, so that's what happened.

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Yeah. Well no, contraindication, but I think we were considering intolerance with that.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
But I don't think – I mean, medically that's not the same, so we just want to –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
No, no –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
– we want to break it out –

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Well, and you know one of the things we can do as a workgroup too is just follow up with standards and get – Leslie, when you kick that off, maybe we bring some knowledge back in terms of what that thought process looks like, too. Okay?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, we'll do that in the patient-generated health data.

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Okay Charlene, so it sounds like we're set here, we're in agreement with the change on 302. We're going to put the certification criteria into 113 and we're going to request standards follow up on contraindications and intolerances, either here or in the care summary, wherever Michelle figures out is the more appropriate place.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Right – and expanded allergies, expanded allergies.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
And allergies, yes.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Because we haven't done that yet. Okay.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Good. Next slide. Not this one, one more. Okay, so this is again where we had a lot of discussions with the IE Workgroup in terms of understanding the various use cases. So we made some – the concepts are the same, but I made some wording changes to better align with the concepts and use cases. Again they had done the work in terms of the different kinds of use cases. So I'm going to walk you through this.

There was one additional capability that we did think through as we were again using – thinking through this referral case. And again, similarly to when an order – when tests are sent out for lab tests and there's a due date back. Again, when a referral's sent, and again, we're calling these consult requests, but I'm giving – there's also some times a due date that's required. So we chose to want to do that in the same way, so we actually made that update to 122. The other open item, again, based on the extensive work being done in terms of managing various transfers of care again there's...it's being done relative to the kind of data fields that need to be transferred. And again, I think in that particular case where there are standards that are actually being submitted, but again, we're just kind of waiting until that process rolls out and there's feedback to that process to actually act in terms of adding the additional data component. So, let me – so, in Stage 2, and again, it's really – it's hard to see on this document, in Stage 2 again, we're requiring that either for a referral and/or for a transfer of care, that a transfer of care record is sent over in 30 percent of the cases. And I think it's 10 – I can't read it myself, I'll have to pull up the other one.

Michelle Consolazio Nelson – Office of the National Coordinator

It is 10 –

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

– 10 percent of the cases electronic. And then in the case where there's potential of a vendor-to-vendor communication – or same vendor to same vendor, at a minimum you've got to do a test that you can send that outside the network. So again, we saw Stage 2 as a significant step in just actually implementing that communication network to be able to share data. So, in Stage 3 then, we are – we chose to build on that approach and again, we were saying that, and you'll have to stay with me, because changing language I know is always complex. But again, the concept is there are transitions of care from setting to setting and/or potential – or the point, when a physician requests a consult, aka a referral, so I changed it to consultation, and the case when the provider returns the results back to the requesting provider.

So again, there are three separate use cases we're thinking about, site-to-site transfers, requesting a consultation, providing the adequate data to request the consultation and then the third use case is when the consult report comes back. Okay, so – and then it got a little complicated writing it. And then what we did is I changed the language for the objective that we're going to provide the care record for each site transition, consult request or consult result, when the transition consult occurs or the consultation is done. So again, it's based on the occurrence of those, you're going to – based on these particular use cases, you're going to provide the information back on that summary of care document.

For the purposes of Stage 3, again recognizing that we're setting up the framework to advance to more sophisticated care planning, we said in all cases – or – and this is – again, it's a bit complex. But in the case that you're requesting a consultation or doing a site transfer, then you include a concise narrative that captures the current care synopsis and the expectations for the transition or the consult request. And there may be some better language on that, but it's just a short concise statement that the doctor writes and submits and that becomes part of that record. And that's for those two use cases. In addition, for the cases when there's a transfer of care, three additional data elements or three additional fields are provided. The overarching patient goals and patient-specific goals for the transition, instructions for care for 48-hours and then the last piece was the care team members, including the primary care provider and caregiver name and contact information. And again, the extent of how deep that goes, I think, is just some – a ques – the piece in question, but we felt those three fields were important in terms of establishing the framework for care planning in the future.

In all cases for those three – actually, for all four elements, free text is permissible. So where we would like to see an advancement of coding around, for instance, patient goals, again we recognize that in the timeframe that we're asking, that may not all be defined, but we thought those three fields were important. So, I'm going to actually – the – I think we left at this point in time, we actually increased again the measurement to 50 percent and 30 percent in terms of being able to do that communication, so we upped it from 30 percent and 10 percent respectively. Or Michelle, did we go back to those other numbers, I can't read, did we go back? I think we backed it off again, 50 percent of the transitions –

Michelle Consolazio Nelson – Office of the National Coordinator

Yes, 50 and 10.

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

All right. So with that, I'm going to stop because there's a lot of change that went into this one. And you can see where the original referral loop is now the consult report and that's included as part of this objective.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Charlene, this is Christine. Just a quick question about the thresholds, the comments you just made about the threshold and scaling it back. What – I thought the performance in Stage 1 and 2 was pretty solid, like pretty high, so I'm trying to understand the logic in going –

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

Well in Stage 1, with care summary, it was simply attest, right. Stage 2 was where we –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Oh.

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

– yeah, so Stage 2 was when we actually did it and I think we'll wait on that feedback. I think that's one where it will really start to roll in Stage 2. There are people certainly that are doing that exchange today, but it's not being measured.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

But I don't think it was attest in Stage 1 that was like the information exchange piece, which has been removed from Stage 1. I thought that it was in there, at least as a menu item. I'll take a look.

Michelle Consolazio Nelson – Office of the National Coordinator

It was in there – so the 50 percent piece was in there just as the transfer of care, no electronic piece was included as part of this objective in Stage 1.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Oh, okay. Right. Uh huh, it was attest.

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

So again, I think this certainly based on experience we can come back and look at too, in terms of what those thresholds are.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So there's 50 percent and 10 percent electronically which, okay, I see it now.

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

Charlene, I have a question on a different aspect if you're ready to move on.

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

Yes, yes.

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

The care team members you said including primary care and caregiver name, role and contact information, what if you don't know the caregiver's name and certainly the role or the contact information?

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

I think we also – did we lose this one, I thought we left this one, it could also be free text, is that Michelle, is that correct? I thought we could.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, it's somehow not on this slide anymore, but it was supposed to be there, yeah.

