

Meaningful Use Workgroup
Subgroup #3: Improve Care Coordination
Draft Transcript
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Presentation

Mackenzie Robertson – Office of the National Coordinator

Thank you. Good morning, everyone. Thanks for waiting. This is Mackenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #3, Improving Care Coordination. This is a public call and there will be time for public comment at the end. The call's also being transcribed so please make sure you identify yourself before speaking. I'll quickly go through roll. Charlene Underwood?

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

I'm here.

Mackenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Michael Barr?

Michael Barr – American College of Physicians – Vice President, PA&I

Here.

Mackenzie Robertson – Office of the National Coordinator

Thanks, Michael. Jessica Kahn? David Bates? George Hripcsak?

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

Here.

Mackenzie Robertson – Office of the National Coordinator

Thanks, George. Eva Powell?

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

Here.

Mackenzie Robertson – Office of the National Coordinator

Thanks, Eva. Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

Mackenzie Robertson – Office of the National Coordinator

Thanks, Leslie, and Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Here.

Mackenzie Robertson – Office of the National Coordinator

Thanks, Larry. Is there any faculty on the line?

Elizabeth Palena-Hall – Office of the National Coordinator

This is Liz Palena-Hall.

Mackenzie Robertson – Office of the National Coordinator

Thanks, Liz.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

Mackenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay. Charlene, I'll turn it back over to you.

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

Thank you very much, Mackenzie. Again, I want to thank the workgroup. We've had a really busy couple weeks in terms of hosting some listening sessions to better understand the requirements so for today's call what we're going to do is to actually review the content from those listening sessions, from the actual moderators that coordinated them. I wanted to welcome Larry Wolf to our call because the Office of the National Coordinator had asked that we consider the perspective of the long-term care venue in our discussions and there was a hearing on May 3rd relative to long-term care so it really fits into this space of care coordination. Larry will be covering those findings.

The process for today, if it's okay with everyone, is we'll actually review the listening sessions so we all get leveled and understand the findings from each of those sessions, and then, what we'll do is we're going to actually move to the worksheet where we have the potential to provide our Stage III comments, and we'll walk through that, and we'll determine the best process in terms of how to start to define those comments or the criteria for Stage III. We did have one more call scheduled and that is on June 26th, and based on how far we get in this meeting we're going to have to determine if we need another call.

With that, what I'd like to do is actually move to Slide 10 in the Care Coordination Stage III working document, and so this is what our current work plan was. Again, we were chartered as one of the four workgroups to move forward in terms of defining Stage III requirements. We did some visioning and that's actually included in this presentation that we've got as a working document. We've asked some questions so then what we scheduled—that's the matrix. What we did is we looked at— In terms of our charter, we had been asked to make sure that as we evaluate our requirements we use these criteria in defining our go-forward position for Stage III, and you'll see them listed here; aligning with emerging payments, harmonizing qualifications amongst the CMS programs, support population health, improve health of IT, don't penalize success, as our kind of go-forward positioning statement.

In terms of specific requirements, we were asked to focus on the real time impact at the point of care, make sure that we consider patient partnerships, and I think we heard a lot about that in the hearings. As we can, and, again, I think this was really discussed in some of our hearings how we make that transition toward outcomes, consider the use of CDS, and I think we had some discussions around that in our hearing; as well as the use of assessment relative to population health in terms of driving our policy making. At a high-level we were also asked to consider making sure that we keep an eye on managing healthcare disparity, as well as tools to assist the interaction with patients, and we did hear from patients in our hearings.

Those are kind of our marching orders. With that, if we could actually go back to Slide 11 in the working deck, this is a review of the listening sessions that we're going to be reporting on. As I mentioned on May 3rd there was a long-term care hearing. I've asked Larry to cover that. On May 17th we had a listening session relative to Standards and you'll see all the speakers there, and Leslie facilitated that. We'll cover those findings. On the 23rd Eva facilitated a session where we heard from patients and practitioners on the ground and what they're doing today with care coordination and what some of their challenges were. And then, our last session Michael facilitated, and, again, we heard what some future opportunities might look like in this next stage based on people who are more forward-looking in terms of their vision for care coordination. Michael's going to provide some comments on that, and then, we'll follow that with what our next steps are in terms of discerning the requirements.

With that, I'd like to actually turn it over to Larry, and, Larry, I didn't cover who attended the long-term care session or anything either.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, so maybe that's the place to start. The session on long-term care was actually a roundtable that ONC organized, and there were, I'm guessing, around two dozen folks there, and it covered a pretty broad mix of folks from providers to health IT vendors to different folks within HHS to some folks from RTI who have been doing some support for ONC to some associations representing long-term post-acute care. Maybe that's the first piece to jump in on here is while sometimes the abbreviation LTC is used that's often narrowly used to mean just nursing homes, and there's really a much broader mix of providers here.

The industry preferred term these days is long-term care and post-acute care or shortened to LTPAC. That's sort of, I think, the first piece to put out there is that when we're talking about care after discharge from a hospital that there's a whole host of those care settings that get involved, none of which are getting Meaningful Use incentives, and then, there's also a long-term care piece where people are at various levels of needing help with activities of daily living up through pretty high levels of nursing care to stay alive, and there are also site components in there as well for people with dementia. The context is really pretty broad and I didn't put that full breadth in here, and I guess I look to the workgroup whether you think we ought to do that as we report back.

Okay. I'll take no comments to mean no comment. Let's work through some of the highlights on the slide. I think that this is another example of it's really important to put the person at the center, and I chose the language person-centered rather than patient-centered because in many of these setting this is peoples' long-term home, and so they're spoken formally as residents in that context. But I think this notion of the person is the center gets them out of their role as a patient and actually enables more engagement and activation. There's a real concern about how you effectively tell the patients' story, and represent their needs as well as their clinical status.

