

**Consumer/Patient Engagement Power Team
Patient Direct Group
Draft Transcript
April 6, 2012**

Presentation

Operator

Thank you. All lines are bridged.

Mary Jo Deering – Office of the National Coordinator

Thank you very much, operator, and good morning. This is Mary Jo Deering in the Office of the National Coordinator for Health IT and this is a meeting of the HIT Standards' Committee Consumer Patient Engagement Power Team. It is a public call and there will be an opportunity for public comment at the end. There will be a transcript made, so I'll ask the members to identify themselves when they're speaking. And I'll start by taking the roll. Leslie Kelly Hall? I think you're on mute, Leslie. I know you're there.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I'm here, sorry.

Mary Jo Deering – Office of the National Coordinator

Jim Hansen?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Present.

Mary Jo Deering – Office of the National Coordinator

Heidi Sitcov?

Heidi Sitcov – Nurse

Present.

Mary Jo Deering – Office of the National Coordinator

Alice Leiter?

Alice Leiter – National Partnership

Present.

Mary Jo Deering – Office of the National Coordinator

David McCallie?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Here.

Mary Jo Deering – Office of the National Coordinator

John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Present.

Mary Jo Deering – Office of the National Coordinator

Holly Miller?

Holly Miller – MedAllies – Internist and Chief Medical Officer

Present.

Mary Jo Deering – Office of the National Coordinator

And Sean Nolan? Okay, back to you, Leslie or Jim and Heidi.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Leslie, why don't you go ahead and give some context to the bigger picture and then also to the meeting that happened previously this week, if that's okay, and then Heidi and I can then take it from there, if that's okay.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

You bet. Thank you all for joining this morning. We've gotten off to a good start. Arien's team met and has started to work through the themes and also the individual recommendations to standards. Some common themes that will impact this group is obviously that view, download, and transport is important, that information that's provided to the patient is equal to what's provided to other providers, both at the granular level and at the human readable level, that that data also be understandable to the patient was another concept that came over and over again, and also the idea of cc Me, not just cc Me on that record, but cc Me on actions that are material. One of the big messages that we received from our consumer advocate, Nikolai, was that in a hospital he saved his life as a consumer, and as a patient, but basically to say, hey, I have an intolerance to that particular procedure, and he believes very, very strongly that the patient is an important concept in patient safety, so that was a new theme added. As a result he believes that cc Me should also include cc Me on orders, and the group also supported those kinds of questions or cc.

The other concepts that came up were the standards as written, they sound great and they will do in many cases. However, the definition of user in that standard needed to be expanded to include patient and family. So there were some takes on how to potentially comment back with those ideas, how do we take the standards that exist and modify it to be more engaging. Then also one discussion that we had was is it possible that standards are able to actually get ahead of policy, because standards don't say you must do them, standards say here's how to, and this was talked about a little bit because of being conscious of the vendors and others who have to touch code often, is there a way, for instance in the demographic fields to make sure that if there are logical fields that a patient might generate could those fields be added to the standard. There were discussions around that and obviously very pro-patient and very pro-consumer. So I think we have a lot of support in the team to really stretching things a bit, and the goal will be to take the comments from Arien's group, from this group and Liz's group, and we'll combine it into a document, we'll have a draft cover letter by our next meeting, and have that out so that everyone can read it before the meeting. That's the big picture. And I think, Jim, it would be good if we have a minute, if there are new people on the call, and I'm not sure if they are, to introduce themselves just really briefly, and then take it from there.

Mary Jo Deering – Office of the National Coordinator

Actually why don't you have everybody introduce themselves, because some of the new people may not know some of the old new people.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

It sounds great. I'll just start. I'm Leslie Kelly Hall. I'm with Healthwise, a long time Chief Information Officer in Health System, and very active in patient engagement in my role at Healthwise in policy.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

We'll just go down the list. Heidi?

Heidi Sitcov - Nurse

Hi, I'm Heidi Sitcov. I've been a nurse for 37 years. The last few years I've been focusing on nursing informatics and assisting healthcare assistants with implementing electronic medical records. I was invited on the panel, and I'm very glad I was, as a patient advocate. I have been enjoying participating.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Alice?

Alice Leiter – National Partnership for Women and Families – Director of Health IT Policy

I'm Alice Leiter. I'm the Director of Health IT Policy at the National Partnership for Women and Families. It's a consumer advocacy organization, and we advocate for health IT implementation that keeps the patient at the center and not only is patient-focused but engages patients in every step of the way. So you can imagine my delight that Leslie took special leadership in setting up this committee, and I'm really sorry I won't be able to ... the call this afternoon, but promise to redeem myself at a later date.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

All right, we'll hold you to it. David?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Hi, David McCallie with Cerner. I'm a member of the HIT Standards Committee, and a long-time proponent of health record banking type approaches to ... the medical record in the consumers' hands –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

David, can you speak up a little bit? And make sure, you didn't mention your position too.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Oh yes, sorry. I think my line might not be good, so when I finish I'm going to dial back in. I must have a bad connection. David McCallie. I'm a physician at Cerner. I'm on the Standards Committee. I'm interested in consumer access to medical records. I was one of the co-creators of the direct standard, which in my mind had that as one of its target purposes. I'll dial back in. Sorry.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Thanks, David. John?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

John Derr, I'm Head of Clinical Strategic Technology for Golden Living, which is a long-term post-acute care company. We have about 60,000 patients under our care at any one time in the day. I've been in healthcare for almost 50 years and Secretary Thompson in 2004 asked me to coordinate long-term care HIT on President Bush's Executive Order. I'm on the Standards Committee. I'm on the NQF HITECH Committee. I've been a great advocate for patient-centered electronic health since the early '90s and trying to get the caregivers and protect the caregivers and also the skilled nursing facilities and home care and hospice care and ERPs and ALFs and all the rest of our alphabet soup that we have. This is a very important power team to what I believe in.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Holly?

Holly Miller – MedAllies – Internist and Chief Medical Officer

Hi, I'm Holly Miller. I'm an Internist and the Chief Medical Officer for MedAllies. I previously worked at the Cleveland Clinic for 8 years and led the team that implemented the personal health record back in, oh, I would say about 2000. We very quickly went from zero to roughly 100,000 patients very actively using that record. I think the most important thing is really that as we look now at the trends toward patient-centric medical home that the patient really is and their designated family members are very active and engage part of the team, and to that extent has all the information necessary to manage their care and participate as a fully engaged active member of the team.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Sean, did you join us?

Sean Nolan – Microsoft Health Solutions Group – Chief Architect

I did. Hi, folks. I'm Sean Nolan. I run the ... team here at Microsoft, and we've been about six years into our journey of trying to help folks do what we're talking about here, which is make sure they have the information they need to be more effective and keep their families healthy.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I believe that I'm the last one. If there's someone else that I missed, I apologize, so let me know, but I'm Jim Hansen. I'm currently Vice President and Executive Director of the Dossia Consortium, which is the non-profit side of Dossia, which is really advocacy around the patient and consumer, and in my mind it's really refocusing the attention back to the consumer patient and the physician care team relationship and having that bring that relationship into the new world by having it be informed over time with information, the right information at the right time to support decision making, whether it's the patient by themselves, it's the care team by themselves doing some kind of ... planning, or the point of care, the point of care now needs to be not only physical but it needs to be virtual. And I think if we get that right the medical home, the health home, I love that New York State, by the way, has a health home, they're thinking bigger accountable health organizations and accountable care organizations, and those things will all move out and have been doing all kinds of areas of healthcare for 20 years. I got my passion from the consumer side from George Halvorson at Health Partners before he moved to Kaiser in the early '90s when we did something called Consumer Choice, so I'm passionate about this area. And again, did I miss anyone or are we good to go in terms of the roster?

All right, what I'm going to do is go ahead and I want to give everybody an overview. The ... yesterday, early this morning three things were sent, a spreadsheet, and Sean, my apologies to the Excel team, we're using a spreadsheet technology in a way that it should not be used ... on a screen and ... to the point where people over 50 like me can't read it. But that's the process we have and so in that you'll see that Heidi, myself, and when other folks have given us comments we've tried to sprinkle those in to just give us something out of the gate that's not Greenfield. But everything on there is subject to debate, addition, change, deletion, and we'll walk through that process.

The second thing I sent was a revised set of themes that Leslie had sent out based on the conversation for team one, and she had added some pieces. If you print pages 2, 3, and 4 they fit on 8.5x11, but I did not add some proposed new sub-theme elements on there, so when I say revised themes it wasn't based on the work that we did prep for this call. To me that only can happen after we all have consensus, so what's there is what came out of the first group.

Then the third thing I sent was a document that was produced by Lindsay Hoggle, who's been very active on Holly's S&I framework transition of care group, on the care planning side, and I've been involved in that as well. And, Lindsay, her focus has been nutrition and exercise and their group has been working very hard over the last couple of years through HL7 and through other bodies, including the S&I framework, to finally get those items in the discussion so that we are, as we've been reoriented in terms of at least the discussions with the IOM level that we don't have a healthcare system, we have a health and healthcare system. And since we all know that a significant part of outcomes is based on the consumer patient being engaged, being informed, being jointly accountable, and a big piece of that is nutrition and exercise, we absolutely have to make strides here too, and this is one reason why it has not been engaging for them, personal health has been off on the side and kind of do it yourself, good luck with that, let me know how that happens, and then I'll get back to you. That's not really any way to create joint accountability and ongoing oversight.