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

But the main thing – no, I'm saying it's a must have, so you certainly may not know the caregiver name and you certainly wouldn't now their contact information –

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

– it's almost a privacy thing. But, is that really intended to be a must?

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

Well, Paul and Christine, it's – originally I, my recollection was that it was supposed to be family caregiver status, yes I have one, no I don't and this is the role they play in my care. But I don't recall having the name and contact information necessarily, although I think it's a good idea to have that as a field that is an optional field so that –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Okay.

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

– the information can go from A to B. But I do think presence or absence of family or informal caregiver plus their role, now I see that the DECAF stuff is sort of struck out, but, you need to know a lot about the role that they play in order to know how to interact with them. And I think it does almost zero good to just know that there is one. I mean, maybe that's an overstatement, but I do think you have to have some indication of role, and maybe if folks aren't comfortable with the sort of DECAF vocabulary, even though it is in use, maybe that's something that could be suggested to folks that they use. But they need to have a text box that is able to say, yes, there is one – that's not the text, but there is one, yes or no, plus here's the role that they are playing in the care.

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

I think it's fine to have a certification criteria to have place – fields for this, I don't know that we need to have a must include, I mean a lot of folks wouldn't even know who their – who to list as their caregiver. So I mean, I think having the ability to report information and the more ill somebody is, the more important and more likely they're going to have this information, but a lot of people won't.

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

Well I think what I'm suggesting is that the – since care team members, including PCP are a must, then – that you've got to have at least family caregiver status, there is or there isn't one, that's a must. Right, because you're listing – I mean, it's just I think the people who say yes, I have a family caregiver who's providing a significant amount of my care, that is essential to know. And it sends a terrible signal that we're going to list out care team member's names and contact information but not consider the family part of the team. So at a minimum I think it's essential to know yes there is or there isn't one and basic – if they're playing a significant role in supporting my health and care.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Is that really like – this is Neil. Is that really like a real designation?

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

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I mean – what?

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

If you go to caretransitions.org, is that what you're talking about, the DECAF thing?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

No, I'm talking about the term "a family caregiver," in terms of, if somebody's family member is helping them with their diet or cooking for them appropriately for their diabetes. Or just helping them with one aspect of their activities of daily living, does that make them a family caregiver and I don't think we record all that information in that way. I mean think it – it's a different level.

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

Yeah, so I think in this case it's really up to the patient, since they know their situation, to say, I mean, patients will say, yeah, there is somebody that is supporting me in whatever way that they are. But if they're – I don't think we have to have the perfect sort of definition that enables the provider to assess the presence or absence, you just have to ask the patient, in the same way you need to ask them about race and ethnicity.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Well, every child has a family caregiver –

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

Yup.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

– I mean, so maybe there's...so, I had another comment about, do we want to –

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

But let me just – this is Charlene, so do you want – the options that I heard, I don't know if I've got a proposal yet is, we can either make it, and it sounds like to me it should be a free text field that they put in, especially the family care team, because that's going to vary a lot. So should we make that a certification criteria rather than a use criteria or do you want it an optional use criteria? It's going to be really hard to do optional use criteria probably.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

What I suggested was that the contact information, the name and their role and the contact info could be certification criteria, but that the yes/no, presence or absence needed to be in the core, right, with the care team members.

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

And I think that's fine –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I just want to know, so basically you have to answer either yes or no is basically what you're saying.

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

Yeah.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

It's not just –

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

I guess I'm feeling the same thing as Neil in the sense of not before I dealt with this area today even consider myself, either myself a caregiver or my wife a caregiver for me. That terminology is sort of unusual. So I think the majority of folks who even enter a hospital, let alone who are in the ambulatory setting, would necessarily, if you walked up to them and say who's your caregiver, even understand what that term means or think they have one. Do you see what I'm – I think that's what Neil's saying and I have that same feeling.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

What I'm saying is this is not uncommon and the question is not who is your caregiver, because I agree with you that would be completely confusing. The question that I've seen typically is do you have a family member or friend who helps to provide – who provides a significant amount of support for your health and care. And then you may not put your husband or your wife and that person's probably not playing a hugely significant role in your care. But for long-distance caregivers or for other people, for example, you know when you have somebody who is playing a big role in your care, so it's not who is it, it's do you have one. And I'm just having a hard time thinking that this is not an essential piece of information when we're going to list all the care team members for care coordination. If there is a family caregiver who's playing a big role, you need to know and the record needs to be capable of that.

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

And it could be more than one, which is why I was kind of advocating free text a little bit.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, I agree with free text, I'm just trying to get through the yes/no first and then the free text piece, yeah definitely.

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

So this is George, just to clarify and so we can move on. I think this is asking the patient do you have what we're calling a caregiver or perhaps another vocabulary, and they'll either say yes or no. If they say yes, we'd like them to include some information about them. If they say no, then they've met the objective.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

If they say – well no, actually I'm saying if they say no, they've met the objective. If they say yes, they've met the objective, but there are certification criteria that enable the record to collect the follow up information, which is, contact information. The provider may want to – they should ask what role they play in their care, but I understand people would be hesitant to have that as part of the objective, the requirement right now.

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

Right.

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

Okay, so that's a slight change then –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yup.

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

– from the way it's implied on the screen.

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

Yes.

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

Okay. Other questions on this slide?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah, this is Neil. I think that number 3, the way it's worded, instructions for care during the transition; it doesn't really apply to the consultation process.

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

That's right.

M

That's right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I think there's another way – but I think that the concept is very important. So what we really want to know in the consultation process is what future orders are there, what are the future – what are the currently identified future plans for the patient, which I think, it might be a different way of kind of – but the 48-hour period doesn't really make sense. So if you were doing a consultation, you'd want to say to somebody, I've ordered an MRI, which is going to be done next Tuesday and I've done something else. You want to be able to do that and I think free text is fine, but we should state that differently so I think it covers the consultation process as well as what you're trying to cover now, which I think is more related to a hospital consultation.

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

Well Neil, right now, number – consult request will just get number 1, which is concise narrative in support of care transition or consult request captures current case synopsis and expectations for transitions –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Oh, I'm sorry, I didn't realize –

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

– 2, 3 and 4 – care summary.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Okay. I'm sorry. I misunderstood. Thank you.

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

Yeah, we tried to make it really simple, just so you could just get it there and be abbreviated. It's not totally sophisticated yet.

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

By the way Michelle, you're missing a for after four.