Some critical things I think are different in these settings: There are often multiple chronic and acute conditions that are in play. This is not see one specialist, get your care, and be done, or go to the hospital for a single condition to be treated, have a short stay, and be done, but people with multiple conditions many of them chronic and sometimes more than one of them in an acute flare up of some kind. The teams in the various care settings are very much inter-disciplinary teams. This is not just bring in three different specialists each of which treats something in isolation, but because of, in general, the frailty of the individual and the severity of their illness the care needs to actually be much more tightly coordinated, so using inter-disciplinary rather than multi-disciplinary is the notion here. There's often a very high reliance on allied health professionals so a whole host of therapists and social workers, so what's necessary to actually help this person get themselves healed and recover from whatever the immediate crisis is and live a full and rich life as possible, and often heavy use of paraprofessionals whether those are CNAs or other kinds of aides that might be involved with helping someone get their care.

Different care settings are really different. This is sort of like children are not small adults. These settings are not just sort of watered down acute care hospitals. They really have a different focus in the care cycle and the kinds of care they're providing. Often in an acute care setting you can be really focused on this is the thing we're doing. We're doing knee surgery, we're putting in a replacement knee, and that's what we're doing. You're here for three or four days and you're done. A lot of the problems that the patient has that are being managed on a chronic basis either can be ignored or can be unmanaged, if you will, in an acute way. Whereas when they're in these other settings where they're going to be there for weeks if not months and years you need a very different approach to their chronic conditions, and also, you need a different approach to where they are in their healing process. You may focus more on intense rehab to get them functioning now that they're well enough to actually be in rehab.

The settings themselves are different. Their conceptual language is different. The resources available are different. Today payment methodologies and regulatory requirements are very different. I put in here a note that three of them have specific mandated assessments, and those assessments today are not aligned in terms of the questions they ask but there is some initiative on the part of the Federal Government to over time more tightly align them using an instrument called Care for elements out of care.

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

Does Care transcend any other settings, Larry, on that?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Care does transcend other settings. Care has also been piloted in acute care hospitals. It's been piloted in long-term acute care hospitals as well; in addition to these three settings.

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

And I know, for instance, nursing homes have been reporting transparently on their outcomes for quite a while so you know.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah. There's been—so the prior generation of MDS had some quality measures, which were publically published. There's also a pretty rigorous survey process that happens in nursing centers, and there is also that have been published, and they've both been published for a pretty long time, and there's an integrated five star rating system that CMS has developed as well. There is a lot of public reporting on nursing facilities.

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

Have they ever thought—I mean, as we look at the convergence around public reporting did they think about taking this one and use it as a model or did that discussion happen or is this an afterthought?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

The government has a bunch of compare websites and I don't know what the thinking is in terms of integrating them.

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

Okay. All right. Thank you.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

But it currently is a good question and as we look more towards sort of bundled payments and integrated care the separation become more artificial.

Okay. Some other highlights here, if we're looking at care coordination, and these next chunks of thought comes out of the work that the Impact group is doing in Massachusetts, is that they've identified really three different types of interactions that need to be coordinated. There's what I'm calling directive consult requests and out-patient services. This is where you're in some setting but you as an individual go out of that setting to get some short focus care. It could be that you're in a nursing home and you need a consult and you go to the specialist office. You're there, the consults done, consult report's written up, and you come back to the nursing center; could be something as simple as that.

The next one is there's an emergent condition that's happened, and emergency department is used to assess and treat event, and the individual might be going back to their prior setting. This is not the ED is a gateway to an acute care hospital stay but the ED has a place to either do an emergency treatment or it could do an assessment of an emergent situation and figure out what the treatment plan ought to be.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Larry, this is Leslie and I'm wondering about a couple of important concepts. As we believe that care coordination includes the patient there could be a fourth one in here, which is really care coordination by itself or patients and families. A patient could actually be doing their coordination because it's centered around their home setting and it might be between their primary care doctor and themselves or it could be between their community members and themselves. I wonder if it would be worthwhile to add that, and then, as well as above the different settings are different, you know, another setting is the home, and so even though we're talking about long-term and post-acute care we have transitions in and out of the home including the phrase you taught me, which is the home of your choice, right. We need to figure out how to integrate those concepts because part of improving costs and quality will be patients being able to do as much as they can for themselves, to say no to the care that they don't need, and really give them tools, so maybe we could add a little bit more of that home of your choice around this.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah. You bring up a really good point as we think about reporting back to the larger Meaningful Use workgroup, in that's how much of this do we bring forward in to kind of an integrated presentation back and how much do we reflect the structure of the way in which we do the hearings?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right. I don't know.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think there's actually value in our giving them an integrated report.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah. I do too.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And bringing in more some of the things from the other perspectives in terms of some of the patient centered issues that ought to be here and expand the care setting beyond just coordinating with the LTPAC providers.

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

Right. Maybe the question we ask ourselves is because one of our core tenants was the patient is a contributing member of the care team for every type of our slide is the patient reflected? Is the home setting reflected so that everything we do represents all settings of care including the 96% that care for themselves at home?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That's certainly true and all the issues of managing longitudinal care become really important when you say, "The trajectory is now clearly decades."

Michael Barr – American College of Physicians – Vice President, PA&I

Larry, this is Michael Barr. Quick question for you, where do families and care givers come into this? I know it could be part of the inter-disciplinary teams but typically that's related to, as you say, health professionals and paraprofessionals. Then, what kind of needs will they need in terms of care coordination in the long-term care and post-acute care?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Again, I think that they're clearly important, and if we sort of expand the notion of beyond just a single session where the focus really was on these providers and look more broadly at what our charge is that we should do that.

Michael Barr – American College of Physicians – Vice President, PA&I

Yeah. I mean I think I recognize it wasn't the focus of the—the cost corner wasn't on this one so thank you for the clarification, but I think if we're going to talk about care coordination in any facility, especially in this one, the family and care givers are going to be real important, and what their needs are through care coordination is going to be important, what the technology needs to support too.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah. I'm hearing in my mind the notion of this should be a very short slide here that says this was a roundtable, here are the participants, two or three key points, and then, that's sort of an acknowledgement of the history but that the real content ought to be part of an integrated approach to care coordination and not something we breakout separate.