And as we look into bundled payments and into medical home supplemental care coordination fees, etc., it's in everyone's interest to optimize the patient, as the National Partnership for Women and Families frequently reminds us, the patient and the consumer is the most under-utilized resource in the healthcare system, and you'll hear me redundantly say that there's no healthcare industry without a patient. That's not just trite. It actually on an economic basis there are many economists who believe there's no way that

we can figure this out unless we do two things: we apply technology but we also engage the consumer patient. And the analogy I have is that up until now they've basically been logs in a river and they just run into rocks, they run into the bank, they get all hacked up, and they're pretty much just slowing down the process, and we really need to take those logs and make them canoes, or at least get a majority of them to be canoes so they can navigate the healthcare system instead of just flow through it. And so it's with that context that the third item is introduced to all of you as something to give some serious consideration to.

I'll stop there before I move to Heidi and give her little overview on the process that she did. Does anybody have any questions on the materials before we dive in?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Jim, it's David. I have one question.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, sir.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Is it okay now?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

It's still faint, but I can hear you.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I'll try to speak up.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

That's better, much better.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

It must be a phone problem, not a line problem. Sorry. Since I'm late to join the group I'm confused about the broad context. Is this a workgroup of the Policy Committee, the Standards Committee, both committees? How is it structured in terms of reporting up?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

It's the Standards Committee, so it reports to the one that you, John, and Leslie are on. We have an Overall Patient Engagement Workgroup that Leslie chairs, and this team is one of three sub-teams underneath that where we've taken the meaningful use list and divided up, first we were going to divide it up patient direct, patient affecting, patient influencing, but because of the number we had to reorganize it, and again, Leslie, if I say anything wrong let me know, but basically one took roughly the top third and we have the middle third and then the bottom third is team three, and then we're all dividing it up because of the detail that it required, and then we will come back together in a subsequent call with the full group and walk through the combined efforts and then also the letter that Leslie alluded to, and Leslie, is there anything you want to add to that?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

No, I think that's it. We're going to combine the three workgroups ... the team work and then review that as a whole team on our next meeting. And yes, Mary Jo, I did ... to that whole team.

Mary Jo Deering – Office of the National Coordinator

Okay.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Great. That helps a ton. I also had lost track of what was policy driven and what was standards driven, but you answered my question, Jim, thank you.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Well, that's a really good point, because in the first call we had, David, and I apologize that you didn't have the benefit of that, but for the first whole team call that was a question that came up. Some who have been involved in this believe that the standards and the policy groups might have worked better together and that it's not just policies and standards but it really is an iterative process. And I think that was recognized maybe a year ago when there was more cross-teams involved, and even though this officially is standards, we may very well raise issues that then move around to the policy side, and I think that alludes to what the theme that came up in team one's call, which is there may be standards that need to be put in place that are in front of specific policies and that's kind of what Lindsay Hoggle and the dietician and the exercise folks have been trying to do to work on those things really in front of the policy side because otherwise, David, as you well know, last year when we were looking at Stage 1 it was what existing standards do we have. And so I think it's not as straightforward, from my observation and participation in a lot of the workgroups and the overall committees, but I think this needs to be a lot more of a symbiotic discussion rather than a throw it over the wall discussion, and I think I've seen a lot more of that. And I'll stop there and see if anyone else has a comment to that, because I really do think that that's important as a backdrop to the discussion we have today.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Jim, this is Leslie. I would say that right now the scope of this team is to look at the standards in the NPRM as a sub-team of the Standards Committee. However, ONC has recognized that there is some need to have patient engagement considerations across those committees and are evaluating right now how to do that in the future. So they're quite on top of it, and I think our work will largely inform that. That's my hope. What we're seeing, and Jim, you described it, is sometimes we're touching on policies, sometimes we're touching on standards, but our goal is to say standards can provide engagement tools and here's how, and there are the rationale or the themes behind that. So that's what we're hoping, the work rule will be self-evident at the end and we hope that this will inform the ongoing need to have patient engagement across both areas. Mary Jo, have I captured that okay?

Mary Jo Deering – Office of the National Coordinator

Very well, thank you.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Before we try to navigate this unwieldy large text block spreadsheet, if you haven't done so I'd encourage you to go cell 031, which starts with "Content, general comments from the full team, team one and Policy Committee related to view, download, or transmit." Because that's such a huge overarching set of comments that were made in a variety of different places it was too much to put any one place and so it might be helpful to have that on the side, so if you have access to a printer and you can print that and put it to the side, that might be helpful when we get down lower down to 30, 31, 32, the three that are related to view, download, and transmit. And with that, just to review the process that we sent out a few days ago, Heidi was kind enough to take first shot at it and go through it from her nursing expertise, and her implementation of EHR expertise and ask some questions and identify, at least on a first pass for one person, some of the items so that we would have something for you to react to, and then I did the same thing, following her through the spreadsheet, and then we'll all walk through the spreadsheet together. And, Sean, I did get your e-mail. Thank you. I probably could have incorporated your comments, and I didn't see it until after it was too late, so I did have those printed off to the side, but I'm glad you're on, so please go ahead and make those comments as necessary.

But if it's okay with everyone, let's just start at the top and we'll just walk through. We're on line 21 and we're going to be over in column M. Actually we need to start with the overriding theme, so it's column I, so we're on I21.

Heidi Sitcov – Nurse

Excuse me, Jim, it's Heidi. Are you going to be able to bring the spreadsheet up or no? I need to bring that up. Are you –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I don't know.

Heidi Sitcov – Nurse

I have to go to a different computer then to bring it up.

Mary Jo Deering - Office of the National Coordinator

Caitlin, are you on?

Caitlin Collins – Altarum Institute

Yes –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

... I have control of it, or not?

Mary Jo Deering – Office of the National Coordinator

You may have control of it, yes. They can give you control of it.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, let's –

Caitlin Collins – Altarum Institute

We'll put up the spreadsheet in just a moment and you'll be able to move around.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, but I can't move it to the one I've got opened on my system, you can't make my desktop active, it has to be the one that you guys have?

Caitlin Collins – Altarum Institute

It's a different thing. We can do it. You need to share your screen, which we can do if that is what you would prefer.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Either way. It might be easier to do ... have to explain how we're going to navigate it.

Caitlin Collins – Altarum Institute

Sure, one moment.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I don't want our logistics to get in the way of moving forward, so whatever is the most expedient way to get started.

Caitlin Collins – Altarum Institute

Okay, we'll go ahead and put up a PDF and give you the ability to move around it yourself.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay.

Holly Miller – MedAllies – Internist and Chief Medical Officer

I have a comment on 21, this is Holly speaking. I'm looking at J and K and I think as an internist for me when I most frequently use this kind of functionality in the EHR I'm looking for diabetic patients that have not had a hemoglobin A1c within six months. I'm looking for my diabetic or my hyperlipidemic patients who haven't had an LDL measured in the last year and I haven't checked their liver function tests and so this, in my mind, when it comes to the consumer really is sending alerts and messages to them that these tests are needed, that these are things to maintain your health or to improve your condition that we're needing to monitor. And so I think in my mind this is where it would be linked to the ability to, to a portal,

and again, if we think of meaningful use whatever the patient's preference is, a phone call or a letter or a message, to let them know that these things are out of range or haven't been done and we need to do things.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Holly, that's a great introduction, and I just realized I didn't set up the context for this, so thank you for doing that. Before we get to that specific comment, I had mentioned pages 2-4 of the theme sheet. If you printed those out you'll see under there that there's overarching themes, so of the ones that were there the one I selected was how does the care compare to clinical quality measures, and then I'm proposing a new one called "Use of the system to ... identify that I'm getting the services that I should and when I should and compare to industry standards or to people like me." And so, Holly, given the context you just said, if that's not accurate or adequate then if you could propose something different that would be great. That would more effectively capture this idea.

Holly Miller – MedAllies – Internist and Chief Medical Officer

Yes, Jim, I think there is one other element, and I tried to bring this up on our large call, which is that often, particularly now in the environment we all are living in, often patients have to pay something for these tests, they are uncomfortable, at a very minimum it's a needle stick, sometimes it's more, you get a colonoscopy, that's a lot more for the patient and it takes time out of their lives, and so I think that it's very important to have the ability along with this whole reminder concept to have expensive information on the benefits of why should I do this test, what's in it for me. Because it's inconvenient, it hurts, and it's time consuming, it takes time out of my life, the other activities that I enjoy more, hopefully, and so I think that there really needs to be some data that's available to consumers, patients, to understand the importance of these tests.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Right, so it's the action part of this. This specific NPRM requirement is the ability to create lists with these pieces here, but when I get that resulting list and it results in some action, a care coordinator calls this patient and says you really need to get a cholesterol test, or like you said, a colonoscopy, then immediately it's connected with an education opportunity all in one flowing process.

Holly Miller – MedAllies – Internist and Chief Medical Officer

Exactly. That's exactly what I'm saying.

John Derr – Golden Living LLC – Chief Technology Strategic Officer

That's sort of that information button, this is John Derr. I would also like to say that once we start getting trending information we can show the patient that, we said earlier in this meeting, this call, to get patients with skin in the game, and I think that's the one way we're going to do it, to show them, say their cholesterol is going up or down or that and they need tests to start monitoring that over time so we can proact on dosage, and I forgot to mention about pharmacists, but one word I never hear hardly ever is "titrating" dose, and I think that's important in polypharmacy as we move forward in this whole thing.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

All right, anything else? David, you sound like you're chiming in.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I'm just trying to catch up from where the group's coming from. From the point of view of either certification of the record, or measuring an activity towards a goal, what are we commenting on here? There is a requirement elsewhere for consumer handout education and it proposes to use the Info button standard, which to my knowledge hasn't been used for consumers before, but that's another debate.

