

Information Exchange Workgroup
Draft Transcript
April 2, 2012

Presentation

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Good afternoon, everyone. This is Mary Jo Deering from the Office National Coordinator for Health IT. And this is a meeting of the HIT Policy Committee's Information Exchange Workgroup. It is a public call and there will be a chance for the public to make comments at the end of the call. I would ask for group members to identify themselves as you're speaking because there will be a transcript made.

And I will begin by taking the roll. Micky Tripathi.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Hunt Blair?

Hunt Blair – Vermont Medicaid

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Tim Cromwell? Jeff Donnell?

Jeff Donnell – President – NoMoreClipboards

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Judy Faulkner?

Peter DeVault – Project Manager – Epic Systems

This is Peter DeVault for Judy.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Thank you, Peter. Seth Foldy? Jonah Frohlich? Larry Garber?

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Dave Getz? Jim Golden? Jess Kahn? Charles Kennedy? Ted Kremer?

Ted Kremer – Cal eConnect

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Arien Malec?

Arien Malec – VP Product Management – RelayHealth

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Deven McGraw? Stephanie Reel?

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Steven Stack? Steven, I think I heard you were on.

Steven Stack – American Medical Association

I'm sorry, here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

All right. Chris Tashjian?

Christopher Tashjian – River Falls Medical Clinics

Here.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

John Teichrow? Would staff please identify themselves?

Adam Aten – Office of the National Coordinator

Adam Aten, ONC.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

Josh Seidman – Office of the National Coordinator

Josh Seidman, ONC.

MacKenzie Robertson – Office of the National Coordinator

MacKenzie Robertson, ONC.

Kevin Larsen – Office of the National Coordinator

Kevin Larsen, ONC.

Jim Daniel – Office of the National Coordinator

Jim Daniel, ONC.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Okay, back to you, Micky.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Great. Good afternoon, everyone. Boy, is there anyone left at ONC manning the fort? That's great to welcome to the Information Exchange Workgroup. Thanks so much for joining and sounds like we got a terrific turnout, so I really appreciate everyone's participation. I know these meetings are coming fast and furious and some of the work is kind of a hard slog, so I really appreciate everyone's participation.

And also, welcome anyone from the public who is listening in. We will have the opportunity at the end to have input and questions from the public and we'll make sure to reserve time for that at the end of the meeting.

Today we're going to continue our work going through the Stage 2 NPRM objectives and making our recommendations and comments review of the next set of objectives that we haven't yet been able to cover in our past meetings. Just to remind everyone there is a Health IT Policy Committee meeting on Wednesday – it's Monday today – there's a Policy Committee meeting on Wednesday at which time we along with the other workgroups will be presenting our first pass review of the objectives that we've able to consider in the time frame between NPRM was released and the meeting.

So, we'll have another opportunity at the May meeting to present our final recommendations, but what we want to be able to do is go through this meeting, cover four transaction areas that we haven't been able to touch at all in our deliberations, so these will be the final four that we'll consider before the Wednesday meeting and then we will try to synthesize where we are with respect to all of the objectives that we've looked at, get it graphed out for everyone to be able to, hopefully, do a very, very quick review or turnaround and we'll try to recap at the end of this meeting because I know there's going to be a lot of time pressure for us to get that out. So, we'll try to get everyone's high level sense at the end of this meeting about where we are with respect to almost all of the ones that we touched on.

We don't have to have resolved or come to a consensus view on any of them at this stage. As I said, the Wednesday meeting is really just the first pass or our assessment of where we are in our review. Some things that we have to come to consensus on and there are other areas that we have left open to have more information to be able to consider. So, I think we can just give a status update to that effect rather than trying to force resolution on some things where we haven't had the full amount of time to be able to process the information and have a good discussion.

So, I've been trying to push for at least being able to touch on every one of the objectives so that we at least can give a first pass indication of our view and for any that we can quickly get consensus on be able to get that consensus. I think we've been able to do that fairly effectively in the meetings up until now. And today we'll be looking at the four objectives.

One is Transitions of Care and Summary Care Record; second is Medication Reconciliation; third is View and Download of Patient Information and then fourth is Secure Messaging with Patients. So, what I propose that we do is go through each of those in the same manner that we have in the past calls. We'll turn to the grid, start to walk through those, open up conversation in each one, identify areas of further information needed or further clarification and have some discussion and see which elements we can get some consensus on, which all of us may need more information and then we can move ahead.