Michael Barr – American College of Physicians – Vice President, PA&I

Well said.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. So two things at the end of this slide; one of which we've been talking about, which is this need for longitudinal history and there's been a focus on that in a lot of ways so it shows up in various kinds of transfer documents that different organizations and states have proposed and have used over the years. It shows up in the focus on CCD as the primary interoperable document type that Stage I Meaningful Use addressed and Stage II looks like it will put it front and center. That's a good document type for getting a summary, but it doesn't really address the complexities of a care plan.

There's an emerging sense that actually we need two documents, one of which talks about kind of, if you will, the patient's status, what's going on with them, lab values, and things like that; and a second one, which is sort of much more action focused, which talks about what's being done, what's being planned. Why is it being done? What's the desired outcome? I say a little bit more about that on the next slide. To me there's sort of an emerging sense of there's two aspects of coordination that need to be addressed in terms of the kinds of information that we move from one setting to another and that we share with patients and care givers.

Let's move on to the next slide. I framed this as sort of recommendations. Maybe that's too strong a phrase to use here, but I heard at that session and have heard before and after it this notion that CCD expanding into consolidated CDA and the various templates in the consolidated CDA is an important piece to build on. We shouldn't throw away that building block, and, in fact, it's very valuable and seems to be getting a lot of traction and we should go with it.

The second piece is working on a structured standard space care plan that starts with the patient's goals, links in intervention, desired outcomes, and probably should say in here their problems and conditions and sort of the classic elements of a care plan and that it looks to support multi-setting care and assignment of roles and responsibilities. Again, this is a great place to really look to make this comprehensive and bring in patient engagement and what the things are that the patient is doing, what the things are that caregivers are doing, and this really becomes an active document type for looking to do the kinds of care coordination and knowing who the various players are providing care.

There's also, I think, a clear need to clean up the information that's gathered in the different settings. While there are different assessment tools in some of the care settings and there aren't assessment tools in others, there certainly are standards in place in a few settings through the care assessment tool and other assessments that have been used over the years. I have some examples here of things that would be high value to address.

One of the things that didn't make it to the slide that I think is really important to get on the slide is advanced directives because that's something that's been identified even in Meaningful Use I as something to put in place, but it really is important to know what the limits are of what people want done and who the individuals are that they've handed over care decisions to. The Meaningful Use initial stop really just says, "Is there an advanced directive somewhere?" And I'm hearing a lot of desire to do what's currently done in the paper-based world, which is indicate the specific directives and the summary status in the current care setting as a transition to a next setting. While those particulars may not apply in the new setting it gives people a starting point and they understand the initial intentions of the individual and their families. I identified some related activities that are going on that can be looked to as examples where people are actually doing things in the world and we might learn from as we move forward.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Larry, this is Leslie. I think that the advanced directives also got some play in our discussion last week on patient generated data as potentially a place where patient directions could be included more easily in the workflow so that in a CPOE step there might be included no intubation, no hydration, and so forth based upon the patient's actual advance directive and pull. I think that's worth further investigation.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah. I agree with you. That would be really good to sort of link those to get below the level of no intubation to other levels of life support or preferred methods or methods that, in fact, have been problematic in the past. Although, the example we had of a patient with thrombosis, to me that feels like also a huge failure of the healthcare system even forgetting about more patient centered information. I mean, those are just contraindications that got lost; an individual with a history of bad outcomes and no one was paying attention to those bad outcomes. I don't want to let healthcare as an institution off the hook saying, "This was a problem because we didn't have enough ways to deal with patient preference." That was not an example of patient preference. That was an example of system breakdown. Okay. I'll get off that soap box.

Charlene, are we ready to move on to the next slide or you want some more wrap-up on this done?

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

I'm sorry; actually, I wanted to make a comment. Two things; this group lives in the space of patient's interest. They were really clear with that, and their perception of some of our current Meaningful Use requirements is that it's acute care centric, just kind of as a comment to frame where they were coming from, but they're very passionate about being patient centered and the kind of input Larry gave you. The other piece, I thought they had said too that what would help them a lot would be to immediately on transition have a real life discharge summary rather than a couple days after the fact. Was that a requirement that you've heard?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That is a requirement I heard, and this is a good example of what tends to be practiced these days seems to vary. There are many settings that are able to get at a discharge summary at the moment of discharge, but even those settings may not have it baked into their bylaws to say, "We'll do a discharge summary at the moment of discharge." Their official structure gives them lots of time to actually do the discharge summary and typically up to 30 days. I'm wondering if this is a place as we talk about what would be good measures of care coordination that maybe this is a place where we actually ask as part of Stage III that people start submitting the timeliness of the information that they're supplying on discharge.

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

This is Eva. I like that solution and I recall from when I was working in the hospital and discharging people to nursing homes, nursing homes won't take a patient without a discharge summary and so obviously those discharge summaries were done real time or as much as that was possible in a paper world, which basically the paper copy went with the patient. I mean that's clear that it's conceivable to do this in real time. It's a matter of prioritization of what it takes to get the discharge summary done. And so given the focus on care coordination and the importance of this kind of information to it I like that titling solution, and I guess I can also see that this would tip-toe in some areas that need attention that aren't really under the purview of Meaningful Use, such as the bylaws kind of issues and some of the discussions we've had about transcriptionists and that kind of thing. It's just the electronic nature of the information to me would seem to facilitate a more rapid production of the discharge summary, but I might be thinking too simplistically about that.

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

Well, and then, I had—on the quality matrix we had talked about electronic notes again, and it struck me that for Stage III elevating the electronic note at least to be able to do the discharge summary in a more timely manner seemed to be a good candidate. That's kind of why I wanted to keep it on the list because as we kind of harmonize them across we might want to consider it there.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

One of the thoughts about this is the data from Setting A to Setting B isn't done with the discharge summary. It's not uncommon for there to be lab tests that are outstanding at the moment of discharge, and they're often really valuable results to pass along to the next care setting, and it's very hit or miss whether those results get passed along today. That would be another place where we might look to electronic systems to facilitate that because they would know. They could know the results have come in after someone's been discharged and if they knew where they went they could maybe do an auto forward or a human assisted forward of information to that care setting.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think the summary of care standard allows for appending results, and then, when that result is created it is forwarded. I believe that's within that standard but I can check on that, but I agree. This is a prime area for acceleration of getting those notes in the chart because they're dictated before the patient can be discharged, the last bit of note. I think it would be a great area to accelerate.