Holly Miller – MedAllies – Internist and Chief Medical Officer

What we're commenting on really is the fact that in my experiences, and I can order things, and I always do, I order ... and so if we look at my ordering patterns, my CQMs would be perfect. But there's another part of that, which is if the patient follows through and does those things, and the part of that requires patients to feel like, okay, well, what does this mean to me? Why should I follow through? And so we haven't linked that patient information. Usually that patient information, the way it's set up in Meaningful

Use Stage 1 is at the time of the visit. But now I'm sending reminder information of please go do this, along with the fact that it's already been ordered and I want you to do this, so why, and so it's having the ability to have information about that available to the patient at the same time I'm sending a reminder.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

And what standard would we –

Holly Miller – MedAllies – Internist and Chief Medical Officer

We're on patient list right now, so we're talking about patient list and so the functionality for patient list is, okay, I'm being able now to monitor my practice overall and see what is missing, what's not meeting the standard of care that I'd like to be providing to all my patients.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

My understanding is that the patient list is a provider facing list.

Holly Miller – MedAllies – Internist and Chief Medical Officer

Yes, we're talking about a provider facing list, exactly.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I'm not clear how that captures whether the patient is engaged or not.

Holly Miller – MedAllies – Internist and Chief Medical Officer

I guess because in my mind the only reason I'm running that provider facing list is to be able to send reminders to my patients about things that they need to have done to maintain their care, or to maintain their health.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

But you're suggesting that we're missing categories here on health maintenance?

Holly Miller – MedAllies – Internist and Chief Medical Officer

No, I think what I'm suggesting is that there's a linkage that's being missed that if these provider facing lists ultimately are going to be used to interact with patients and it's very important as we interact with patients around these lists that we not only tell them what to do but why to do it.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

But in terms of ... on the standard we need to specify a new category of information that should be managed by these lists, that were ...?

Holly Miller – MedAllies – Internist and Chief Medical Officer

I'm sorry, you're breaking up. I couldn't hear that.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think David's asking, this is Leslie, that do we need to add a category for this list for the standard. So the ability to draw out lists of patients, I think you've really articulated well why the doctor does it for the practice, how to manage a patient population. The list also might be created for population health management. One thing that is not captured here is perhaps notifying the patient that they are participating in a disease-based program. Is there a need for that kind of notification within this list process? The messaging that you talked about for patient engagement I think covers, and we can talk to that specifically in the reminder section, which is trying to get to reminders and preventatives and wellness, coaching, those kinds of materials in the actual messaging. So one is how do I prepare the list, which is this, and then further down is what do I send once I have the list? So in the list would it be worthwhile to consider that part of that list is notification to a patient that they're participating, and that's a question.

Sean Nolan – Microsoft Health Solutions Group – Chief Architect

That was actually the comment that I was thinking about. And actually I'm a little hesitant on it, because I think it may be overstepping, but it does occur to me when I think about it that at least in some sort of

intuitive way something that I might do to create a list and say, here are the patients that I need to go focus on and I'm going to do whatever, that seems pretty straightforward. As this becomes more available, I would imagine that it becomes used for much more, such as I might actually re-contact patients that I haven't seen in a long time from a business perspective, or I might be particular about research, and so my thought, and I think that I'm a little hesitant about it, is there some kind of notification of patients from a privacy or consent point of view at some trigger ... when these cohorts become persisted or they're used for some other addition, I'm not really sure. But I wanted to throw out there the idea that are we going to open up something here where the patient really ought to know, just from a privacy point of view,

Jim Hansen – Dossia Consortium – Vice President and Executive Director

And they would know if this was used to create some kind of panel that was essentially a clinical trial or something along the research basis, Sean, then they would have to then be engaged to consent to that. I don't think we need to do that. I think that's something we need to make a note of, because I think that's a great point. If you can't look at how we use these systems today, if we have to look at how we use them in the future, it's very much like the way customer relationship management works. Right now we have these registries and we have these lists and people work the lists, but it's a relatively manual process and it's not very connected. In the future, really the system is going to be automatically dynamically generating lots of different lists of different combinations and providing all kinds of queuing for care coordinators and even if they're not even a medical home or physician it's going to be doing a lot more capabilities from a software perspective, and so I think it's important that the next one, Holly, down, is the reminder, or the engagement piece to the patient really is the part B here which says if I trade a list that does that, when I reach out to the patient then I should be ready to immediately connect them to some information that shows them the value of what I'm proposing them to do.

Heidi Sitcov – Nurse

Jim, this is Heidi. As I was looking at those two I really thought that there was a gray line here because the patient list, as you said, does generate the patient reminders. So I guess this is the place to draw the line here, but, yes, you're making this list so you can make reminders, correct, so you can send –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, that's one use. It can also be if you see something, like we've had some bad food poisoning at a particular zip code, so you might want to look to see all of the people I've seen in the last week from this zip code. And that's my comment down below about Stage 2 and Stage 3, is find a problem list, medication demographics, lab for Stage 2, but really Stage 3, any attribute you have on a database ought to theoretically be able to be put together in some kind of list that allows you to be able to generate whatever you're trying to go after and it shouldn't be hard coded to just these four categories. So that's the reason why I had added that last piece in there, is to move it to that next step.

Heidi Sitcov – Nurse

I also had suggested something that Sean had here for row 22 is including family history, because that data does drive reminders. Is there a family history of breast cancer, ovarian cancer, those kinds of things?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. Also, remember that many of the systems today don't need a list to generate reminders and basically once that patient has been identified with a particular condition it's in an automated system way. So we need to make sure we're not too prescriptive that we don't allow for the multiple uses of those lists.

Heidi Sitcov – Nurse

Okay.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, you're right, the ... mundane stuff can be handled by that, so that dynamic, the food poisoning or the sickness in an area of a population, we ought to be able to do a lot more to address those things. And we can't do it if we don't have the flexibility to create lists in a very quick way.

W

I just wanted to echo the previous comment, though, because I think I did see comments from others about concerns about being able to change reminders and in most EHR systems the clinician can change the schedule of reminders based on factors like family history or actually not have reminders for patients for whom those reminders do not apply, for example, a woman with bilateral mastectomy shouldn't be reminded to have mammograms.

W

Right.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Right.

W

So I just want to reassure that the systems do have that flexibility. Most of them do have that flexibility now, so I think that we wouldn't want to be too regulatory there.

W

Oh yes, I remember many a time when patients with bilateral mastectomies got calls or e-mails about coming in for a mammogram.

W

That's horrible. Hopefully it works better now, and again I think that we'd want to be careful not to be, because that's often too a discussion with the clinician and the patient and the patient gets included in

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I'm going to be the time police because I want to make sure that we don't run out of time, and so maybe we'll come back to some things. But specifically to address what's here, there are four areas. It sounds like family history is accommodated in most of the capabilities, so Heidi, it sounds like that might not have been your experience, so that seems like that's an open thing that we need to –

Heidi Sitcov – Nurse

It is true that reminders are generated other ways too, not just by patient list here, there are alerts in some of the systems that will automatically come up if a patient hasn't had a mammogram in over a year or needs a colonoscopy, it's been over so many years, so, yes, you wouldn't want to duplicate the work, but I've also seen patient lists with a section for family history; it's been helpful for some, maybe not so helpful for other physicians and healthcare team members.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Do others feel one way or the other about including family history as something that's mandated as a core for 2, or a menu for 2, or save it for 3, or not at all? Does anybody else have any strong opinions either way?

W

I think there's so much clinical variability and I would be reluctant. I think that's often a discussion and so that's just my two cents.

M

Just to be clear, we're talking about for row 21 in particular, we haven't moved on to 22, correct?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

No, no, no, we haven't, that's why I'm trying to close that. We need to move on.

M

Okay.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Each one of these we can talk about literally for two hours and peel the onion away and get through them all and maybe we can come back, so that's one item that's on the table. It sounds like maybe we'll hold that aside and maybe talk about the fact that it's important, but what about this last piece, the suggestion for a menu for 2, and core for 3, that really literally any of the attributes that are accumulated on a patient should theoretically be able to be used to create a list. Is there anybody who feels strongly for or against, or that's detracting and irrelevant?

W

I think that's a great suggestion because I think you're absolutely right, if the organization ... part of the HIE is not going on statewide, the kind of symptomatic review, if there's an epidemic I think that that's an excellent suggestion, so that the systems could search on any discrete data.

M

My only concern about it, Jim, is that it's a little hard to certify because if I think about the test and I say, oh, in some random dialogue I select a phone number or an opinion on something, or who knows what, can I get pushed on the fact that I may not certify if I can't include that in a report. I certainly agree with the ... at a million percent, I just wouldn't want us to get in the position of not being able to certify effectively or ... more objectively and get into trouble that way.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

David?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. I don't agree. Again, coming at it from the point of view of what can you certify, I think that's way out of scope for certification.

W

But what if the data's already there as discrete data?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

The tool sets –

W

... be able to search on it.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

The tools that the vendors create do that, but it's quite specific to what they actually have access to, what they capture. I think we're setting here a minimum standard with respect to core capabilities, and the vendors will extrapolate from that as they can depending upon what's in their system and what they have access to, what about HIE related data, would that be included or not? There's a ton of variables here that would make it very difficult to certify at the stage that we're at, and again, when we're asked to respond to the NPRM we pretty much can only respond to questions that they ask us. There are policy issues for the future that may be worth debating, but in terms of the response of the NPRM they're going to say what's missing from this list.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

But it wasn't our charge to also, and I heard this again in the policy meeting two days ago, that wherever we can we need to signal.