And then, as I said, at the end of the meeting I have created a grid that gives a very, very high level snapshot of where I think we are on the objectives that we've covered to date. That was distributed to you in a PowerPoint as well. We'll try to put that up toward the end of the meeting just to see if people are generally in agreement that that's about the status of those and that will allow Adam and me to then take all this information and produce a summary for the Wednesday Policy Committee meeting.

Before we move ahead, does that sound like a fair plan?

M

Sounds good. Micky, are we supposed to be in attendance for the Wednesday call, too?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

The Wednesday, that's the Policy Committee meeting, so that's just the meeting itself. I don't think that there's any special requirement for any Workgroup members to be there. I'll be there in person presenting. I think I have a half hour on the agenda.

So, unless there are any other questions or comments about the process, I suggest that we just dive in. We have a lot to cover today and some of these issues are pretty meaty and pretty complex so I think we'll want to go through them.

And I will also ask Michelle Nelson, who is on the phone, she is from ONC and has been staffing the Meaningful Use Workgroup and I know Josh is on the phone as well; I'll try to flag where the Meaningful Use Workgroup landed on some of these issues and I know they had a meeting this morning that I wasn't in on, so, Michelle or Josh, to the extent that there's any clarifying information or certainly if there are any areas where you think that we may be diverging from where the Meaningful Use Workgroup has already weighed in, would love just to be able to have that flagged. Not that that's a problem. It's just that we want to be able to know which areas those are so that we are prepared in the Policy Committee meeting. I'd like to be able to coordinate with Paul and the Meaningful Use Workgroup in advance, if possible.

So, let's now turn to the grid, if I could ask the folks from Altarum to put that up on the WebEx. I think that page nine of the grid will be the Transitions of Care and Summary Care Record for those who want to follow on the version that was sent out to you. It's the IE Workgroup Grid; it's a Word document and page nine is where we'll start. And the agenda has the page numbers for those who would rather just follow on their local copy rather than looking on the WebEx.

So, this objective is about Transition of Care Summaries and it's for EPs and EH, so it's for Eligible Providers and Eligible Hospitals. It's a core measure and it is about the sending of Summary of Care documents to follow Transitions of care from one clinical setting to another. The Stage 1 requirements – let's set the stage – the Stage 1 requirement was that 50% of all Transitions of Care had to have a Summary of Care record which could be transported in any way, shape or form, so there was no requirement for electronic transfer or for any particular type of electronic transfer.

The Policy Committee recommendation was that they continue the 50% requirement and there also be some care plan goals, that there be a care plan for more than 10% of all of the patients and that team members be included in that care plan for at least 10% of patients.

The NPRM came back and it increased the threshold from 50% to 65% and also put in a second requirement that 10% of those transactions happen electronically according to the specifications that are contained in the parallel ONC certification in NPRM related to Direct and SOAP being optional.

So, that's a little bit of the history and the NPRM as stated right now, there is a note from the Meaningful Use Workgroup here that you can see in the column under MU Workgroup comments that they said that they have a note here that in order to support the measure the provider would need to capture the fact that a transition is about to occur and there was also a question about the requirement that the transmission have to occur, the 10% electronic requirement, has to occur between different vendor systems as well as different clinical entities and so there was a question about whether that would be something that would be practical in areas where you have a large dominance of one vendor across multiple clinical settings.

And then, finally, this last comment that they had is actually going back to the recommendation that they had made early on in the process to CMS, which was whether there should be a requirement based on percent or a countable number. And, as I recall, the original recommendation, which isn't stated here had a requirement that it be for 25 transitions and then the NPRM has come back and said that instead of the numerical objective of 25 it should be for 10% and CMS is specifically asking for a comment on that.

But that's why you see that comment there in the Meaningful Use Workgroup comments about whether they should recommend going back to a countable number, an absolute number versus a percent of transitions as a measure.

With that complex background, let me just open it up generally and see if people have general thoughts on this and then we can dive down into some of the specifics.

Ted Kremer – Cal eConnect

I have a general question and maybe it's specific. For the care plan section is that envisioned to go within the CCD somewhere and, if so, where is that supposed to go?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I can provide a quick answer to that. In the preamble it says that as the recommendation came it was suggesting that the care plan be something that was separate and instead what CMS is recommending is that the care plan elements be incorporated as a part of the definition of the CCD and that the ONC certification requirements also in parallel do recommend having these care plan elements be a part of the CCD definition.