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

For after four.

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

The following four for site transitions, anyway, you'll see it later.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Well that's interesting because I guess I was looking at that as the only one that didn't make sense for a consult – so, I mean –

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

Yes, well that was my question too Neil, because I had the same sort of reaction that gee, it seems that you would want 1, 3 and 4 to go with the consult.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Well, you'd want 2, you'd want some statement of what the – what your overarching goals for the patient –

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

I'm sorry, that's – yeah, I meant 1, 2 and 4, yeah.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah, so I mean – I think it's a good starting point.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So what's the change to number 3, or is there one?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

No.

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

No, there's not.

(Multiple speakers)

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

The way we, again, we kind of put a four down and we said if the EHRs can be smarter and populate the other fields; we said others as clinically relevant. So it's a minimum number 1, you're just – transition of the consult and then if you had overarching goals or – I don't know if you want to refine what we said in Stage 3 as well as care team members, if that information's available, populate it.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well, okay, because that's a little, I think, different than what's written here, but – so I have, I guess, two points. One is that I think for consults the goals and the care team members should go with – I mean, and should be there, and I guess I don't see why they wouldn't or why we wouldn't want them there. So that's my first –

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

Well I think, Christine I think it was because we're saying we're doing a site transition, so we're saying this is a big switch for the patients, we want you to go through a big process. And so the question is, do we want them to go through the same process every time they do a referral? Now if they've already done it, then it should be done and in the records so you can just transfer it over, but if you haven't done a big sum – let's say you have a patient comes in and then you say, okay, well I see, but I want you to see this other person while I'm in the midst of – you're not sending them away, transitioning their care, you just want to get a consult there. I think this thing was a big thing to okay, now we're going to do goals, problem-specific goals, we're going to do care team members and figure all this out when they're at their first visit with me and I just want them to find out something specific about diabetic. I'm going to start seeing a diabetic, I want them to get a foot consult, do I really have to go through all this. Versus the first one, which was most relevant; here are the goals that are relevant to this consult that will be in number 1.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I got you. Okay, that's really helpful. So but when you say site transition, do you mean – or would that include, so a primary care doc who realizes and diagnoses a serious heart condition and they're referring the patient to a cardiologist for that – for their care, and they expect that the cardiologist is pretty much going to take it from there, is that a site transition?

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

Actually, in this particular scenario, and I need to add this, because those – actually those transitions of care, the very specific ones – the transfers of care very specific ones, and it's probably in our notes somewhere, and I need to add that into here. But that would actually probably be a consult request, in that particular case. And again, we're assuming that the relevant data, if it's in the EHR will populate the fields. But at a minimum –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

No, I mean I get the data thing, but I guess I am and not a doctor, but I usually – I wouldn't – a consult is consult with me about this patient, which seems to me to leave a gap in, I need to refer you to a specialist and I want all of this to go with you. So the – it's more of a referral because I'm not going to treat – I'm still going to provide your primary care, but I'm not going to treat this particular specific condition that we need a specialist for. And it just feels like that's not covered in this list, because I don't know that that qualifies as a site transition.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I don't really think that there's – I don't really think that those are dichotomous.

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

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Sometimes when you send somebody for a consultation, you really don't know whether the person is going to need ongoing care with that person or not. You're sending them for an initial evaluation and they – depending upon what the findings are, they may or may not need ongoing care from that person. So it would be kind of hard to know that a priori.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, and I understand it. Can we just clarify the language though, because I just don't know that everybody is going to know what site transition means? My concern is that they're going to think that this only applies when it's setting to setting, like hospital to home or I mean hospital to ambulatory, for example –

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

Yeah, I'll add those in. Go ahead Michelle.

Michelle Consolazio Nelson – Office of the National Coordinator

So this is Michelle, sorry. So on the slide there are three different types of transitions, so if those don't cover it, maybe we need to expand upon those and then – back everywhere else.

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

Right.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And I think these are – but need to clarify.

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

Michelle, we had the different use cases in there ERs, like we do in the nursing home when you go to the ER, we covered a lot of those cases, we just need to make sure that we list those, we have those in there and then that would clarify.

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

And also remember, they're also getting the summary of care records. It's not just the four fields; they're getting the whole summary of care record.

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

Yeah.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Oh right, thanks George. That's good. But – yeah. Well, I agree with that, but for consult requests, particularly if Neil's right that you don't know if the patient is kind of coming back to you or not, they may or may not. That's when I think particularly the patient goals and care team information should go with, just in case they're not coming back to you. Otherwise, the patient's just going to get asked about all that stuff again, we hope.

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

But remember, the fields will be there, if you go on the next slide remember, we put these fields in. The purpose of this was to say when it was mandatory.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right, I know.

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

So I'm not sure if I'm ready to say it's mandatory for all consult requests. And so I don't think we're ever going to perfectly tune this, so some of this has to be up to the professional to do the right thing. They will have the fields to fill in, and that's what's on the screen now, you see, care team, etcetera. So, we should just clarify site transition and I guess that includes ambulatory site to ambulatory site, right?

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

Yeah.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Well, it depends – no, I don't – I think they were – I don't have them in front of me.

Michelle Consolazio Nelson – Office of the National Coordinator

They're listed on the slide, transitions of care, consult requests and consult notes. So if those don't cover it, then we need to fix them. So we should really just have – we should add – I think this will be – add referral, okay. Thank you.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So – but can I –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Time out, time out. We're not – we just changed the phrasing from referral to consult, so –

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
– doesn't do it. Transfer of care, the intent – changing doctors. You're either going from hospital to – ED outside, hospital outside but also PCP to other PCP I think was our intention from the beginning.

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

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
– site transition, George, that's what your intention was that site transition would cover that?

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

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
I mean, that's all I'm asking to be clarified, that's great.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
And then consult means you're coming back.

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

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So can I make another suggestion though with respect to the data that's like really mandatory? We just went through this with the after-visit summary that the patient receives, right, because we got a lot of feedback from Stage 1 that it was just too cluttered, it was pages and pages of stuff, there was too much mandatory fields. And Stage 2 had the ability, in the certification criteria, to customize those fields, so that makes a lot of sense. What I'd love to suggest though is if the group could look at the mandatory fields that are not these four, the other ones, and come up with a master list of what's really required, I would just argue that I think the patient goals piece and the care team members are really essential. And maybe there's other information that needs to – that isn't – that should be fall – should fall under that customizable category.