W

Yes, we have to be specific about the standard as it's presented, and comment specifically about that, but that it also should say how do we think this standard could be enhanced for future engagements, and that might be Meaningful Use Stage 3. However, we want it to be specific enough to say it's mom and apple pie. Mom and apple pie are the themes, so if we're going to comment on the standards, for instance, on this list, what items do we feel need to be added and standardized so that in future we can do exactly what this conversation has talked about. So if we have problem lists and medication and medication allergy and demographics and laboratory what other kinds of things would enhance patient engagement? Is it something that indicates the patient participation or family members or preferences? The reminders, for instance, are clinical in nature. Do we need to know what the patient preference is for how frequently they wanted to be communicated with, so those might be some examples. But, yes we do need to comment on the standard as it exists, and yes, we do need to say how this standard can enhance patient engagement in the future and we do need to try to be specific. Does that answer your question?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, so then I guess what I would say is of those four that are listed is there any that anyone would delete and is there anything specific that you would like to add?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Jim, to your point, I would love to have your point recognized because I do think that there's value in just commenting that making it very explicit and maybe it is just throughout implicit, but is it valuable to say, hey, to be very ... this is a minimal list and it is not expected that this would limit the addition of other fields where ... appropriate. I don't know if that's just noise, but it might be a way to try to just make it clear that what we'd like to avoid is people implementing a feature against this and not thinking forward to know that they'll want to include more, which is probably easy when they're doing it the first time and hard if they have to go back for Stage 3.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

That was exactly the point. The point is this, Leslie, is there a vehicle or mechanism to do that if it's not specifically addressing the line item and being prescriptive about something specific here? Is there way to do that or is it like John said, noise?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think that we don't want to ... the themes to say they're overarching and then in the standard section what would we like to see changed about this.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

The problem is obviously we don't have a defined holistic, what are all the fields you're in, in EHR, so we can't test against it. I think that whole point was right on, you can't test against a list of vendors, that it varies by vendors, I wouldn't say dramatically, but at least 80% of it probably.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

But one thing that is glaringly missing from this list is age.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

That's actually the last point was so demographics, but it doesn't define it and so, Heidi, do you want to talk about demographics?

Heidi Sitcov – Nurse

Yes, I actually went to the federal registry and looked at what they define as demographics, and it says language, gender, race, ethnicity, and date of birth. So I wrote do we agree with this as the most important demographic data needed, and that's actually what it says in 170.314 and going to see how demographics is defined.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. And absolutely, age is critical. You can also consider family history. If we're sending patient reminders to patients and the purpose is that they're clinical in nature, and I think, if the physician

said earlier, hey, I want to be prospective about this and the information can also be around family history, what do I have a propensity for, and can we send education, wellness, prevention reminders as part of that work? So I think it's very much within our scope to say when patients need to be reminded what are the things we need to know to make sure they're getting very patient specific information?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, so to move on, can I write down that family history and preferences and then is that good enough for now, and then the last comment will be more deleted and put into an overarching piece. Is everyone okay with that so that we can move to the next one?

W

Yes, ..., Jim.

W

Yes.

M

Yes.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Good. And I think we talked a lot about reminders, so this next section shouldn't be as much and hopefully you're following on your own spreadsheet, because the tool takes up so much real estate it's still microscopically small.

W

Jim, if you can just always remind us what field we're in, like –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Sure. The problem is that because it's a view on here, in order for you to know what to sell I have to almost go back to my own to do that. But I'm going to move to the next one, which is line, actually I wrote this down on my other sheet because I knew this was going to be a challenge, so the next one is 22, I believe, and so if you're following on the sheet on the screen 22 is the one related to the reminders, preventative reminders, there it is. It's right where the green arrow is now. So we move across there and so what we put down for overarching opinion, again, please challenge, add, delete, change, again, how does this care compare to the clinical quality measures? Again, the whole idea of reminders is that we're trying to get you in step with what evidence-based medicine or what care client is being put in place for you, and then, again, use that same made up new second sub-theme that sounds like we need to adjust to talk about the back end piece, but maybe the theme of good enough because the reminder piece is the back end piece of some of the lists that are created in the previous section. So does anybody want to suggest a new overarching theme or a new sub-theme other than what's listed there?

Heidi Sitcov – Nurse

Jim, this is Heidi. I just have a question, and it keeps coming up for me. Problem list versus diagnoses, when we're doing patient reminders or patient lists, because they're not always the same, or are they the same for some people? I guess somebody needs to define this a little more clearly because you may have a problem, maybe your problem is intractable itching, okay, who knows, maybe it's a mood disorder, whatever, but maybe your diagnosis is actually psoriasis or maybe it's eczema, maybe for diagnosis when it comes to mood disorder, severe depression, but I'm just trying to get my head around this, when they talk about problem lists, is that the same here as diagnoses? I don't know.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

For people keeping score at home, we're on cell M22, so the same line but way over to the right. And this is the comment that Heidi actually put in here around diagnosis versus problem list.

Heidi Sitcov – Nurse

Yes, because I don't think every problem on the problem list is a diagnosis. And so I guess I wonder where diagnosis does come in here. Should we specify the difference here? I'm not sure. I'm just putting it out there.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Holly and David, can you comment? Two things, one is, forget that we're on a consumer engagement panel and talk about that from just a clinical working perspective and then see if there's any difference as it relates to consumer engagement, because it's always easy for us to, we have to make sure that we at least talk about the consumer engagement aspect, if there is one at all. So I'll shut up and let you two give us your physician opinion about that.

Heidi Sitcov – Nurse

Are you talking to me, Heidi?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

No, Heidi, you said you had a question, so I wanted Holly and David, since they're the physicians on the group, to comment on diagnosis versus problem list as it relates to –

Holly Miller – MedAllies – Internist and Chief Medical Officer

Heidi, the way that I think of that or deal with that is really very, very much that something that the patient is going to have chronically goes on the problem list. So your intractable itching, something that is something that the patient has long term is going to be on the problem list. If they come in for an upper respiratory infection and I know it's viral and they're going to have it for 10 days, I'm not going to put that on their problem list. So there's a difference for me between visit diagnoses, which is all the reasons the patient came for the visit, but the ones that are going to be persistent are going to go on to the problem list. Atrial fibrillation is something that's probably not going to be going away or if it does get resolved then I'll take it off the problem list, but that would go on the problem list. A urinary tract infection isn't going to go on the problem list unless it becomes something where they have chronic UTI. Does that help?

Heidi Sitcov – Nurse

Yes. So MS, for instance, is on the problem list and also as a diagnosis, because MS is chronic.

Holly Miller – MedAllies – Internist and Chief Medical Officer

Anything that either a visit diagnosis or something on the problem list are all diagnoses, so anything is a diagnosis but a diagnosis that is something that's going to be short term, I don't put on my problem list for the patient. Something that's going to be long term goes on the problem list.

Heidi Sitcov – Nurse

Okay, okay.

Holly Miller – MedAllies – Internist and Chief Medical Officer

Does that help?

Heidi Sitcov – Nurse

Yes.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

David, I assume that's the way Cerner works too?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Well, I would say it's quite idiosyncratic from provider to provider as to what they decide they want to treat as a long term focus problem versus a short term problem. And in the word diagnosis is unfortunately highly overloaded to be both clinically meaningful as well as billing meaningful, so some physicians refer

to a billing diagnosis for the encounter but may wish to put a different entity on the problem list to track what's clinically going on. It's idiosyncratic. It's confusing. I think we need to be very careful not to try to over design or over regulate here. I would leave it vague as problem list and other places where that's being certified let that shake out.

Holly Miller – MedAllies – Internist and Chief Medical Officer Yes, I also think that that's really been helped by Meaningful Use Stage 1, that really requires physicians to maintain a problem list for patients. I think that also the SNOMED standard that's being suggested within problem list has a lot more granularity than this indicates. So I think that we're covered.

Heidi Sitcov – Nurse

Okay, thank you.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I think ... what we've got.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, and then the other clarification question was around demographics and what's being defined as demographics. Does anybody know specifically elsewhere that we can refer to or say that, yes, we agree with how that's being defined, or we challenge it and we want to add to things?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David again. I think that the debate about the CDA and the data elements that go all through the whole certification ... are clarified and unified, there are a number of groups working on trying to get consistency across what ... of the CDA are ... in the various places, and I think demographics would be one of the ones that gets addressed there.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Should we say something that whatever is determined out of that consolidated CDA process is what should be determined as a standard, or is that just self-evident and not worth commenting on?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I would say that it's self-evident.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay.

W

I think the only thing is that it would help to pinpoint things that help patients like patient specific information, then you need age and you do need things like family history. So I don't know if that's listed under the demographics or not.

M

Family history, I don't believe is. The discussion we've had before ... makes sense here are family history as input and procedures as input, as procedures would give us the ability to do the things like the mastectomy cover and make sure that that's not something that gets baked into the system when they support

Heidi Sitcov – Nurse

I would have to say that so many of the systems that I've seen capture this information very poorly, so I think we have some vendors on the call and I'd like to just query them to see how heavy a lift this would be.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. I think procedures is another area that's unfortunately difficult and not consistently done. Some people put it in the problem list, believe it or not, some people have separate procedure history sections, some people only document procedure that they did and don't document procedures that are done externally, which might reflect on the health reminders if you had your colonoscopy done somewhere else. It's complicated.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

... as input, it's relevant input, right, so ... it seems to be ... with some of the other things that are listed and ... I might want a procedure list, regardless of that complexity. Wouldn't you agree?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Yes, and I think the system to generate reminders today takes that into account, but they do it in ways that are probably not as consistent as the notion of a med list or a problem list. We could add in procedures should be available as a –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

That's all I'm suggesting.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Yes, and I think it's self-evident but it's not a bad idea to mention it.

M

I would also add family history, and we talked to you about it before, but it's the other one that has similar importance.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Yes, the family history, there were comments at the last Standards Committee meeting about the lack of a standard for a family history and I think that was generally thought that maybe that's something that we'll address in Stage 3 is specific –

M

That's another thing, there actually is an HL7 standard that's used by a certain ... and it's represented in It may not be ... to the extent that mostly it's ... unstructured today, but there is the standard that I think is unchallenged. I don't think there's actually a lot of competition for it.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Well, the Clinical Operations Committee rejected that. They didn't think it was ready for primetime.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Do we make it menu 2 and then give guidance for 3, or suggest menu, I guess we can't demand it.