Arien Malec – VP Product Management – RelayHealth

This is Arien, and just a brief correction the new implementation guide is the consolidated CDA, which does have; so CCD is one of the possible documents that could be sent via consolidated CDA and there is a well-defined specification for plan of care, which has been mapped to all of the data exchange requirements here.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Great. Thank you, Arien.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

While we're on that topic of the actual content of the document that's being sent, I know that on the grand scheme of Meaningful Use Stage 2 was supposed to satisfy the coordination of care needs so that Stage 3 can go on to quality measurement, but I want to just at least say the fact that while this is a step in the right direction, it doesn't satisfy all the care coordination needs using the consolidated CDA templates as they're defined right now because a fair amount of the stuff is set as a placeholder, with not necessarily the level of detail that's truly required to truly define something, whether it's the care plan, the functional status, the cognitive status, the wound status, the advanced directive.

There are S&I framework workgroups that are working to further define those now and I just want to keep on the radar that even if we use Stage 3 I think we still need to continue to evolve to improve care coordination beyond what we're doing here in Stage 2.

M

Amen, and I'd also add to that list placeholders for future activities, such as future appointments, referrals, tests, that sort of thing. I think there's a lot more work that needs to get done on the standards side relative to plan of care and I think there are a lot of very fruitful activities that can be done there.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Agreed.

M

So, Larry, just to clarify the areas that you mentioned, when you say they're placeholders does that mean that implementation guides are underway and we can expect and hope that by the time we get to Stage 2 that they will be ready or that they're literally placeholders and there's no anticipation the implementation guides would be ready for Stage 2.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

I don't expect that there's going to be more detail ready for Stage 2. So, for instance, and someone correct me if I'm wrong, but I believe it says that there's an advanced directive date present, but there are a lot of details to what's in advanced directives in most forms and that those details are being defined probably in time for Meaningful Use Stage 3. So, there is some level of definition that's ready in the

consolidated CDA templates for Meaningful Use Stage 2 as sort of a place to put this information, but it needs to be further defined and that won't be ready until Stage 3.

Arien Malec – VP Product Management – RelayHealth

So, just to be precise the structures are applicable for the kind of information that wants to be sent in Stage 2. There are cases where you want to be able to have, for example, more actionable information in a plan of care instead of just goals and instructions and to the extent that you want finer skill detail, more actionability, more interoperability among things like EDLs and those kinds of things, that's really where there's work to be done.

So, we've got a structure in place that's sufficient for the minimum exchange requirements for Stage 2, but I think everyone recognizes it's insufficient for truly interoperable plan of care given where we need to go.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Great, that was very helpful, Arien.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

I do have a question as to whether there is a definition for what the care team is, because it does talk about you should be specifying beyond the sender and the receiver who are part of the care team. Is this other specialists? Does this include a podiatrist, a chiropractor, a dentist? Does it include other kinds of members of the patient care medical home team, a primary nurse, health coaches, how about the visiting nurses or is it associations like the whole VNA, physical therapists, social workers? Is there somewhere a definition of what a care team is?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I'm not sure that I've seen a more detailed definition than what was contained; here it is, if you look down in the grid, a little bit further down, there is an extract from the preamble that says team members are primary care practitioner, referring or transitioning provider's name and office contact information and then the amorphous, "any additional known care team members beyond the referring or transitioning provider and the receiving provider." I haven't seen anything more specific than that. I don't know if anyone else on the phone has.

Jessica Kahn – Project Officer – CMS

Micky, this is Jess. I don't think we decided any greater than that.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay, great. Thanks, Jess. Thanks for joining.

Amy Zimmerman - Rhode Island Office of Health & Human Services

Micky, this is Amy and I joined late, so I apologize. Earlier this morning I was on the Meaningful Use Workgroup call and there was some discussion about this. I don't know if anyone else overlaps and if they're shared any of that, so because just joined late I don't want to go back if that's not helpful.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

No one has, Amy, so please go ahead.

Amy Zimmerman - Rhode Island Office of Health & Human Services

So, I'm assuming we're talking about the Summary of Care Record. The discussion a little bit was, and actually I raised part of this because I was trying to really clarify is this envisioned to be provider-to-provider or provider-to-patient or both? Is it trying to be all things to all people?

And I had started off the conversation raising some concerns that what goes from physician-to-physician isn't always helpful for what goes from a physician or a hospital to a patient on discharge. Actually I just had a recent incident with a family member and we got a discharge summary, which I could understand

better than my husband, but he was sort of like other than giving it to the next doctor, this isn't very useful for me because it wasn't in language he could understand.

Patient instructions and discharge stuff was, so we had some discussion about sort of that, in general, and I think where I recall the Meaningful Use Workgroup coming out was agreeing that not necessarily separating out the stuff and I'm sure there's been a lot of discussion about combining it for all sorts of reasons, but really commenting that the parts most appropriate for patients need to be done in plain language that's easy to use, that means something to patients. I don't know if that's been discussed at all or if that's helpful.