But I think we have to look at the whole picture so we know what we're looking at, because I agree with your goal George which is, don't make this a cluttered mess, start with a concise narrative that makes a lot of sense. But I'm just very worried about since we don't typically – well, let me rephrase, since often times we don't ask patients about their own goals for health, for example, and we don't have the care team member list going from provider to provider. Those are things that I would rather see mandatory and let the stuff that should now be a basic standard of care be in the customizable optional category.

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

Okay. So this is Charlene. To clarify then, I think again on slide – the next slide with all the – this is slide 9, all the data elements that are currently part of the care summary. And the mandatory fields, at this point in time are the current problem list, current medication list, current allergy list, and they have to exist. What – the additions we made for Stage 3 as mandatory fields were again, the ability for this overarching statement of purpose, right, patient goals, again, and in the case of a transfer of care, a major change of doctor, the patient goals, the instructions of care and then the care team members, so that transition could occur. And we made those fields optional in the case of doing a consult. But in addition, again there's a whole list of this other data that would be made available if it were in the record. So – tried to minimize – a kind of balance, what was mandatory because the feedback – really clearly in terms of making this work. Like if you could give the physician the kind of – area to say his purpose and goals and what he wanted to accomplish, they're trained to do that and they would be able to make a difference with this document. So we really tried to support that as opposed to adding a lot more detail on this.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right, and I completely agree with that conceptually, and I am, thank you for pointing out slide 9, looking at slide 9 and it does say that care plan fields including goals and instructions is mandatory, if the provider knows it. So it's going to be confusing to have one look like it's mandatory and one look like it's optional. But regardless of that, I think again we went through the same problem with the after visit summary and I would rather see all of the care summary items on slide 9, have folks take a look and really figure out well what's a basic standard of care, patient name, come on, of course that's going to be on there.

So if we want to reduce the burden on providers, all of the bullets on page 9 are mandatory if the provider knows it, which means they're mandatory, pretty much. So it might be a better approach, I'm suggesting it is a better approach, to go through that list and think about, well what can we take out, because we know it's going to be in there and we want the providers to have flexibility to customize it without doing massive amounts of data and new data entry. So what's really, really important here versus what's probably going to be in there anyway because it won't make sense without it, and remove those things that are really basic practices at this point. In other words, have Stage 3 focus on the data fields that are more advanced, more patient/family centered, more about outcomes than about the basics of care provision, which, as you point out, everybody's trained to do.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I think that makes a lot of sense, because you want people to focus on the things that are new and important to them and some of it is so obvious.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And I think there are some things that we can clean up, like reason for referral EP only, that's going to be taken care of by the concise narrative that's – so there's some redundancy and then there's also some stuff that we probably just don't need to require anymore because we're in Stage 3 now.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie. But we want to make sure there's alignment, so that as Christine's point, we have the care team that includes the patient and the family caregiver, if known and other participants in the care team that the patient might designate. So – and including the goals and instructions should also make sure that it's including the goals that the patient set forth, as we have in the earlier slide. So we just need to align the words between these two slides.

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

Yeah.

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

Well, this is George. I mean I'm just thinking we have to be careful how we phrase this. I mean, if I go to an orthopedic surgeon, I do not want to spend my 15 minutes talking about my care team and my goals for care and my future and my advanced directive, I want to spend that 15 minutes talking about the pathophysiology of my finger or whatever. And so, at some point there has to be some kind of like –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

But George, I agree, and that's what I'm trying to accomplish, that when you get referred to an orthopedic surgeon, the referral's going to contain that, so the patient only has to have that discussion once with let's say the primary care provider, that they're – who's doing the referring, and then because the orthopedic surgeon has that information electronically already, they don't have to spend the 15 minutes talking about it. That's exactly what I'm trying to accomplish.

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

So that's the future, but for now, the person – the other – my PCP's not on meaningful use, let's just say hypothetically, so I don't want the orthopedic surgeon to spend her or his time figuring this out, I just want to have my orthopedic – or I may not even have a PCP.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well, but I guess I'm arguing that if the orthopedic surgeon is the one initiating the consult or the referral back or something like that. Then in that case, I want – I do want to spend time talking about what's my goal because it gets to the heart of shared decision making, it gets to the heart of preference sensitive conditions, more conservative decisions, quality of life, quantity of life, expensive testing or not. I mean that's exactly what I think is the – reflected in ACO criteria and the PCMH criteria that we need to really focus on here, as opposed to, let me collect your smoking status, your demographic information, your encounter diagnosis, that stuff is all like a no-brainer and is going to be part of it anyway.

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

So –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I'd rather focus on the stuff that really matters in this context model.

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

Christine. So Christine, I think one of my hopes, again this whole patient goals one is a really important one, and we left it free text, but again, there don't – we don't have standards around this today and to kind of get where you want to go, we need to move there. So we were really trying to signal pretty strongly the need to advance at least that particular area. Because that would again move us to the kind of real discussion that you're having, in terms of know what the patient goals are and be able to transfer them and more than just look at them and that kind of thing, and actually make them relevant.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah.

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

So that was kind of our intent for Stage 3 was to like advance these couple of elements that are related to the care plan to set that infrastructure, but if we could even get standardization thinking about – because the goals, it's all over the place right now.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, but I agree with that Charlene, that's exactly what I'm trying to do is get the focus there and not on the stuff that we've been doing for four or five years now, that's really basic. And it's fine to have them be free text.

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

Okay, so I'm not sure I'm clear on the recommendation. I mean, kind of what we showed on slide 9 is the current state in Stage 2 and the focus that we were adding some additional fields for Stage 3.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, my recommendation is that the group go back and look at slide 9 and how it relates to slide 8 and really focus on the stuff that's important through – and make that be the required fields and then everything else be customizable so the provider can include what's relevant. But you really focus less on basic standards that will happen anyway around demographics and smoking status, that those things can be included as needed, but that really to focus just on what you have on slide 8.

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

Well Christine, wait a minute, I would say that right – this is George – that right now what I see as mandatory is problem list, medication, allergy list and if it's a transition, sorry, got to get back there, goals and care team members. So that's –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

That's –

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

– what's required? It just so happens that we didn't do it for consult requests because we thought that was too heavy to mandate, although at the discretion of the professional, they can put it in. So that's where this is now, right?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well, yes and no. So when the piece of information says, if the provider knows it, it means that if you don't ask and you don't know it, you don't have to include it. So having those – having goals, for example, be required means –

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

– the goals are required if it's a transition, on the previous slide –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Sorry George, I dropped my phone. What, can you say that again?