Heidi Sitcov – Nurse

I think that this is a really, really important discussion. I think that in general my experience with so many of the EHR systems are the way that the flexibility of setting up the alerts works is that the physician has to indicate if there's a deviation, if the patient has bilateral mastectomy does the physician have to go and manipulate the reminder system so that that gets turned off, etc. So I think that if we start to, and I like the idea of proposing the menu, because if we start to make this based on discrete data instead of the physician who's running through a clinic on roller skates making this dependent on them doing things in the EHR, making it automated based on history that's gathered will make it a far more useful tool.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

And then the other piece that I added on there was we talk about family history diagnosis, but also care plan, having the reminders need to be able to pull from care plans. If we have a milestone that in two months you're going to lose 10 pounds, and again, we're assuming forward-thinking that you're engaging back and forth between the patient, wouldn't you want to be able to send a reminder in a very gentle way,

saying here's where we were on the plan, how are you doing with that, and so should we also add care plan to family history and procedures as something to put in the menu?

M

I'd support that, Jim, and I would say also just to make sure that ... in the spirit of our particular charter. I think the reason these are important for us in particular to talk about is that these are the kinds of additional data that will increase engagement with patients and make them receptive and feel included and understood in this care process, whereas, the purely mechanical set is where we may get some okay aggregate outcomes, but we're going to alienate a whole lot of people. But I do think that this is specific to our charter.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, the care plan is core. That's one of the biggest disconnects that there is, is that the care plan has always been thought of as each independent physician group or element of the PCP or ... whatever have their own care plans, they're hardly coordinated, let alone actually having contextual preference input from the patient and jointly agreed so that – you're right, this is essentially the core of that whole engagement discussion.

Heidi Sitcov – Nurse

But if you take it one step further, and I love where this is going, if you can pull that data out of the care plan and the patient is able to document in their portal, in their PHR how they're doing along the care plan, that information flowing back into the physicians or the patient centered medical home and someone is saying, bravo, good work, keep up the good work, it will encourage and reinforce the patient to stay on the care plan, so not just like a reminder that, oh, this is coming up, how are you doing, but make this interactive.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. I'll go back to a year ago when we started the virtual care plan, Holly, I remember, within the S&I framework, and that's exactly the vision that we collectively had, and actually the medical and care manager or coordinator isn't even checking on it. Each system is doing its exchanging of data and if you're not off plan, there might be an automatic reminder that says, great job, keep up the good work, I'll check you next month. But if you are off plan, then the intervention might be a care coordinator call, it might be an e-mail, depending on preference, or if you've really fallen off and it's glucose and you've had three weeks of uncontrolled things then it's a physical visit intervention. But we're now only putting people in the process where it's by exception not by manual process like we had today.

Heidi Sitcov – Nurse

Jim, I think this is great because it just shows that the natural evolution of providing people information like a reminder to do something is that they want to say what they've done. And so I think it's very appropriate to say there needs to be able to have some sort of patient response back into the record that reflects their change in status and health and a reminder in itself is not engaging, a dialogue is and so I think it's very appropriate for us to comment on that.

W

And I would say reminders engaging when it's for a specific activity, like to get a test.

Heidi Sitcov – Nurse

Patient specific.

W

If you have an explanation. So if I'm getting reminded, oh, you're overdue for these things and this is the reason why it's important for you to get them done but it's a one-time event as opposed to ongoing activity where I have a goal, so those are two different systems that we're talking about, does that make sense?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I think uses of the same system more broadly thought of then the way we think of it today and the way we've implemented this feature and –

W

And the ... structure might be the same for both.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David, the curmudgeon, here. These are great visions, but they're way beyond current interoperability standards and way beyond what would be certifiable. Aren't we supposed to make sure that we have the list here? This says at a minimum, the list of data elements that should be able to inform a generated reminder, is there anything we would add to that? Minimum is just a question that we have to answer.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

We had three things: procedures, family history and care plan as menu items for Stage 2, David. So it's not required.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

So a care plan, we don't have a standard for what a care plan is, we don't have a technical standard or even, I think, an informal standard. Everybody treats that somewhat differently. Is that the set of current orders? Is that a textual instruction? Is that goals and expected outcomes mapped to each other? So I'd be reticent to put care plan as something that could be certified.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I know, Leslie, so care plan somewhere down in team 3 they have care plan as one of their assigned items, right?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes, it's plan of care. And that skill is not quite yet defined. So I think we can say here are the specific things of the standard today that we want to add, and then yet to define for Meaningful Use 3 but to be considered as a requirement of Meaningful Use 3 might be care plan, because we really don't have a standard yet to address those.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, it's just really tough. If you look at ... patients and their primary care collaborative thing for five years, and at the core of all that is today what is a very manual process of care plans and coordinating care plans, and I just think as an accelerated this is really big, because this is really the core of the engagement piece, Leslie, and maybe that's the message we send to folks is this has got to get put on a fast track –

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

... to figure it out. Okay, so thankfully ... move on to the next line, so our next line is 24.

M

Jim, I'm sorry, but can I push back on one? There's one other comment I wanted to make ... which was I think it's probably important that we talk about the patient's ability to delegate where these reminders go and not just where in terms of what channel do I want, which I know is in there, but who it goes to. So do I want my reminders to go to my own personal delegate rather than me, I think is pretty important.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

That's a concept that's for everything, right? It's for download and transmit. It's for any information. It's for the cc Me. You're right, we can put it in here, but it really applies to all these things, and I think that's

–

M

It does, but the reason I was thinking here was specifically if I'm testing and certifying I want to know that, I want them to have to demonstrate that it doesn't just go, for example, to a hard coded –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Got you, okay. All right, so number 23 is the medication orders piece. Sorry, it's a little bit hard to control here. Okay, medication orders, I'm going to go over to, sorry, this takes a long time. Again, I said the overarching theme was how does the care compare, because again the idea is that I'm getting, as these five rights say, the right patient, the right medicine, the right ..., etc., and then again I made up another ... because off the list I didn't see one, so we need to think about how this would be. But what I have made up is, I can barely read that, ensure IT enforces the principle that patient safety is the system property, which is a core IOM principle. That's the best I can come up with. If someone else has something different please suggest it.

M

I don't have a comment on principle, but I would like to encourage that these administration records be part of the Certainly what I got in the hospital is something that's hard to remember, but how I reacted to it is not. And those things may or may not go on a meds list at discharge, I think they may not be ongoing, and so it seems to me that there's critical information here for patients ... not generally considered about actual administration of meds.

Heidi Sitcov – Nurse

And this also gets to ... comments from yesterday in which he said that the patient is an important part of the patient safety checks and they have a voice, so patient intolerances need to be incorporated.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Any other input from anyone else on the team?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. The medication administration question should come up in the view, transmit, download rather than here, and so I have some comments about that, but I think we should save that now.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, anybody else?

Heidi Sitcov – Nurse

This is Heidi. I'm just thinking about one thing. It says here that the information will enable a user to electronically verify the following, so right patient, so when you're saying electronically verified, then it no longer is good enough just to go in and ask the patient what's your name, identifying things that you need to, whether it be date of birth, Social Security number, name, whatever.

M

(Inaudible.)

Holly Miller – MedAllies – Internist and Chief Medical Officer

Heidi, it's scanning a band.

Heidi Sitcov – Nurse

That's what I mean. Okay, so they're saying you have to scan a band here.

Holly Miller – MedAllies – Internist and Chief Medical Officer

Yes, yes.

Heidi Sitcov – Nurse

Okay, that's exactly what I wondered.

Holly Miller – MedAllies – Internist and Chief Medical Officer

You scan the med because now they're in packets –

Heidi Sitcov – Nurse

Oh yes, I actually just worked with that whole system, and I just wondered if that's exactly what you're talking about here. So for the next stage of meaningful use this has to be the case then, is that correct, everybody has to be given medication with this electronic scanning system?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Or some electronic way. It's scanning but they're trying to leave it open so that there are other ways to do it.

Heidi Sitcov – Nurse

Okay, so –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

But from a patient standpoint, so it's a patient engagement question here, and whether they, like I said, it goes to the right person. But one of the things that I thought of when we started talking about downstream things, the upstream is my preference, did I really want that med in the first place? Was I even given the option, given preferences to have that or have something else, or have it not at all, or to wait three hours, so that's the thing that popped into my mind after the previous discussion.

Heidi Sitcov – Nurse

Right of refusal?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Well, I don't know.

M

... EHR certification issue, is it, Jim? Yes –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Well has the preference for the drug, again, if it's appropriate, obviously if they need something right away they need it, but if it's appropriate like a pain dosage, right, did they use their pain meter or their pain scale or did they say, do you know what, I don't want it, or was it just given to them and not asked. I'm just thinking one of the certification can be has the patient's preference been checked before these five questions?

M

That would be a meaningful use measure, not a certification, and I think that's –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay.

M

... medicine than it is of technology.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I was just thinking of the ... has it been checked, not as a matter as to if it should be checked or not, but has someone actually checked the preference if in fact that was the case? But if no one else has passion about that we'll move on. Next is 24, imaging. Imaging, this is so hard to read. Okay, so I changed –

Heidi Sitcov – Nurse

I have –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Go ahead.

Heidi Sitcov – Nurse

Jim, I have mine up now. I don't need you to have it up, and I don't know if other people do now, but I'm able to get it up on my screen.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, well it actually now helps me track because otherwise if someone can't, because I know Alice, I don't think, has it so I'm trying to give her some verbal direction. But if no one else needs that, then I guess we can just talk through the categories. The overarching theme that I put on there was one that existed, that many EHR actions have a corresponding or correlating patient system reaction and the sub-theme was create once, use often in both patient facing and EHR. So any challenges, suggestions for improvement in those ...?