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

Okay. Well, thank you, Larry, and then, shall we move on? I think Leslie you were next in terms of the Standards hearing.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think I've updated my slide since then, but I think the big takeaways here are that the standards should not be getting in our way, and, in fact, there is such momentum right now that we could see standards being advanced in time for Meaningful Use II. Some significant developments are what we heard from Russ Leftwich and Dr. Holly Miller and also Dr. Larry Garber about transitions of care, care plan being worked upon, the consolidated CDA, patient generated data so I think there is great momentum.

We saw in this slide some to dos for this next year, and then, the following year for Meaningful Use III. It would be great to have Standard's work recognized and accelerated to expand the transition of care work, a collaborative care model, patient generated data, and potentially a patient facing API was discussed all along. I think that's probably too narrow rather than a patient facing API that potentially a care collaboration API that would allow for people to use things like the emerging query system to go in and requesting information from an EHR with the idea that would be used for continuing collaborative care documentation.

Expanding that S&I work, I think, would be a good recommendation to expand and accelerate, and then, also to recognize that some of the work in DIRECT, which will allow for the consumer or patient to be integrated in communication, could be finished at least in a preliminary stage in order to meet Meaningful Use II by the end of September, and also, the consolidated CDA that would allow for patients' generated data ready at that time. There is great momentum and there are work plans in place for the next, I think, two years, and we should not let standards get in the way of advancing care coordination is the big take away from that session I think.

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

Leslie, as part of the rollout process—again, to get adoption these things have to be more than a conscious centerpiece. They've got to be proven. How do you see that happening?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, I think there is momentum for pilots using DIRECT, and then, also the consolidated CDA. We're seeing emerging companies like Intuit who have large consumer bases and ... who are eager to try things like patient generated, consolidated CDA. I think there's opportunity emerging in the market. They might not be in a more traditional EHR approaches but definitely in the more community oriented approaches like ... and Intuit or Microsoft that can help with that. I think this is just the opportunities will be there for adoption in non-traditional sources.

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

My recommendation would be that, again, it's not only certainly the development of standards but their implementation and testing during this period because this is a very complicated space as you start to work through this space but if that could happen then I think the potential for broader adoption by the broader market could be there based on the practical experience that happens during this time.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah, I agree but I don't think we should limit what we would recommend based upon huge adoption up front because this is still an emerging practice.

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

Yeah. No, I think we're saying the same thing.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay. Great.

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

Yeah. I think we're saying the same thing. I just think we've got to get out there and get some experience with it because it is exactly what you said. It's changing the practice and the culture as well as changing the tools, and the tools might support the change, right, but it's still going to be a process that has to be changed in the next couple of years.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I don't want us to get trapped in the standards have to be perfect before we can use them. CDA is a really good example that documents are meant to be able to support multiple levels of coding, and we should, I think, encourage that kind of broad thinking as we go in to expanding areas in which we want to move data. If you have a good section heading and move human readable text while that's not perfect, I don't want it to preclude our ever developing coded vocabularies. We seem to be spinning our wheels around coded vocabularies in different ways, and we need to be moving ahead with developing information exchange that human beings can see what's moving and that we deal with the elephant in the room of patient identity and that we move ahead with reconciliation processes at various levels of automation to address the gaps in coding.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I agree, Larry. If we waited for perfect then the ADT messages we all started using in 1990-something that were maybe five fields long and now they're, what, 150 fields or data elements inside an ADT message, we would have never had connectivity.

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

Are there any other questions on the information from the Standards listening session? Okay. Then we'd like to turn to Eva, and you could maybe report out your summary from the Patient and Caregiver Session.

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

Okay. What I tried to do is to go through my notes from the session and kind of consolidate what I heard into some buckets of things we need to bear in mind as we move forward. What I took from the session was that there are certain critical elements of coordinated care. The first being a consistent, ongoing, real-time, and bi-directional communication method, and that having such a thing serves a number of purposes and a number of specific criteria kind of things could fit under here as well such as the care summary and that kind of thing. But first of all, it serves as a reminder of what happened during the encounter both for review once the patient's home and the patient caregiver tries to do self-care, but also a reminder of not just the things they need to do but also just what was discussed and what options are and answers to questions and such.

The second thing is transparency, and this is one thing that really struck me as being very important. The transparency has a positive psychological impact and that it tends to increase confidence in a person's ability to manage care at home. I see a real direct relationship or hint at least between this and the patient ... measure, which we also head in the hearings last week, can have a pretty significant impact on how well-equipped and how providers can help support patient's ability to manage their own care at home, as well as an effective tool for triaging for understanding who needs a little more support and who needs less support so that you're not just kind of giving this blanket coverage of support. Then, the other piece of that kind of communication loop as I kind of talk about it is the lack of readiness for health information exchange. I think we hear that over and over again that one of the main barriers to truly coordinated care is the difficulty and just exchanging data more generally and some of those larger issues. That is that first bucket.

The second one is the notion of shared accountability and engagement, which has been discussed already, I think, as part of what Larry was talking about, but the need to focus on the sending and receiving and the notion that once you've checked the box sending the patient out the door that your responsibility is not over and that's very much the way it's viewed now. That we somehow need to instill accountability kind of beyond the walls of the institution to ensure that transitions happen safely and effectively.

Also, what I took from this was that there's a fair amount of inconsistency in what kind of information is shared and who actually gets to see it, which seems to me to be an opportunity here for us somehow in terms of maybe there might be a Standards opportunity here. I think it also points to the Patient Generated Data Hearing conclusion of one of the first steps we need to take is to identify small sets of pieces of information that we need to be collecting from the patient themselves. That applies here as well, figuring out what is the most pertinent information to share in a transition, and then, also involving a number of care team members' not just physicians, not just nurses, but understanding that in different places this will be implemented in different ways. Also, the notion of an integrated acceptable care plan came up as part of the shared accountability and engagement, and I'll talk a little bit about that in a second because I think that's a big area that we need to somehow get our hands around.