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

Oh, sorry. Goals are required if it's a transition, that's what the purpose of having it in the measure is. So the goals is required for transition –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

No, that's my point.

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

– even if they don't know it, they have to put the goals in.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

That's not what slide 9 says.

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

No, slide 8 says that you have to get the goals.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Oh –

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

Slide 9 just says if slide 8 doesn't say you have to get the goals, then if you know it you put it down, if you don't know it, don't worry about it.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

No, slide 8 says you have to get the goals, but only for the site transition.

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

Right.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Not for consult requests, consult –

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

Right, well that's because we decided that that wouldn't be a small thing or a big thing. If it's a big thing you ought to do it, but we weren't sure how to distinguish those two. So we're saying for the transition, it shouldn't just be site transition, because that sounds too limited, so I agree we have to fix that phrasing –

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Yeah, we'll fix that.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
– if it's a real transition, we've got to do that. For a consult, some of them are going to be tiny consults and some will be bigger and so that's what we're leaving to the discretion of the professional.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
Yeah, I understand that, I think it doesn't – I'm not sure I 100 percent agree, I'll ponder and ask some folks. But I think what I'm suggesting is still relevant which is, we don't want this thing to become like the after visit summary where it's just a mess of a huge list of stuff. That the group could go back and really make some recommendations around what is essential versus what – like what we would want to focus on versus what is such a routine part of care that we don't have to require it anymore, it just has to be available to be there as needed. That's my recommendation.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
– but didn't the group come up with, it's problems, med, allergy and if it's a transition also team and goals.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
No, that's not how we've been told – the after visit summary in Patient/Family Engagement is structured the exact same way, and that is not how we're told that people implement it. Because all the stuff that says – when it says must include the following information, if you know it, you do know smoking status because it was required under category 1 to be collected, you do know vital signs, you do know labs –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Yeah, that stuff's already in the EHR, that's my –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
Right, right, which is why it makes the visit summary so cluttered.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Well if you're saying that we – that this is visualization prob – that we need to prioritize how it's displayed, that's a different issue than –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
No it's not visualization. I mean, Paul – is Paul still on the phone, because he's been on these calls with me and Mike Zaroukian where Mike is like very, very clear about this, that when it says it's known, you're going to get everything.

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
But we do want everything – go ahead Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
No, I'm just responding to Christine. So one of the concerns is if we force a bunch of fields that may or may not be relevant, then as you describe, you get people – the easy way out is just to print everything and that's where you get these 8 page after visit summaries and they're not useful. So we've sort of undermined our intent. If we focus on what most relevant piece, then not only will the people contributing, like the providers say, well, of course, that makes sense, I need to get that in there. So, there will be a lot more thoughtfulness in that rather than try to comply with a list of 20 things.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
Exactly.

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

So should we be saying if relevant instead of if the provider knows –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yes.

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

Yes.

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

– if relevant to the transition rather than if the provider knows it?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

If relevant –

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

I think that's better, yeah.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, I think that is better.

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

Okay.

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

Okay.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I think that is better, but then you have to think about what does that mean for the mandatory list below that's on the bottom of slide 9. And if what you're trying to do, which I would agree with, is that the four things from slide 8 into the care summary every time, which is what I think makes a lot of sense, then maybe we need to go in the bottom list of bullets with problem list, meds and allergies. But again, I would even argue we should think about if problems, meds and allergies are our basic standard of care and they're going to be in there anyway, then do you want to focus – continue to focus attention on them or just have everything be put it in there if it's relevant, but here are four things that you really have to have.

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

Well I would say that – I think we can leave problems, meds and allergies, that's part of reconciliation which I know we just –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah.

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

– a little bit, so I'm okay with those, there won't be too bad of a cognitive load. And then the – and I would still stick with the four or one, depending on whether it's a transition or a consult.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And so I agree with that, I just worry about the one, only one – so the only one goes with a consult request –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Right.

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

– says also if relevant –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

The thing Christine is actually it meets your requirement the best because if you're just writing a single text that sort of describes that what you're going to describe are the things that are most relevant –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

– and I – it sort of – it goes right back to what you're saying, it's like what people are going to write about is what's most relevant.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, I agree with that but my concern is that for consult requests, it would not be required to have patient goals or care team members. That's what I'm really hung up on, and I just think that's essential to have and it gets people focused on it.

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

– consults.

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

And I – that's – I guess that's more about like a consult request is defined as a PCP to a referring doc, a consultant or PCP SNF to the ED, so it's those two cases, those two use cases.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right, which makes sense to me to have patient goals and care team list in it, that's all I'm saying.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

So the care team piece you said was – maybe I misunderstood this, but is basically at a minimum is a yes or no, right?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well no, because – you're talking about in terms of family caregiver, yes. But the care team members would include primary care in that too, or hey, this person is seeing an endocrinologist and me, the primary care provider and I'm now referring to you the cardiologist, so you should know who's on the team.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Right.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

That's the essence of what we heard on the hearings on care coordination. So, I'm suggesting to make for consult – first consult request, 1, 2 and 4, not just 1.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I mean I think the care team is an important part to include and there's so much question that comes up about that in the process of a consult, in terms of who else people are seeing and whether there are other people involved and so I think that is an important piece.

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

Yeah, I mean – this is George again. It's the kind of thing where either it comes out of care summary and becomes a category I objective that you have to get goals as soon as the patient comes in, you have to get the care team as soon as the patient come in, and it gets carried along with the care summary as part of consults. It just seems odd to enforce figuring out the care team at the minute you just want a consult where you're just sending them to the diabetes nurse or perhaps a little bit heavier than that. But that's the place where now that's – where the decision's going to force you, well now I've got to get the goals and the care team because I'm sending them for a consult.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Well my assumption is that you're capturing this in another part of the course of care and what we're talking about here is just the transfer of information. I mean, I'm hoping it's not the first time people aren't capturing that information is when they're going to send somebody out and they realize they need to do it. It's they're capturing it sort of in the course of care.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I agree.