Okay, so I'm looking at the time and we have 40 minutes, so we're picking up speed. That's good. On the right hand side you have two clarifications. One came from Heidi. It said make it immediately available, and so she's right on to say what does immediate mean, and then I added the comment that is there any reasonable exceptions to that, so you don't want to say not immediate, because it can't happen in 20% of the time, but maybe it can be immediate within 20% of the time. What are the exceptions? Again, maybe this isn't so much, as David just pointed out, so much a certification piece as a feedback to the policy folks to say if you haven't really thought about this, you need to think about it. I can't think of meaningful use, in the all day meeting, I don't think we actually addressed this word or this particular line item.

W

I think one of the questions is does the user get modified to incorporate the idea of a patient ... seeing this as well, because today the images are not really part of the consolidated CDA, I don't think, Jim, and so the idea was if this standard exists for imaging to be electronically available, then that has a reaction in patient facing systems.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

That makes total sense. My note was that we can hit that a little bit in 31, 32, where they do talk about ... availability, which that was surprising, I hadn't realized that. It is down there for the patient availability at a later thing. I don't know if you want to wait for that or not.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. I'm wondering what is contemplated here for the patient who is actually a patient at the time in the hospital or in the clinic. Are we envisioning that this is essentially a requirement that the patient be allowed access to the ... system if they want it, to see whatever is available for that?

W

We don't want a ... system, it's the image, and there's still discussion, I think, on whether or not that's the DICOM image that has to be considered in the viewing capability standard, or is a JPEG good enough? I think that –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

... references DICOM, which was surprising to me, but ... down to 31 the reference standard is exclusively DICOM.

W

But it's a DICOM viewer standard, it's not a DICOM diagnostic standard.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Actually, it's –

David McCallie – Cerner Corporation – Vice President of Medical Informatics

It's generic and it needs to be –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

... I'm not sure. That's fair.

W

So maybe later when we discuss what's available for the patient, the patient should be able to have, if they are going to, let's say, direct a transmit, the provider protects transmit and the patient can direct transmit, then it should be meaningful to whomever receives that data.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Right, so this gets into the system and then it gets available for view, download, and transmit. But I think David's question is, because they frequently do that, right, and nowadays a lot of times they won't bring the film in, they'll have a monitor in the room and they'll up the image and they'll show you your break or whatever it is, and the patient actually does get to see it, ... and the question is from an engagement standpoint, is there something we want to say along those lines, or should we just let that go and move on?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David again. The way I read this is exactly that use case, the patient is sitting there in the bed and he wants to see the images. It's different than view, download, and transmit.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Right, to get back to Nikolai's point of, hey, I need to be seeing stuff along here, not just after the fact, because otherwise if I didn't intervene while I was here, things would have been really bad for me. So the question is, should the patient, should their preferences be checked as to whether they would like to see diagnostic imaging as part of the joint care process between patient and care team?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I wouldn't get into the domestic part of it, because many times the doctors on the floor don't even see diagnostics.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Right, they just get the – you're right, they get the report.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

(Inaudible.)

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Well, I don't know. Holly, you've been quiet on this. What do you think?

Holly Miller – MedAllies – Internist and Chief Medical Officer

Yes, I start to become concerned about if we get really prescriptive, like when we were talking about the meds before, I started thinking what if we get really prescriptive and they go in and they wake up the patient every time they're going to put vitamin K in the IV, or this patient who's lying in a bed that if we get

really prescriptive they get them up, put them in a wheelchair, and take them out to see an x-ray. I just have some concerns about patient experience in the hospital if this becomes very prescriptive.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Well, and clinician experience and –

Holly Miller – MedAllies – Internist and Chief Medical Officer

No, no, no, I'm really thinking literally tasting experience here, because if these things are mandated people are just going to feel, oh, I have to do this and –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

No, by preference, remember by preference, if I want to see it. ... should be preference –

Holly Miller – MedAllies – Internist and Chief Medical Officer

Yes, yes, and I think that's very important that we make that very clear. ... are patient-facing symptoms should also be able to accommodate this by ... and that I have a preference in my engagement level for care decisions. Does that make sense? I'll tell you whether I want to be involved or not.

W

Or that they have the ability to selectively – yes, those are my thoughts.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Why don't we move on because we don't have time, and then we can come back around, maybe that's a general comment of this and medications as really being something that just needs to be in the preferences section in terms of how do you want to be involved in your care, and maybe there's a general thing there and then that covers these sort of in a general way. Does that make sense? Okay, we're getting tired.

Heidi Sitcov – Nurse

I also think that the point someone raised, and I think this is critically important because I remember staying with both of my parents during hospitalizations and being at the bedside 24/7 at one of the best hospitals in the country just to make sure everything was correct. And so I think the point that we've raised about being able to clearly delegate an advocate in that circumstance that can be at the bedside, that has access to every single information and can challenge anything is very important.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

And that's part of the preferences that we –

Heidi Sitcov – Nurse

Yes, exactly.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, good. So the next one is 26, which is enter at least one electronic note, so again, this is really about clinical process, and the comments that were made over here on the right hand side, well, first the categories. The same thing, there's a corresponding place to put it and create once and use often, so again if you've got a note can the patient make use of it. Well, the comment that I made on the right hand side was well, even if the patient can't make use of it, and this was made again in the Policy Committee meeting this week and it was made in Meaningful Use, so it's been made over and over again, everyone thinks that the end person of this information is the end consumer. It may not be. It may be something that is printed out and handed to their PCP and ... if the information is not ... and it's dumbed down to say you have a cardiac condition, that is absolutely no help to the cardiologist that you've now handed it to. He really wants to see exactly what is the issue and the problem, and so this is the same thing.

John Derr – Golden Living LLC – Chief Technology Strategic Officer

This is John Derr. It's an important one and they hand it down to a nursing home or home care agency.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Exactly, so it may be goobledy-gook to a patient, but it may not be that their mother-in-law who's a nurse, it may not be to the nursing home that this gets handed to, or the PCP, or whatever, or it gets moved into the PHR, it's that same concept of just because it's given to the patient don't assume that that's where this stops. I think that's what we heard multiple times in the last two weeks in a variety of different settings, and so that was my point there is that there is a need to have this made available, just like we talked about other things being made available, and again, it's preferences. If you don't want that, then you don't have to have it ... with it. But if you do, you should have the option to be able to get it to be leveraged.

W

Right.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Any challenges, additions –

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Jim, this is David. I'm lost as to what question are you asking now.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

This is like the meds and the imaging, right, this was thought to be an internal, make sure the physician puts notes in, and we don't want physicians to create notes just to create notes, but if the notes are put in again, the consumer patient engagement question is, if they're put in they should be made available to the consumer or patient if they so choose to either absorb themselves or hand off to one of their clinical partners who may very well not be associated with the facility you just

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Or again from a certification point of view, when we come to view, transmit, and download there will be a question of what is downloadable, which I think there's no question which kinds of downloads are downloadable is an important question for that part of the discussion. Are you suggesting a meaningful use measure of access to the notes for the patient while they're in the hospital above and beyond the few transmitted ...?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

No, the ... transmit and download but the ... is that it's teed up to be made available to have that happen.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

So this –

W

I think what this is talking about, to answer the question, is that all clinical documentation now is made available to the patient, including physician notes in any circumstance.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

That's not what this is about. This is about –

W

That was my understanding from what I read, so please clarify if that's not what it's about.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

That's kind of what I'm asking. I think this is targeted at users, as in provider users, provider users will capture electronic notes that are searchable. It's not talking about consumer or patient access to those. That would be covered in the view, transmit, and download. I'm not reading user to be consumer, are you?

Heidi Sitcov – Nurse

Yes –

W

No, but I think that's what this group is talking about.

Heidi Sitcov – Nurse

And I think this is where it was mentioned earlier we really need clarification about the word “user,” because it is unclear in certain circumstances throughout this document.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, David, I always assumed that this, and maybe it was wrong, that the user was the physician, and ONC's comment was, or HHS' comment was, I don't know if we need this because the majority of physicians are already doing it, and my comment is that that's great, then give them a target to hit, and for the, let's just say, 20%, 30% who could do notes but don't do notes, for whatever reason, strongly send a signal that you want notes in there because then the downstream clinician doesn't have to call them, the downstream clinician has more information than the rest of the ... and the patient has it as well. And so that's the consumer engagement piece of it is encourage them to do notes and then when they do them get them. That's how I was reading this, and maybe I took that wrong, but that's what was out there.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. I think so. I think that the goal here was to focus on the provider capturing data electronically so that all the downstream benefits of electronic ... accrue. I didn't read this as having any particular consumer facing implication

Jim Hansen – Dossia Consortium – Vice President and Executive Director

It has consumer ... because if someone, I don't want to use the term “lazy” but someone hurried and thinks you know what, if someone asks for that I'll be able to give them the context if I get consulted on it, and my point is that that's a huge assumption that you're available but you're in the same facility, that you're in the same organization, and I've just talked to so many physicians who get referrals and they don't get any background and if they do it's partial, and then they rarely get the notes and so they get frustrated. I'm responding to the involvement of having the patients in a primary care collaborative of those referring to ... not getting the notes. And so I said, hey, yes, go, encourage, do anything you can to get them to do the notes because then they can be sure that if we don't strongly encourage them to do notes and give them credit for doing notes, then the patient will never get them. And again, I think ONC's right, it's probably a relatively small percentage that don't do it, but why not send a signal that everyone should do it.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Yes, I would agree that electronic notes are a good idea.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, exactly. So send a signal, but not do notes just for notes purposes.

W

I don't think he finished what he wanted to say.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I'm sorry. Go ahead, David.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

No, I probably should finish, because what I was going to say would probably get us down a rat hole.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

All right, well I'm making a note, David, you're going to have to finish it later off line or something.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

...