The final bucket that I put on here is culture change, and I'm not sure exactly what we will do as a Policy committee to affect this. At the very least we need to be aware of it, which I think all of us are, but this seemed to come up a number of times that culture change is a huge part of this for a number of reasons and that there are certain opportunities to address that through policy. One of which is the notion of focusing on safety and reliability and a more patient-centered approach, which in and of itself requires a certain degree of culture change, but by designing things that take that approach and being very focused on the patient. I don't know that I'd say forces the culture change but it helps facilitate that because your perspective is changing.

Also, the other thing that I heard as part of this, which I think is a huge cultural shift, is the notion that care planning perhaps should begin with the patient's goals rather than clinical goals, and then, the patient goals then drive the clinical goals, which then together drive any sort of shared decision making process. I thought that was an interesting thing to work with along with the notion that requiring people to demonstrate outcomes will start this cultural shift as well.

Those were the major buckets. I also noted in my reflection on the discussion that there are certain gaps to fill; one of which is something we have already been talking about, connecting individuals across multiple care systems. Another one is connecting with community partners that are not necessarily healthcare related but connecting with them somehow in the context of those patient plans, having an ability to address individual patient needs while also instituting a degree of standardization. That's going to be a difficult thing to achieve, and then, finally, assigning responsibility for sending and receiving information.

I had asked—and actually these questions are all from the follow-up questions that I sent folks after the session and these are the responses that I got. The second bucket of necessary information that's not yet collected—I thought it was interesting that we got some fairly clear specific things—one would be patient goals; one would be patient preferences; and then, just, again, the accountability for sending and receiving, who's responsible by NwHIN and have they done it.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think we also had—I don't know if it's under the patient preferences but we also had value and intolerances as well.

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

Yeah. I do think that those values may be able to be categorized under patient preferences but definitely intolerances I see as different.

Let's see, and then the final bucket was ideas for specific uses of technology, and I wasn't sure how to talk about these in the discussion today, but I didn't want to lose the information. Just the notion of using registries as a way to help coordinate care, I thought was interesting. That might be something to pursue further in other listening sessions or Incorporation of risk assessment is something that I think is talked about more with respect to care coordination and doing some preplanning to understand what this patient's specific need are. And shared decision making tools and making sure that those tools are in a patient friendly language and multiple languages, and then, involvement of other disciplines in the management and sharing of information, and I don't know, this may be an issue that's kind of taking care of itself. I don't know what things are like in actual implementation whether this is actually being done or if things are being implemented with pretty much physician and nurse users only or if there are other user roles being designed according to the individual provider setting.

Those are my notes on the session. I thought it was a great and very enlightening session that really showed us that there's a lot of good work going on but figuring out how to boil it down into some specific criteria is going to be difficult. The one thing I'd like to go back to is just the contrast of the care plan. Obviously, it's central to care coordination, and it's difficult because we still don't really have a definition to speak of it, and it came up on the Meaningful Use workgroup call the other day that it might be more really of a hearing. And I think that they're going to move forward with planning for this to discuss specifically how we go about creating this longitudinal shared care plan because it touches on so many other elements of Meaningful Use. The advanced directive piece, obviously, is a component. Clinical decision support while it's not necessarily a component of a care plan certainly should somehow tie to it, and whatever the result, the CDS or the suggestion posed should somehow be connected to the rest of what's in that patient's care plan. It's just a rapid spiral, if you will, of complexity so I think a hearing is a good idea, and so perhaps this group could come up with thoughts for what we need to be sure to discuss as part of that hearing.

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

Leslie, I know Larry Garber presented the thoughts and what they're doing in terms of developing kind of this integrated care plan, and I don't know to what extent you see the aspect that—Eva talked about patient goals. Are those things included in it or how is that process working? Does it need to be informed by us or—?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Well, they've assumed in the structure document that a patient is an equal contributing member and there are goals for care and there are daily living kinds of goals, but I can talk further with him. They may ... those assumptions that the patient is just simply another participant and person who can contribute to those. I think they have that concept quite well but there is still work to do, and that's why I'd really like to see us accelerate within the S&I framework the whole idea of the collaborative care model, which is care planning and the patient is a participant. And then, also, which I should have done a separate line item, which Larry brought up, the patient identity issue has to be resolved in order for us to get to care coordination; that is a do not pass go issue that we need to get resolved. The Standards committee had asked the Patient Engagement Power team under Standards to take that on, and we're waiting for ONC's direction to know whether to move that forward or not.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I wanted to jump in with a comment about patient identify that often sort of gets very focused on we need a national identifier, end of story, but I really don't think that's the end of story. Some of the work done over the last year or two surfaced the need to get good, quality data about the information we are collecting, so get the person's name spelled the way they spell it, the way it's on their ID, and get it consistent. Get their address current and right, and use the postal standard for address information. Additional identifiers you do collect, their home phone, their cell phone, their email address, those are very powerful identifiers, let's start using them. If we know payer information and we have payer IDs those are also good identifiers. There are a lot of identifiers out there that could be used to cross correlate who this person is in the different settings. As we send messages back and forth between the settings if we send our ID for that patient and the receiver keeps it and knows that when Kindred sends a patient this is the identifier they use and when General Hospital sends a patient this is the identifier they use. It recognizes the diversity that we have and lets us begin to move forward.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I agree. I think that's been very much talked about that there could be an agreed upon framework for identity that could achieve these things, which is very different than a national identity card or number, which, by the way, we can't work on specifically within the directives of ... of ONC. And I think that the emerging technology and what you just described, Larry, is the real world and adoption will become much easier if we agree to a framework of identity.

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

Yeah. I agree with that too, and I just got an email from Suzanne Metz with responses to my questions, and the one thing that she added was collect care giver status, which I should have added myself, but it strikes me that could potentially be part of this identity structure given the importance the role of caregiver has, particularly for people with chronic illnesses. That should also be part of the information that's collected along with what role that caregiver plays specifically, but that some sort of identifier structure might benefit from that as well.