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

The ones who aren't doing it yet, that's where it's going to hit them and not –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

But that's kind of – I mean, if you wanted to put something up in category I, that's fine too, but I mean I guess that's pretty much the essence of the point that I'm making. Which is, there are people who don't necessarily ask those questions today in the course of care, but, this will enable them and help them and incentivize them to do that. I agree with Neil though, I mean I would hope that that's not the case, that as soon as they learn that the first time, I bet you it won't happen –

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle. So I was going to suggest that we put the yes/no question in with the demographics, but if we do that, there is no use case right now, so it would really only be certification criteria. So – of care or move it up?

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

Right –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And I think – important – criteria.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry Christine, I missed your response.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I was just saying, I think that what we've agreed is that we want this information collected not just to have it be certification criteria.

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

So say that again Christine.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Michelle was saying you could put it – I'm sorry – Michelle was saying you could put it in demographics, but that if we did that, they would only be certification criteria, which I don't agree with and I don't think the group intended. So I guess again, my proposal, because I know we want to keep the discussion going, is that the consult – so you must include for the first consult request, number 1, a concise narrative, number 2, the goals and number 4, the care team members.

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

This is Charlene. I think the feedback that we had heard in terms of – and again, the clinical community is going to have make this judgment call. I think that's going to be a reach and I think we were hoping that at least 2 could be accomplished with what they said in 1 if necessary, just to make it efficient.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well I'm not sure how much of a reach it's going to be since slide 9 is the list of care summary – I mean, data fields for Stage 2. And if – I think – but again, back to my point, if it is a reach, I'd rather focus people on those areas than – and have the summary be able to be customizable outside those.

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

Yeah.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Anyway, I'll stop, because I think my point –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie. We really haven't advanced much. We're really trying to set the stage for collaborative care in the future and just these basic items and saying 1, 2, 3 and 4, is a very basic step – so –

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

– disagreeing on what's a consult versus a transition at this point, how big is the transition space and how small is the consult space, right?

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

Yeah, and I can give you –

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

– that's – we're going back and forth.

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

Yeah, I can give you the definitions again on that. The consult we said was PCP to consultant or PCP SNF to the ED, so in that case, that the patient gets transferred back to the emergency room. The transfer of care are the big ones, the hospital to the SNF or the PCP, so again, you're being transitioned from one site of care to another, the PCP to a new PCP, again some major transitions where there's a change of physician. But again, there's a lot more content required in that particular case.

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

Okay, so – all right. So the question is whether we move 2 and 4 into all consult requests as kind of a way of forcing the goals and care team to be collected for everyone, basically.

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

Yes, that's the question.

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

So I guess that the Policy Committee's going to decide it. So maybe what we do when we present to the Policy Committee we just say, here's the issue, it could move – which is a little bit this way or a little bit that way –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well can we – George, can we get a sense of where the rest of the group is at? I mean it's clear where I'm – I'm in favor of that, but I'm not really sure where everybody else is.

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

Thank you Christine.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

This is Neil. I think – I'm in favor of the care team members being listed. I'm not so sure that the goals piece as a separate piece is really going to be that useful, because I think it's going to be covered in the first section, which is just the narrative of why the person's being consulted. And I think putting it as a separate piece is going to be confusing to people and –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So Neil, tell me – that's – I wanted to clarify that also because, and I'm not sure what the group meant, but when I read overarching patient and problem-specific goals. I think it's going to be very confusing, because I'm not sure – I mean in an ideal world, right, as a patient, you would be asked, okay, you've got some sort of functional limitation, what are your goals? Well, I want to walk to the mailbox, be able to do that or I want to be able to do this, that. To me, that's a very patient-centered thing that should move with the information, but I think what people will interpret this as is, okay I'm referring you to an endocrinologist and your goal should be that your Hgb A1c is less than 7, or whatever. And I don't think that's what we originally intended last year when we did this work. So Charlene, can you clarify what you mean here.

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

Yeah. So the intention was one and/or both of those that was why it was overarching patient goals, we named it patient.

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

We can't –

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

So it would be that first case. And then again, there are problem-specific goals, so it's one and – we weren't –

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

– let other people vote. What do other people on the call think?

David Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

This is Dave, I would agree with Neil. I'm a big fan of goals, but I think it's too early to include them here.

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

And other people on the call?

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

Yeah this is Art and I would agree with Neil and Dave as well that 4 is important and 2's a little bit vague still to me.

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

Others?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie and I believe that putting goals in – that are the patient's goals in here are some of the more important things that we could do and far-reaching as a way to push the agenda and push care coordination. Again, we've put – it's just an important concept that the patient might have very different goals from care, it might not be my A1c, it is walking to the mailbox, isn't that important to know? From a patient point of view, it might be the only thing that's important that they want you to know.

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

Okay and then others? Marc, are you still on?

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska(NCHNET)

This is Marty, I agree with David and Art. I think it's a little early. I think this will work itself out as we move through from Stage 2 to Stage 3, you're going to have more data.

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

And this is Paul, I'll agree with Art, David and Marty.

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

All right, so let's – so we're going to leave it open to the Policy Committee will make the final decision. It sounds like we're leaning towards perhaps including care team members.

Michelle Consolazio Nelson – Office of the National Coordinator

George –

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

Yup.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, this is Michelle. We still have another Meaningful Use Workgroup meeting, so I think, I might suggest, because we do have some language to clean up here, so we're going to have to go back and revisit some of these things anyway. So I would suggest on that meeting when we clean up the language, review it again, we can do another vote perhaps and see who's on the call, remembering how it was voted, we'll bring that information back to group and go from there, to have one more chance at this before bringing it to the Policy Committee.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, it's Christine. I like that approach, but the reason I was asking where the rest of the group stands is, the Policy Committee reacts to what's on the paper, but the workgroup is making a set of specific recommendations. So I think based on where the group is today, what I heard is that at least for the first consult, number 1 and number 4 would both be there, the care team –

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

Yes.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

– and the concise narrative. I think if the group could talk about how do you get a little more specific around the goals and obviously we've been – I mean, that's part of Stage 2, so we don't exactly know what the experience there is. But I just want to make sure that the one thing that I think everybody does agree on is included on the next slide deck.

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

Yeah, got that. This is Charlene.