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I'm sorry, go ahead.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I just said electronic notes is a good idea. We agree. We endorse that.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

We have 25 minutes and we need time for public comment, so we have one more and then we have the three hairy ones at the end, which in some ways can be collectively done. It looks like my screen just refreshed. Okay, so 27, hospital labs, is that directly or indirectly structured clinical lab data and again this is internal and for the question is there any patient facing element to that, and I'm not sure. I just lost my ability to be able to change the one on the screen, Mary Jo.

W

I'll fix that in just a second.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I'm going to move over to my spreadsheet. Oh, there it goes. It's back. Okay. Sorry, if I did something I apologize. Back over in columns, the two areas I said, the same thing, corresponding for correlated patient system and then I also added create ..., and then over to the right Heidi made a comment that the standards should include name of test and code number on the test, do you want to say anything in addition to that that's patient engagement related, Heidi?

Heidi Sitcov – Nurse

No. And again, I'm just looking at this here, just reading it, transmission electronic laboratory test, two ambulatory providers, oh, this is the inpatient, enable the user to electronically create laboratory tests. I'm not sure exactly is it enable a user, so are they talking about the EP, eligible professional here, to electronically create laboratory tests, results for electronic transmission in accordance with? I guess I'm just wondering what enable user to electronically create laboratory tests, who was the user there, the physician?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. This is strictly targeted at the hospital lab being required to send the lab results back out to the referring providers.

Heidi Sitcov – Nurse

Okay. So I basically was saying that, and if I remember correctly I went actually back to the federal register notation and saw that there should be a name of test and code number of test.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

And I think that's all covered in the HL7 standard that is –

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. One other comment to the larger group is at inpatient laboratories or laboratories and hospitals are ... 40% of the commercial lab business, and the ... recommendation is that provide those results directly to patients. Now even though this is talking about providing lab results as inpatient only, because hospitals act as a commercial lab and patients can self-refer in many states and generate their own lab orders, is there a need to also state patient self-referred laboratory orders should also have laboratory results for the patient.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. That's certainly not what this is targeting. But I think if the patient ... and orders and pays for a lab test of course they're going to get the results, aren't they?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes, okay.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Well, they get the results, but it may not be offered to them electronically downloadable and viewable. It may just be people ... in the mail.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Yes, and I suspect that's out of scope of what we have regulatory influence over.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay. Anybody else on that one? I did make a note. On the left hand side there was a note that the Standards Committee had that said use LOINC where applicable and I didn't have time to go back to see if in the NPR if that was not there. But if it isn't, obviously we want it standardized and coded and able to download and able to transfer to someone. So, if that's redundant I'll take it off, but until I'll put it in a placeholder until we can actually verify the ... in there. Does anybody know offhand ... true?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I believe it is.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay, so if it is we'll just take that off. All right, now to the three hairy ones, and we have about 15 minutes, so hopefully everyone on this call had time to print out, I think I said it was 033. What I'd like to do is go through that list because that is an overall cap to, again, this combination of our full team meeting and Policy Committee meeting, actually meaningful use previous all day meeting that was two weeks ago, and even the Standards Committee meeting, as well as our first group called here and the call that was done earlier, the notes ... that I looked at. There were these significant themes that we have to figure out how to somehow deal with in these three sections, so I'm just going to hit these real quickly. I'm not going to read these to you, but please scan them if you've had a chance to look at it.

The first one, view and download are associated with the use case of a person collecting existing records that they're ... and so as many of us in ... have been calling, that's the pull, it's like online banking and this gets to select date ranges and date types, and remember we talked about data types, so maybe I want to see the meds, or I want to see the images that were done or anything ... the lab tests that were done, inpatient, whatever. And if you've used online banking and if you haven't I have screen shots of at least how one large bank does that kind of thing, and the outputs are readable, we put PDF in text, ... discrete, and in the banking analysis you get lots of options, you used to have ... money, but Quicken, ..., and there's ASCII and PROMISE upgraded and some other stuff I didn't put in here. And then for us ... so mentally I think a lot of people are thinking it's the healthcare equivalent of online banking, but this comment, again, has been made multiple times, data must remain in its raw form so it can be passed along to be used by whoever is processing it, whether it could be a personal health advocate that is doing ... in the health risk assessment, or whether it's a physician who isn't yet connected to the hospital and you're the mule who's giving the information to them through you, so that's the first element. Does anybody have any additional conversation or discussion that I missed and try to pull notes from the various places that would enhance that vision or definition of what view and download is? Go ahead, David.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I was just on the human readable and the discussions that happened in the past were mainly by specifying human readable we were concerned to make sure that the download is human readable, not that it be limited to human readable, so if the download was some arcane XML coded format that consumers couldn't read or parse, ordinary tools on an ordinary computer, that would fail. So I don't think it's to preclude the inclusion of structured data, but it is to make sure that at least it's human readable.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

And that's a great comment, because that's exactly what a physician yesterday on the Policy Committee said, look, it needs to be exactly the same data and there can be a view, I don't think the person used to work templates, there can be a view that has a fifth grade health literacy level that translates to the patient and that's what they're handed, but I want to see exactly the same information, raw, in its natural state, so that I can then make it quickly actionable. So, David, that was the point is that, you're right, even though you can theoretically read XML code unless you're a technical programmer person you can't profit as a consumer patient.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I think the question for us is whether we would say does the minimum have to include not only human readable, but also the codified data?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I think the answer is clearly yes, at least that's what's proposed, right?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

I think that's what we should discuss and debate. I think the answer is yes as well, but it doesn't say that.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Who says no?

Sean Nolan – Microsoft Health Solutions Group – Chief Architect

I think it does. ... but I thought about this hard last night and I thought I was sure that they said it must actually do all, or download a file in human readable format, so B1, and then B2 was the summary of care record format according to the standards adopted. I don't think there's ambiguity about doing both, unless I read that wrong.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

You may be right, Sean.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Even if it's not the case I don't think it hurts for us to be very clear from a consumer engagement that the option of doing one or the other or both is from the patients or their designated proxies' viewpoint. I may never want to have a human readable version because I'm just going to take it and throw it in my PHR and I'm going to let my PHR process it and aggregate it and map it and track it, and so that should be mine. I shouldn't be forced to do both, and also the option should not be from the system vendor to say, well, I'll give you either discrete or readable. Does anybody agree with that?

Sean Nolan – Microsoft Health Solutions Group – Chief Architect

I certainly have no objection with making it very clear that we support that, absolutely.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay. For time, let's move the transmit push following the ... where the specific information as a part of the patient's standing preference and this really overlaps with the ... next one, but let me get going through the – that's set to one or more designated recipients. And again this came up yesterday and it came up on our first call, everyone's thinking it's just handing it to the patient, but it's not. It could automatically be throwing it into Health Vault, or Dossia, or again my PCP is not hooked up at an HIE and the hospital is giving the consumer stuff but isn't quite yet doing the other stuff, I may be the ... and then again there's this whole concept of if I do care on vacation and I'm at a ... clinic in Vail, Colorado, I may want that thing to be set to my ACO or my medical home. Yesterday in the Policy Committee they talked about the cancer registry and disease registries, and people with Crohn's and other things, there could be lots of places that goes to that and that's really a preferences piece, and that ought to all happen automatically and I think this is an area where I think industry really hasn't got their head around it, but as someone who with the Dossia Consortium and with employers in other industries, this is the way their industry works.

The idea is to have things go from system to system in real time for fractions of a penny based on standing trust and standing processes, and that's certainly what they would like to see. And so that's the transmit, it could be just to the person and it could be just something that they said they wanted to get now, but typically it's somebody who has a chronic disease and does not want to go to four different portals and download records from four different providers with different capabilities and different formats and have to figure out how to manage and integrate that. That's non-value added time to them, and it doesn't help them share that information with their patients. I added the via direct address, or other mechanisms, since direct is our standard and we need to start thinking about the process, again, these are standards that are customer affecting and if I give you addresses to all these places is EHR going to be able to be able to manage them. Then what's the process for setting those up? Can I go into a portal and just set them up myself? Or do I need to do that in person? And so those are the two other elements that I added to that, again, based on the discussion. Anyone else want to add, subtract, or change what's in the transmit bullet?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Where do you have the ...? On the transmit is that column M?

Jim Hansen – Dossia Consortium – Vice President and Executive Director

David, what I did was because this really affects the next ... and because those things had an enormous amount of fields listed and processes and stuff, the only way to really attack this was to pull up and try to talk about some bigger themes and then as a group figure out how are we going to pepper those into the specific column M. This was actually a solve, and I put it over to the right of that, it's on, I think, O31, ... that has the things I'm walking through. There was already too much text in the little boxes and I didn't want to be redundant so I was trying to get us focused.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

So is there a specific question, one specific question is –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

The question is, and everybody's envisioning it and we're all doing a different part of the ... at this point, does anyone have a different opinion of what transmit is than what I listed here on the sheet?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

One broad question that's come up in a number – this is David again – of conversations is where does the multiplexing, yes, I guess it's the multiplexing of the transmit occur? So is the expectation that the provider or the eligible hospital would be required to keep track of lots of different targets for the data, or would it be that the data is assumed primarily to go to a consumer controlled multiplexer which would then keep track of the ... targets? In other words, ... and make me responsible for fanning it out, or do we expect provider systems to be able to keep track of many different fan outs and strengths as to who gets what and when and how it's filtered and the like, which I think the HIM department might be able to do but providers would probably not be able to do, just from an overwhelming workload point of view.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Let me tell you what we've envisioned when I did that, was that if I went on to a portal and I could do self-management and I could list, I could actually put those people in there, then it's not a clinical workload thing. If it's part of the ... inpatient as part of an admission and one of the parts of that ... is that is there anyone you want to share your information with, and I provide that with them, and again it's not part of the clinical workflows, it might be part of the admin flow or part of the automatic system generator as well, but in my mind this has nothing to do with the clinical workflow.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