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

Okay. Thank you, and are there any other questions? Again, I concur they were great ..., Eva, in terms of the findings that came out, and just listening from the patient perspective I think the thing that struck me the most was that we're talking about communication here, and communication is always two ways; it's not just one-way, and then, I think, Leslie, you came back later with it's not always point-to-point either so it's hard to make it a transactional process. Again, I hope that's a space that we can look at a little bit more as we move forward in terms of how we start to get that bi-directional communication or multi-directional communication start to support the collaborative care model.

Okay. It's Mike's turn. You still on the line, Michael?

Michael Barr – American College of Physicians – Vice President, PA&I

Do we have slides or do you want me to wing it?

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

I think they're in there.

Michael Barr – American College of Physicians – Vice President, PA&I

Okay. I know we gave them to you so I wanted to

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

We've got them all on one slide.

Michael Barr – American College of Physicians – Vice President, PA&I

Wow. That's pretty impressive. Thanks. We are getting some feedback from physicians doing things, from Dr. Illena Pena, our ... specialist David Kendrick from ... Community in Tulsa. It's interesting; a lot of what they told us echoed what's already been discussed. If we start with the points of Dr. Pena—and again, both actually emphasized culture versus technology, not one against the other but you could have the best technology but if there isn't support to train your team or the culture behind using technology then it's not going to get the end result that we all want to achieve. She focused on clinical decision support to support appropriate use of indications, especially in transitions of care, and particularly highlighted post-discharge medication management; given her expertise in heart failure that was the area that she focused on, but obviously that that could apply to any clinical situation of transition.

One thing that hasn't come up a lot and certainly is not represented in any objectives of ... or optional MENU is sort of the training of the staff to use technology appropriately. I hear a lot from physicians in the field that lot of what we're asking them to do in Meaningful Use falls on their shoulders. I'm not saying that's appropriate ... than necessary, but I'm not sure we focused on helping them train their staff to help them, and I think that might be part of the pushback we get when we hear from the field. As we hear from the field and the professional societies from physicians who are trying to achieve Meaningful Use and the appropriate training of staff and the technology and the culture change associated with having many of these. It's something we probably ought to ... our narrative perhaps meeting objectives should focus a little bit more on.

She thought that technology should help identify patient who lack appropriate follow-up. I think we've all talked about that but that came up in the conversation. One of the things that Dr. Pena also identified is trying to help link professions via the technologies and the team approach, again, trying to broaden responsibility while not losing the fidelity of the information across people caring for patients including the patient, him, or herself, and then, she identified reimbursement support. I know that's not part of our periphery but just to recognize that it is a challenge out in the field as recent as this particular session.

David Kendrick from the Beacon Community; he started off by saying the CCD is not sufficient by itself. In the care transition document besides trying to make sure that we specify as clearly as possible (that's the last bullet) what it is that we want to achieve and how we should do it because there is a lot of uncertainty out there among the health professional community. Workflow modification is as important as technology implementation, again, echoing sort of the culture change but also that there are better ways to design systems to use the health technology that we are putting in place, and he thought that should be part of it or he talked about culture.

Legal issues on health information exchange—again, probably not within our periphery—recognizing that it is an issue came up that there are still some concerns about the duty to know what's in health information exchange across a community or region or nationally. For physicians across a community say the same patient is ordered something what's the duty of the primary care clinician, for example, to know that's in there.

He had some technical recommendations that might be good on my personal knowledge but I'll just record it here. Make patient referral messaging standard a Meaningful Use certification criterion and leverage HL7 standards. Those of you in this space probably know more about this than I do. He also called for certifying the transition/referral management systems sort of like a SureScripts model for care transitions, and that was a hard recommendation in terms of a specific not a hard form. He thought that extending Stage II Meaningful Use into Stage III to require demonstration of close loop referrals so that if something goes out it comes back in and that's registered. Charlene, you may have something to say about that, again, from the technical perspective. CMS should extend payment for telemedicine for documenting Store and Forward telemedicine encounters. I didn't have a chance to ask him more about that but it's something that some of you may know more about than I do.

That's the overall value that I bring from my notes from the meeting. There are several of you who attended. I hope you can contribute if I left anything out from a summary of this I made at the earlier conference call.

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

The thing in David's comment—and, again, this is something that we can kind of discuss. Similar to how when you admit a patient kind of like an order he said when you do a transition of care we need to start to think of it in the same way. It's an order and that's kind of why he said that framework of using the referral document, which exists as a standard, and you do the referral but make it closed loop and come back is important because a lot of transitions get lost out in space, if you will. It's a more transactional approach that at least starts to close the gap of the transition.

Then, the other point he brought up I thought was—and, again, I think Leslie, you commented on this—was by knowing to whom you're transitioning to then you can get more appropriate in terms of the kinds of data that you send along with. Similar to how we place orders in the hospital, if it's an order for an imaging exam we send certain information or if it's a medication order we collect certain information or if it's a laboratory order we collect certain information. Again, it's like you're not always sure we're going to go but, again, it started to emerge the need to start to collect some site specific communication information when that transition occurs.

I don't know if people want to comment or if you heard the same thing, but, again, it struck me that David has really been thinking hard about this problem.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think that it's really interesting because his approach of the orders is really about the process. You've got sort of the processes that need to happen, and then, you have the accompanying supporting materials as documents. And in many states patients can self-refer and patients can order their own labs, and so accommodating both the process and the needed content I think is material to both the professionals and the patients and their care team members. I thought his presentation was very interesting, and even though we think of orders as a professional rule it really is much more of a collaborative team model; it works in both.

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

When you think about it as an order you can have clinical decision support. I mean, you can get smarter too in terms of actually treating it as an order too in some cases. I thought that just kind of elevated the model a little bit.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I agree.

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

Any other comments or feedback on that one? Okay. What the suggestion was actually we move to the matrix and, again, I don't want to miss the point that all of you have been making. I think we've got to come forward with, again, an integrated set of recommendations but I thought it was important to kind of review the input from these different perspective kind of as the basis for going forward. Now to create, if you will, a limited set of requirements out of this broad perspective, I think, will be our challenge. Let me kind of just—let's look at the matrix and see if that helps us, but if we need to step back and maybe highlight what we see those top principles being we can certainly do that too before the call ends.