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

So Christine, this is Art. And I do like number 2, it's just that I just don't know how that's going to work out in the workflow and Leslie earlier mentioned about the use of patient-generated health data and how that's contributing to the record. I'd like to see that number 2 somehow solved with that method.

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

Art, so the deal is, we're going to come back with it and we'll look at 2 and 4. If we're voting, we're voting and we have 4 in and 2 out. If we're not voting, then we're going to come back and discuss it.

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

Yeah.

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

So it sounds like we're going to come back and discuss 2 and 4 coming in.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Great, thank you.

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

May I ask one other question on this slide, this care summary 303.

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

Yes.

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

The Stage 2 Final Rule, under the core measures it says data set 3, 4, 5. What does that refer to, it's in red?

Michelle Consolazio Nelson – Office of the National Coordinator

I'm not sure where you're looking, sorry, but there's a common data set included in 2014 criteria. Is that where you're – oh, actually –

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

It's under the core measure under the Final Rule for Stage 2, data sets 3, 4, 5.

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

Michelle Consolazio Nelson – Office of the National Coordinator
Charlene that is from the work that Larry did, correct, the –

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

Michelle Consolazio Nelson – Office of the National Coordinator
– synthesis that he gave?

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

Michelle Consolazio Nelson – Office of the National Coordinator
I don't have that slide in front of me right now to tell you what they are.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
And I can actually tell you what those data – again, and this is the piece, that will be another whole discussion this group needs to have. But they had done the work to actually look at again these different types of transitions, walk through each of the use cases and the type of data that was necessary to support each of them. And again, these are pretty substantial data sets. So there's certainly a consult request separate, but a major transition of care, which is physician-to-physician, site to site and then there's a subset of that which are consultant back to the PCP, so some of the consult report kinds of things. So, it's a subset of that. And I'll add those into this next round of requirements, so I've got those carved out.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health
Thank you.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Okay Charlene, do you want to go to slide 10?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Okay. So slide – okay, so again, 305, what we did is, because this slide had really narrowed down to simply be providing the consult report back. And what we cared about was that when we sent the consult report back, it had the adequate information in the consult report, which is today encompassed in the consolidated CDA document. So we just merged this particular objective into the care summary document, because the same context and the same data is being used. Okay?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Right, because it's not adding anything over the other one.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Right, right. Because we had narrowed it down to simply the just sending the report back in the measure and so it didn't make sense to make standalone anymore.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Okay. Any comments on this? Okay, slide 11.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Okay, so in slide 11, again, this was the ability to be able to exchange a care plan. So we again identified – we got some excellent feedback relative to this objective. Some of the key feedback was that again, the work is being done by the Standards and Interoperability Workgroup to actually model this so the standards are merging so we can better understand what that subset of data may be for future stages. So at this point in time, because that work is in progress, we actually just put this as a future stage. But again, there's solid work that's advancing in this particular area.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Okay, so let's not discuss it in detail because it's a future stage, in the interest of time.

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Other specific comments about the future stage?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
No, I think –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Okay, good. So the next slide is 12.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So slide 12, again when you think about care planning and interdisciplinary problem list, that's a key element of having a patient-centered care plan. So we actually consolidated this to be part of that care plan discussion, so we'll have to come back to this one. But it needs to be part of that care plan discussion, and again, central.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
All right, because basically we had an idea, and it was a good idea, but then we split it – we put it in as a separate objective and realized it's really part of a couple of other things.

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
So we're trying to get it back into where the rest of it is.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Yes. And again, I'm going to – I'm going to share a concept a little bit on 11 and 12. Again, there is – as – the care plan, there are some new nomenclature they're thinking about using to frame the care plan, and again we'll have to make a transition when we get to that point. So, we're setting the stage in Stage 3, but again, I think it'll be advanced in future stages.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
This is not actually – so it's consolidated but it's actually a future stage anyway, so it's consolidated for the future.

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

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

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
Right, and just so you guys know, it's Christine, the Consumer Empowerment Workgroup and the Consumer Technology Workgroup are looking at care plans for future stages pretty closely, because there's a lot of work to do there.

W
Okay.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Yeah, absolutely. And Christine again, some of the work coming out of I&E is kind of rename and – renaming anything will be traumatic, but let's change this concept to health concerns and we did not go there in Stage 3, but we could certainly see thinking about that moving forward.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
Yup.

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

Christine, is there anything you need signaled in our future stage thing that isn't already in there? It looks pretty comprehensive, I think it does a good signal, but –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well I think part of the work is, and we can talk about this later because I know we're tight on time, but part of the work is to reframe, first of all what this is, because it's a very medical model. And from a consumer viewpoint, there's a little more interest in a more I'll call it "whole person," but more of a planning process than a sort of static document, so we need to really understand what's the process, how can we support it with technology. Where does it live, does it live in the EHR? I kind of don't think so, in a way, right?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Right.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Where's the – it's that collaborative care platform that facilitates bi-directional communication. What do we need to do to get there?

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

Okay.

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

Yeah, fine. Well, so again, some of the work being done by the I&E Workgroup is thinking through that type of process, so –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yup.

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

Okay, then –

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

Then 13.

M

(Indiscernible)

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

Slide 13 – again, what we had originally proposed was the ability for an elec – and actually, it could be a registration system, to be able to actually send or receive a notification in the case of a significant healthcare event. And we listed the different types of events, arrival to the emergency room, admission to the hospital, discharge and/or death. Again, this is a new criteria so again we are finding actually this is being operationalized in many settings already, but we thought it was important that the health information system, electronic health record be able to accommodate this and/or it could be an HIE. So, for purposes of that, what we did is we focused it back on getting it – putting – making sure that we had the infrastructure in place for stage 3 for notifications. So we backed it off to certification criteria for Stage 3, partly be – another challenge again is figuring out the denominator in all of these cases. But we felt it was important to add in in terms of the capability.

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

So Charlene, this is Art. I understand why you would back of the certification, but I'm a little concerned here that – I mean, this actually happens in most systems today, within the system. So it doesn't really reflect a change if you just have that certification because the registration system, like you say, broadcasts that inside that organization. This should be communicated to somewhere else, to the –

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

Right, that's –

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

– care team, to the provider outside that system.