So my straw man argument would be that the user interface at which you can decide who to send what under your complete control as your PHR but not the hospital portal. In other words, the vendors I think will resist pretty strongly the notion that there should be a complete consumer controlled PHR set of

capabilities, if for no other reason than to ... what that is, but also obviously due to the fact that it's really not what EHR technology is designed to do. Again, I'm throwing this out as a

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I think it's pretty credible to suggest that you ask the provider for a single target that others can then, because there is the capability, again, ... certification and minimum it would be great for an EHR system to have a more flexible model. But because you can achieve what you need once the patient has it, they have the ability to multiplex and pick a primary delegate, I wouldn't go to the mat over any of that myself.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

The other thought is hospital information management departments, HIM department, medical records, they do have in place today release of information protocols ... and have pieces of the record sent to a variety of places, and they have the appropriate consent forms for release and all that. Those services obviously should be able to take advantage of direct so that if the recipient can take the information electronically the HIM should be able to send it electronically. But I'm not sure that's what's being targeted here. It's really more what the

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Let me give you two very specific examples; one member of ONC and I've seen a member of the steering committee, has had their parents have crisis situations on the other coast and they're both M.D.s and there's no one there to do consent because the patients are unconscious or not able to do anything and they have absolutely no ability whatsoever to get into that information because there's no standing preference to say that this particular M.D. from the right coast can see any of this information from the left coast, and of course they have to get on a plane, so that is what comes to mind in terms of the ability to be able to have those standing orders of sharing from the provider not having to go necessarily to the PHR because that person's still in-house.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Let me be clear, Jim. My comment was only referenced to be the difference between forcing EHR to hold one target or many targets. My sense was if we could do one target that's probably an okay minimum. I would absolutely want to ensure that it is the appropriate one. Your case is very legitimate there, absolutely.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

So now, look at the time, we have just a couple of minutes. So let's start thinking about how we're going to move forward. Just for the reason of explanation let me run through the next few real quickly. Data recipient ..., we just talked about this, it's got to come to whoever the ... person is and we need to just give it in that format. We did talk about it already. Avoid data ... loss. Unfortunately, sadly this happens, where it has been kept in EHR in a discrete manner and it is being outputted into CCD as a blob even though the data was kept discrete. So there really should be some, we see this all the time, ... frankly, where we know the system keeps it discretely, and what we get is something that takes away the power to be able to compute it. Info button, this ... we have the Info button on the EHR side. The idea is to extend it to the patient side ... to the portal, we talked about this earlier. Introduction of ... healthcare, we didn't get to it, but please look at the document around nutrition and exercise. The exercise one is great. It's essentially one metric. How do you check for this and do they meet this, yes or no, 30 minutes, five times a week or whatever, 150 minutes. It's a very low bar start.

And then Stage 2 and Stage 3, this is the important piece that we talk about, about the patient sourced information coming back to the EHR and there's a strong chorus of voices where it says that as a menu item we need to be able to send, again, the signal that we really want to encourage that, not require it, obviously, because there's a lot of work to be done, but if we're really at Stage 2, which was information exchange, that was what was brought up by Christine at the Policy Committee this week. We need to be able to get down this path, so that's the last piece.

Leslie, I'll turn it over to you and see how you want to end up, because we only have a minute or two.

M

Jim, there's just one more really – and I'm sorry to interrupt but it's not represented anywhere here, but I wanted to get if we're going to have a continued conversation the idea of the immediacy of the information availability, I think we have to have a conversation about, because we're the only ones who are really going to push on those delays, and there's no reason for them I don't think.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay. Leslie, where do you want to go?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

There was a group talking about harmonizing all of the access questions. Our group has said this should be based upon the patient preference but it should be available immediately electronically based upon that patient preference, that seems to be the idea from this group. I've also heard that the availability is when it's available to the provider, obviously, and so right now it looks like there's still some issues about it's going to be within two days available to the provider, or is it immediate or four days, so what I've heard from this group is the preference is that this should be available immediately or based upon patient preference. Is there feedback on that?

David McCallie – Cerner Corporation – Vice President of Medical Informatics

This is David. Some of the debates about the delay have to do with one concern obviously is there information ... wants to communicate personally before it's available to the patient and the physician hasn't had a chance to communicate it and ... different opinions about whether that's important or not. Second, is some of the information, if it's done via dictation and transcription, isn't available immediately, and the patient if they look immediately may get an incomplete picture and not be aware that there's missing stuff in a transcription loop, so a couple of days ... sometimes people don't dictate until later, at the end of the day, for example, I know some do.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think immediately available means when it's complete, not a partial record. So maybe we can clarify that, because it could be transcription, it could be other, but that completion is available.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

We've had that discussion, too, Leslie. The problem is if you've got a lingering lab result, pathology may take four days, to hold everything up for that one last lab result takes away the value of everything else.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes, but the lab results are discreetly separate. If lab results aren't completed you still should be able to get your discharge summary.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Right, so as long as we define partial in that intelligent way I think there's a reason why – and then we do this with labs and reports all the time, there's a status on them that talks about ... and I'm just really hoping we pushed it, because what David says, the idea of transcription, is we ... but it's also sort of a little bit of an old saw excuse at the end of the day and the more we push from our side, I think the better we'll get to a reasonable conclusion.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

... from an ONC or CMS point of view is measuring this and so they picked a window, four days, to say –

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Right, but if, David, you change it around and you say what the guidance is as soon as you have the information it goes, including and have some definition of partial versus complete, that covers them in the same way. It's a different way of covering them that doesn't persist the idea that there's some gap that's okay generally.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

And even though it's not on here the standing conclusion from the ... Workgroup recommendation is two business days, which could be as long as four days, but depending on the weekend it could not be. So it's actually different than what you see here. That's what the Meaningful Use Workgroup recommended to the Policy Group it to be two business days. So that's consistent across the hospital ... piece.

W

I think a timing question is worth the total team discussion maybe at our next meeting, the first agenda item, because I think that of any of the groups commenting this is going to be the most likely ... patient focus, so I think it would be worthwhile to get a good idea of the consensus of the group.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Leslie, how do you want to handle, because we ran out of time, how do you want us to handle getting additional, should I just have everyone send any additional thoughts they have on any of these items to me today so that we can do the aggregation, so I can get it back out to the folks by Monday? Is the view, download, and transmit such an important thing to everyone that that should also be an item on the big group? How do you want to move forward so that we're addressing it?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I'd like to get the comments to you and then we will also review that as a separate agenda item in the whole group, but let's get all the comments to Jim today and then you can capture those and forward them on to me, Jim. Not that I think the view, transmit and download is so important, but some common themes I heard now from all the groups is our transmit should be patient directed but provider protected, so that it's secure, and private when it's being sent. Another common theme is it should be as computable when I direct transmission as it is when the hospital directs transmission, or the provider, and also that another theme was that if I download it's directed by the patient and then it's protected by me once I've downloaded it. So those are some things I heard from each of the groups. The timing question I think is one that I've not heard consistency on. I do believe that our comments are important in this area, that there is a high need I think to see harmony from both the standards and the ... so I think this will be more directed by policy than it will be standards, our recommendation, though, should be what we think a standard should accommodate.

So that's a long-winded answer, but yes, get your comments to Jim. He will incorporate them in the document that he forwards to me and Mary Jo, and we'll combine them with Arien's and then Liz's group on Monday, and then by our next meeting have the entirety, and hopefully send that out to you a good time ahead so that you can comment.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Does anybody else have any comments? I know we're over, but I think it's important for the folks that can stay on that we do finish this conversation and we don't cut it off. Is there any burning item, just as Sean had mentioned he wanted ..., anybody else, John or anyone else who hadn't spoken recently, ... that you want to make sure that we get front and center?

Heidi Sitcov – Nurse

This is Heidi. No, I'm just thinking about the demographics and the five or six things listed on the demographics that we have listed. I think that's something maybe we're going to have to look at again, and I'm going to look at again too, is language, age, what is it, ethnicity, race, and whatever the other one is, and do we want anything else?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

This is John. I have nothing specific to add to this. I'm concerned with a lot of these things that long term post-acute care is not part of that we'll set a standard in physicians and hospitals and then possibly CMS will do an unfunded mandate to us. So I think it's either we make sure that when we say something we can also do it in long term post-acute care. That's all I wanted is just a broad comment.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Okay. Alice, are you still on the phone? I think she dropped, right?

W

Yes, she had to go, I think.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

I had a note from Holly that she had something come up that she had to take care of medically, so I think that's it, unless anyone else has anything to add?

Mary Jo Deering – Office of the National Coordinator

Jim, we do have to have public comment at the end.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, I guess, Mary Jo, that's it. I guess we're ready.

Mary Jo Deering – Office of the National Coordinator

Okay. Operator, would you open the lines, please?

Operator

(Instructions given.) We do not have any comments at this time.

Mary Jo Deering – Office of the National Coordinator

Thank you.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Thank you, everyone. Thank you, Heidi for taking so much time to diligently go through all of these and cross-reference them back to the 54 page regulation. That's a lot of work, so thank you very much for that. So to do is for anyone to get comments to me today. If you want to put it in a spreadsheet, fine. If you don't you can just say whatever, cell 23 is this, ... Sean gave me that kind of feedback and that was great. And just get it to me by ... and I will get it over the weekend and then get it off to Leslie to aggregate.

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Have a good holiday weekend.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Thanks.

Jim Hansen – Dossia Consortium – Vice President and Executive Director

Yes, thanks, everyone. I know that was hard. Thank you for pushing forward through it, and I really look forward to our next conversation. Thank you very much.

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Have a great weekend, all.

W

Bye.

David McCallie – Cerner Corporation – Vice President of Medical Informatics

Bye.