Michelle or Caitlin could you bring up the matrix, please? All right, so as we look through this—and this is kind of what we were doing in our other calls. We kind of just took each one in the Quality workgroup and we started to walk through it kind of integrating the information that we've seen already. Again, the top of it kind of lists the principles we should be considering as we are coming up with criteria. Again, I think a really—and I think this group is being sensitive to those goals of health reform that we're all trying to achieve. The framework just gave us, again, the category of what was in Rule 1, Rule 2, what happened in the proposed rule, and then, what our expectation was, or what our feedback was to the rule, and then, we kind of did that for each category. There are quite a few. We have quite a bit here to go through.

Do you think that's an appropriate format to use, that we kind of go through them and we kind of identify each one, and then, we add additional requirements or would you rather step back and perhaps come back and discuss some high-level recommendations? This is kind of open to the group.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think it's a both and.

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

I know. I'm trying to think what tool is the best way to kind of—because we've got a lot of information. Should we just—

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We've just been through kind of the ground level view from each of the hearings. Maybe we can do a quick pass through this matrix in the same kind of way to sort of view where we are, and then, have a high-level discussion about what we think the priority areas are. Then, having done that and kind of gotten directive about where we want to go to then come back to this document and look to—then we'll know where there are areas that we want to address, and then, we can fill in specifics around the things that are already in play and where we want to extend it.

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

Okay. That works for me. Others?

Michael Barr – American College of Physicians – Vice President, PA&I

Yes.

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

Okay. So we'll just kind of walk through the documents. You saw on Page 1 in terms of transition of care the rational there was, in terms of the first page, the transition of care document was because of kind of the confusion and that was related to by David in Stage I of what to do and there is no one to transition to, and that was kind of removed from Stage I, and we kind of said, "Okay. Let's then really do a transition then. If you're confused about who to do it with you should really do one." We're not sure what will come out of the NPRN but similar to what Leslie said we're trying to keep momentum in this area because the direction of getting the standard in place, getting the data collected to fulfill the standard, as well as to figure out to whom you're going to exchange it to takes some work, and we're trying to keep the industry momentum going in that order.

The second one was med reconciliation, and, again, it was moved to core as we see here in terms of being proposed in Stage II. There was an elevation of the threshold to 65% for EHS and EPs so it was increased, and our comments here was we needed to make sure that the criteria to document, that the transition—the scenario is and the feedback we were getting is, how are we going to create a denominator that we know a transition actually occurred? There needs to be a provision in the system. Okay. Think about that; that kind of links to orders. I'm jumping, I'm sorry. But there needs to be a documentation that there's a transition to occur, and we definitely need to agree on the definition of the transition. We felt as a workgroup that we needed to, at this point in time because this is a relatively new area, keep that threshold at 50%.

M

We're also moving to core.

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

Yes, it moves to core. It was a big jump.

Okay. Moving to the next slide, this was, again, the summary of care record, and, again, I think it was recognized that in Stage I achieving—and this is for the EP that providing the transition of care summary has been a challenge for 60% of all transitions and referrals of care. I think there were a lot of questions around what is a transition as well as what is a referral? We spent a lot of time on this for Stage II, and, again, because—the vision was in our workgroup as we talked through this and we went through discussion if we could get to total rollout—and you can correct me, Eva, on this one but what I recall was the view, download, and transmit capability may not need to do this but in the interim it's still important that we actually support this electronically to make sure that transition happens between care givers.

No, I take that back. That was not the case. There was another one that we thought we could actually take off the list because if we had view, download, and transmit we could do that. This one we left in place between caregivers, and we raised the threshold. Again, it was we left it at 50%, which was what was proposed, and we had recommended that—and we had spent a lot of time on this—for those people being transmitted that 10% then have the patient care goals and patient instructions actually documented. Now, what was in the NPRM, they actually didn't quite interpret it that way. The EP transitions for the care setting should provide a summary of care so that objective is there for the EP as well as for the EH, and they have two measures; one for EP that they do the transition of care for 65% as it transitions for referrals. They increased the threshold, and then, what they did under EP was in addition—I'm sorry, the first one was EP critical access hospital as well as eligible hospital, and then, they also added in the requirement that there were 10% of those transitions being sent to a different certified EHR vendor.

We actually had our Meaningful Use group, as you can see, had a lot of comments on that. We felt that—I'm going to take a step back. When we were trying to define this originally, again, we tried to for this particular capability keep it pretty straightforward in Stage II because we knew we didn't have a standard in place yet for this whole longitudinal integrated care plan. We said we just kind of wanted to capture two fields. We wanted to capture who the care team was and what the goal was. As we talked it through, one of the important pieces of information is to kind of understand the reasons for the referral or the transition, which seemed to be apart from the goal so we made that recommendation. I think in some cases this could be overlapping but, again, we made that recommendation.

This was the same case where we said we need to know that a transition's going to occur so we can put it in the denominator. To know that a transition occurs we need to either order it or have it documented somehow in the system. We very strongly pushed back against having to have that 10% go to a different vendor system because in many markets you just can't make that happen. What we're really trying to do is to encourage the exchange of data across multiple venues. That's our point here and not to put restrictions around it and make it more complex, especially since it's a challenging objective to do. Of course, I think this issue to be accountable, number or a percent, we were divided on that. Should it be 25 or it should be a percentage? And, again, the thought process here was once you get this in place it's one of those capabilities because of its value will feed upon itself. We're trying to create the runway here as opposed to necessarily specifying such a high bar that it can't happen. The real intent of our feedback, I think, from the Policy workgroup was let's get this going in Stage II. We want to make this happen. This is really important, and I think that feedback was what we conveyed in our comments.

I'm going to open this up to the workgroup (I know there was a lot of discussion around this) if you want to add additional comments or perspectives on this one.

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

Charlene, are you going through these expecting that we are just going to just add like additions or just?