And in terms of the categories, there were no additional categories of data. The Meaningful Use Workgroup felt that defining the categories that we see in front of us on this grid were sufficient. No one pointed out that there was something missing. The Advanced Directive discussion, though, just to point back to that and maybe we're going to come to that or that's another issue, the Meaningful Use Workgroup, again, my understanding of what we've agreed on was to basically advocate that whether an advanced directive has been done or not is what's captured and it's not ready and it won't be ready for Stage 3 to actually have a copy of the Advanced Directive in the electronic health record.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Thanks, Amy. We did talk a little bit before about the fact that there may be specifications through the S&I framework process for things that will cover what is required for states, too, but that there's a lot more that would need to be done to get us to what all of us would hope would be really effective health exchange towards Stage 3 and beyond. So, thank you. That was helpful.

Are there other comments? I think that there's a question here about the 50 to 65, that's one area that I think we should talk specifically about and then certainly a question about the 10% electronic and there are various dimensions to that that are probably worth at least teasing out and making sure we have the opportunity to comment and discuss.

So, may we should first take the 50 to 65. Comments about that, concerns?

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Micky, this is Larry again. Before you talk about whether it's 65 or 10 or whichever is what is a transfer or a referral? In other words, there are lots of different movements of patients, whether it's to an emergency department or to an optometrist to get an eye exam for their glasses. There are behavioral health counselors, there are procedures; someone is going for a colonoscopy, referring them to get that one in testing, or to an oral surgeon or a dentist, you know, people who are not necessarily considered part of the traditional healthcare, allopathic healthcare system.

So, I guess, is there a definition as to what the limits are, bounds are, home health, hospice, SNiFs?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I think there is, again, in the grid there's an extract from the preamble that gives a very one sentence definition about when a patient is transitioning to a new provider or has been referred to another provider. I know that doesn't answer the question of the details that you're asking, but I think – and maybe Jess can confirm – that the definition of transition is going to be the same as in Stage 1, that nothing has changed about that definition. And there was a lot of discussion and some specificity about what would constitute a transition of care in Stage 1.

Jessica Kahn – Project Officer – CMS

Right, I'm not aware that it's changed and we did describe it or our purposes. Again, just reminding everyone that we're trying to keep it to something that we can measure and it's very hard. We're walking this line between trying to create a definition of Meaningful Use that is reflective of the reality of provider workflow, which as Larry noted is really broad and inclusive of many different kinds of care, but at the

same time we have to be accountable and be able to say at the end of the day, you know, point to something and say, yes, that was Meaningful Use and someone met it per our definition.

So, I think we tried just to be aware that sometimes when it seems like that scope is defined somewhat narrowly it's also so that we can actually have something that's measurable and demonstrable, which is sort of half a dozen of one and six of the other in terms of whether that's helpful or not, but I think that's the context people need to understand.

Christopher Tashjian – River Falls Medical Clinics

I think it's a great idea, again, as a practicing physician, like Larry was saying, but I think keeping it 50% is a huge amount, at least for us. I mean, that's really going to be a stretch to try and get there.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Is that to get to 50%, which is, remember, 50% is that you just have to produce the summary 50% of the time for 50% of the transitions and then send it however you send it.

Jessica Kahn – Project Officer – CMS

I was going to just make sure people understand what's in the 50%. There is also the right of refusal. We get a lot of questions from people who work in HIV clinics or reproductive health clinics or other places where they think people just throw these away. So, we want to just be clear that people understand that it could still be counted even if it was refused in the numerator.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

And I know in the preamble, and hopefully I'm not confusing objectives, but I thought that I saw in the preamble to this that the majority of EPs and perhaps those EPs and EAs did not attest to this, but of those who did they were way above 50%.

Christopher Tashjian – River Falls Medical Clinics

I want to make sure – again, this is Chris Tashjian, one of the practicing physicians – what we're talking about. Is this the after visit summary that we're handing the patient? Or, is this something that we're sending to our hospital when we admit them and say here's a summary of all the care and the hospitalist at the other end picks it up and says, great, this is helpful.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, it's the latter. When you send it to the hospital or when you send someone to the specialist.

Amy Zimmerman - Rhode Island Office of Health & Human Services

Sorry, and my comment was about the former, you're right; my comment as about the summary of care at the end of the visit and this is about summary of care to the referring providers, so it's not quite the same.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

So, does that make you feel better, Chris?

Christopher Tashjian – River Falls Medical Clinics

It does. I have a better understanding of what's going on. I still think 50%, you're saying the ones that did it did more than that. For our group, it's going to be a brand new process, so to do 50% we're going to have to hustle to get there.