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

Okay, and that's the intent, so I need to clarify that that's the intent of this one, it's outside the system.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And Charlene, I think, this is what we really hear a lot that this is one of the biggest – points for doctors, they don't know when their patient gets admitted or discharged and they don't have the information. I'm concerned that it went to certification criteria. Is there – is it pos – but I understand that we probably don't want to do the work in the 10 minutes we have on this call. I mean, is this something that the group would be willing to re-look at and think about having it be an objective? Because this would be huge in so many areas.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

And it's the most mature standards – this is Leslie, the most mature standards we have out there are ADT. So, it's – there is no technical barrier to this, it's just that, I think Art made the point earlier, it's making sure this gets out to external systems notifications. I would certainly support also having a measure of use.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, and I'll just say, this stage is really – sorry, really supposed to be focused on outcomes and this would be a huge way to get down that path.

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

Comments? This is one I'm not as firm on, this one I could –

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

Well I think the problems were not so much with the mechanics of getting an alert out, it was the provider directory and HIE was the limitation, how to measure how effective you were in telling a doc you don't know that the patient was admitted to the hospital and that kind of thing. I think that was the limitation, not so much can you trigger on an admission.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

But we – so how do we – I mean, in clinical, summaries, it's kind of the same thing, right, with a more diffuse universe. So –

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

Yeah, yeah it is.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

– and with the direct protocols and standards and things like that, I just think this is a really big opportunity.

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

Does anyone – Paul, I don't remember how – what the discussion was or Michelle, do you remember the discussion on this?

Michelle Consolazio Nelson – Office of the National Coordinator

I think it was really based upon the feedback from the public that it was moved to certification criteria.

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

So it was the public feedback that set us back.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Can we understand why though?

Michelle Consolazio Nelson – Office of the National Coordinator

Let me just quickly look –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Or maybe we can talk about it on the next call or something?

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

Maybe it's the denominator issue and maybe we just back it off to you have to send a number, not that you need a denominator here.

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

Okay.

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

Well that's a possibility, but let's look at the – if it's menu and a number, then I think – this is subgroup 3 –

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

Yup.

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

Unless Michelle you already have it?

Michelle Consolazio Nelson – Office of the National Coordinator

I do, I can quickly read the summary of comments, if we have time. So some thought the 10 percent threshold was too low, there was concerns about privacy and security implications and the patient's role and consent. There were a few comments about that. And they wanted to define a significant event, which we did. Inefficient technology and infrastructure to support the measure. And then concerns that the 2-hour window was too short and suggested lengthening the timeframe.

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

So it really came down to the second to last sentence.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Which was what again?

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

Well the infrastructure, can we really – as you point out, that's what we're doing with referrals and so forth, but – remember, this one is to people you don't really realize. So the difference, Christine, I think is when you do the referral or the consult, you're with the patient and you're purposely sending the patient somewhere else. Whereas here, this is something that's just getting triggered and we're supposed to know –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Well in general, at registration – this is Leslie, it's asked who your primary care physician is or who your physicians of record you would like to have notification of your visit or copies of your transcript. That happens today in registration, it's just generally to send it post-event. So at the – we would have actually more information than we generally have at a transition of care up front, at least we know at the emergency room or at the admission. We do it today by getting a FAX number, but we do ask the questions at intake, who's your primary care physician or other physician of note that you would like to have copies. Then with the direct protocol in Meaningful Use 2, we also get the ability to send information to them without having to have specific HL7 interfaces. We have a physician directory associated with that, so this really is very, very possible and doable.

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

Okay – this is Charlene. The recommendation I heard was, as opposed to – if we want to make a specific use objective, one recommendation is that it's a menu, which I think might make sense, as well as secondly, that we set a number as opposed to a threshold. Any comments on that? And this is just an EH or critical access hospital requirement. And we wanted to also make sure that – the other comment we got was keep it open so if it was a function of an HIE, they could also do it. Is that –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

It might be helpful to have it written, particularly given the kind of HIE implication, have it rewritten on a slide for next discussion, because I'm having trouble following.

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

That would be fine, I can do that. All right. Then the last objective – I'm going to move on, we'll rewrite it. Then the last objective was med adherence. Again, the med reconciliation, the process to be able to retrieve external medication fill history for adherence monitoring. And again, we identified that as a future stage objective and didn't get a lot of feedback that we should be pushing this into Stage 3.

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

Okay, very good.

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

All right.

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

Other comments on that? I think that makes sense. All right, thank you Christine –

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

Charlene.

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

So, we have some work to do, especially one more, but that's not too bad, we've gone through a lot, so thank you for that.

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

You're welcome.

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

Other comments before we go back for public comment?

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

Just one thing, the early discussion that David had about the UDI, should that be on the list of the care summary items, the bulleted items on slide 9 or –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Great call.

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

We would actually have to maybe put it in there as standards looking at that, is that what you'd like us to do, because they'd have to look at the standards and see where it would fit in the – architecture, etcetera, etcetera.

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

Yeah.

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

Okay.

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

Okay, that sounds right. And that'll be saying as relevant, instead of if the provider knows it also. Okay, other comments? Okay, so let's go to public comment then.

Public Comment

Michelle Consolazio Nelson – Office of the National Coordinator

I don't think MacKenzie's on the phone anymore, so Rebecca, if you're still there, can you open the lines?

Rebecca Armendariz – Altarum Institute

Yes. If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you're listening via your telephone, you may press *1 at this time to be entered into the queue. We do have a comment.

Julie Cantor-Weinberg – College of American Pathologists

Yes, this is Julie Cantor-Weinberg with the College of American Pathologists and I appreciate you're having this open public comment period. I would just urge you as you refine this Stage 3 objective to think about how they apply to eligible providers, regardless of their specialties. We found that for Stage 2 pathologists have to contort themselves into pretzels into trying to figure out what they mean and how they relate to their practice. Because they do still largely practice in laboratory information systems and anatomic pathology information systems and blood banking systems rather than EHRs, but they are eligible for incentives and for penalties. The number of pathologists have – to Meaningful Use so far is very small and it's very hard to figure out what a referral of care means, if you're a pathologist who primarily issues a report to the ordering physician. And all the Meaningful Use objectives to date have been written from the perspective of the physician or other provider ordering the service, not the provider receiving that order and acting upon it. Thank you very much.

Rebecca Armendariz – Altarum Institute

Thank you and we have no further comment at this time.

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

All right, very good. Thank you all for the discussion today.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you Charlene for all your hard work.

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

Okay guys, bye, bye.

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

Good bye, thank you Charlene.