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

No, not yet. We're just reviewing them to level set today. Okay. So as long as you think I've got the essence of it we're good. Okay. Next one— because you guys remember the discussions we had on these—this was a new one. What happened here was we wanted to make sure as a workgroup that we actually record the members of the care team, and we recommended that actually be a data element. This objective was not included in the NPRM because in the NPRM they're trying to be very sensitive to the total number of objectives and they expect, I think, it will be captured as an outcome of the information necessary to be able to put on the care record summary, so because it's a byproduct of that the intention was not to actually include that as an objective. I think our feedback on this one (we actually had some Stage III comments) was okay that's okay. We were okay with that, and then, we had some comments relative to Stage III already.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is just a lot to absorb, and I want to make sure between now and our next call we can provide feedback and edit.

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

Okay. So this kind of shows the work that we've got to do, right, and we've got to close in about two minutes and go to public comments. Actually, let me stop here and we've got some more—actually, this is the last one, improve care coordination. We proposed the care record summary, and I'm not sure how this one—okay. Record care plan goals and patient instructions in the care plan, so this is the same case, I think, as the Care team, and it was not included. We spent a lot of time on this because they felt it was a part of the document that was sent and we left it as that particular—so that's the same thing as Care team because care plan is included in the CDA document that would be sufficient and we were okay with that.

That's the current state of where we are relative to the NPRM and our Stage II comments, and now we need to kind of move forward to Stage III comments.

Michael Barr – American College of Physicians – Vice President, PA&I

Charlene, when is our next call?

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

Our next call is the 26th, I think, in the morning so two weeks from today, and we probably need to start doing what Larry said, come back. What I'd like to do is probably take this input and at least propose some principles as a strawman that I'll send you between times but, again, I think the conversation from our heads is going to be really important in terms of synthesizing that.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

That happens to be the one call I can't be on. I'm actually presenting simultaneously at MLM. Well, somewhere else before MLM, and hopefully, maybe we can do some work over email. I mean, I think what I'm—I mean some observations from these excellent listening, one thing is as a group do you want to like move up a level from doctors, that is helping healthcare systems perform care coordination? In other words, make it smaller steps or we're really trying to make a bigger step which is going across organization? That's one kind of issue which brings about different requirements. One, it's more like the latter one needs health information exchange to get anywhere. It's kind of a bigger jump whereas the ones that are succeeding today are the ones that are intra-healthcare systems like They have nursing homes, hospitals, doctors, et cetera, that they're doing within that structure. I think our goal is to be big until we prove we can't do it but that's just a thought.

The second big theme I saw was closing the loop somehow, and so somewhere here that seems like it will be part of what we're thinking of for Stage III, and I caution, don't get bogged down with the standards. I mean, we have multiple groups working on standards so the standards are only important to us in so far as it limits what we can put forward in the policy, but we don't want to work on it exactly. Like that's for another group for decided, and we will be handing this off to the Standards committee even before we make our final recommendations to ONC so we do have time for feedback in case we're going too fast for the standard. But I don't really want to work on it too much because it's a lot to work on.

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

Yeah. I think the reason we got informed, and I think it's a positive, a lot's happening and we can count on them it sounds like.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Charlene, could you confirm our timeline for the workgroups work? The last slide lays out some things. My sense is that we're not actually going to that timeline.

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

Yeah. Go to the last slide in the working deck.

Michelle Nelson – Office of the National Coordinator

This is Michelle. I will say that we are working on it. This might be updated. This was the original timeline but there may be changes.

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

So you have a new timeline now?

Michelle Nelson – Office of the National Coordinator

It's not finalized yet. We're still working on it.

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

This was the original timeline that we were going to present our draft recommendations. I think that's still in place. Draft recommendations to the Policy Committee for round one feedback in August; I still think that's in place.

Michelle Nelson – Office of the National Coordinator

Right. That date is the one that's for sure, and then kind of the rest is where there may be some changes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. So the details on 19 aren't correct, it says May not August. Oh, okay, I'm in the wrong year. Okay, minor problem.

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

Okay. My recommendation is how about I send some draft—we'll do some work on email but our next call is the 26th but I think we're going to have to schedule another call. Michelle?

Michelle Nelson – Office of the National Coordinator

No, you definitely are going to need one so we'll work on scheduling that.

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

Yeah. The best way in terms of going out to the workgroup and making sure that they can attend this call, I think it's going to be tough to schedule one prior to the 26th unless people can make themselves available.

Michelle Nelson – Office of the National Coordinator

Most likely not but we will need to have another one in preparation for the August Health IT Policy Committee so we'll work on scheduling it.

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

Okay because we have to coordinate with Paul's call because we're probably going to have to report out in one of those. I know we're not on the agenda for the next one but we're probably going to be on the agenda for the following one I would expect. So you'll look at that?

Michelle Nelson – Office of the National Coordinator

Yep.

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

All right. Well, thanks all of you for being on the call today because the intent was to really kind of get us leveled and as you've got thoughts in terms of the principles send those to me. I would appreciate that, and I'll try and on slide whatever it was just put some principles and conclusions down there so we can use that as a starting point next time, and then, we can move to the matrix and start to work from that if that works for you, but it will be a pretty complete call. All right?

W

Sounds good.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

In the meantime do you want us to send out edits to you?

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

Yes. Please send any edits and if you could use the working document that would be great. I'll keep it consolidated in that document, and I'm going to add to it relative to some conclusions and findings, the questions we're going to have to walk through. Are we going to use the health system versus doctors' perspective? And close loop, what's that mean? As you start to think through principles, two-way communications, if we can get to some concrete recommendations on that then I think we can transcend into the matrix. Does that work?

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

Sounds good, and you're going to send out what you're going to add to that, Charlene, so we can just make our additions on what you said?

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

Yes. I will do that.

Michelle Nelson – Office of the National Coordinator

This is Michelle. If you send recommendations to Charlene can you please copy me in?

Eva Powell – National Partnership for Women & Families – Director, Health Information Technology

Sure.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Will do.

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

Okay. Thank you.

Mackenzie Robertson – Office of the National Coordinator

Are we ready for public comments?

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

We are.

Mackenzie Robertson – Office of the National Coordinator

Operator, please open the lines for public comments.

Public Comment

Operator

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

Mackenzie Robertson – Office of the National Coordinator

Okay. Thank you very much. I look forward to talking with you on our next call.