Arien Malec – VP Product Management – RelayHealth

Do you currently send referrals or consult notes, I don't know if you're primary care or specialty or what.

Christopher Tashjian – River Falls Medical Clinics

I'm primary.

Arien Malec – VP Product Management – RelayHealth

So, would you currently send referral documents or an order with summary for an ambulatory referral or for an admit?

Christopher Tashjian – River Falls Medical Clinics

Right. We'd send something on paper with them and say, here. Or, we would just personally call the physician and say I'm sending so and so up and this is what I want to do.

Arien Malec – VP Product Management – RelayHealth

Yeah, so it's the telephone call where there's no documentation of the med list and those kinds of things that you need to be augmenting, but hopefully your EHR should support you in the fax-based referrals where you're sending a referral document over and that should include the current medications and the like.

Christopher Tashjian – River Falls Medical Clinics

Sure and problem list and all of that we can print out and send to them.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. So, Chris, do you think most of that information that you provide for a transition is via fax or paper or do you think most is by phone?

Christopher Tashjian – River Falls Medical Clinics

It's a combination of both. I think the fax and paper gives you the hard data and the phone gives you the soft data. I think one of the things we say when we transition care, it has to be doc to doc because there are certain things you can express personally that just doesn't fit well in an e-mail or a fax or otherwise.

But you don't want to lose that information of the medications, allergies, problem list and the other stuff, so having that written is really a good thing.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, but what I'm getting at is if at least 50% of the time you're generating a fax or a letter that you're mailing over to someone then all this is saying is that instead of doing it that way, do it in the way that the EHR is being certified to do, which is push the button and get a standardized document out. And then however you send it, that would still count before we get to the second part here, which says the 10% would have to be electronic.

Christopher Tashjian – River Falls Medical Clinics

No, I think you're right. I think then in that case, again, 65% may work and I think the 10%, I think we can do that. I think we should be able to do that.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

The 10% as well?

Christopher Tashjian – River Falls Medical Clinics

Yes.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I'm sorry, was there someone else who wanted to say something before we move on to the 10%?

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Yes, this is Larry. One of the exclusions here, it says, if the person that I'm referring, I'm a primary care physician, so the person I'm sending a patient to, if they have access to my electronic health record then they would not be included in the denominator of the measure. So, those patients would be excluded.

I'm in a multi-specialty group practice. The vast majority of my referrals are within my group. At the same time if I send someone to the emergency room, the emergency rooms that my patients go to actually have access to my electronic health records so they would be excluded, so pretty much the only referrals

that would count for the 65% are cardiothoracic surgeon and neurosurgeon. Those are the two that we don't have.

It's odd that it's being restricted, so that just for those two docs I have to make sure 65% get a summary. I don't know if there are other organizations that fall into funny categories like this.

Amy Zimmerman - Rhode Island Office of Health & Human Services

This is a little bit raised; I'm sort of flipping back and forth between the Meaningful Use Workgroup comments and our discussion and their documents and ours. In that discussion, in the Meaningful Use Workgroup there was also concern that for places where there's a dominant vendor with market share, like of an IDN type or a large organization, again, going into organizational may be a challenge if there aren't a whole lot of other specialists around to refer to. I think we're saying the same thing that you've just been saying. And that was noted as a concern.

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

I think for eligible hospitals there's a similar concern, unless I'm misunderstanding the intent, if we are providing access to our electronic health record to any and all referring physicians, are they excluded then, from the denominator?

Larry Garber – Medical Director for Informatics – Reliant Medical Group

That's how the first measure reads.

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

So, in the case – and I don't want to split hairs – but in the case of our hospitals at least when a patient is admitted to one of our hospitals the first thing we do is notify their referring physician how they can get access to our electronic health record. Upon discharge that patient's physicians are reminded how they can continue to get access to anything that was captured in the health record while the patient was a patient at our hospital.

So, I'm confused then as to what our responsibility would be. We can't guarantee that the referring physician will look into the health record, but we can make it easy for them to do that. If they choose not to, would they then be excluded and I would have to send them something electronically?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Larry, where are you reading that?

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

No, I was reacting to what I thought I heard was just said.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I'm sorry, Stephanie. I was asking Larry where he was reading.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

At the bottom of page 111, top of page 112 in the NPRM, the version that's the single column.

Arien Malec – VP Product Management – RelayHealth

Is that relevant to the electronic, the 10% electronic, or is that relevant to the 65%?

Larry Garber – Medical Director for Informatics – Reliant Medical Group

That was the 65% one, so after they define the 65%, the denominator, numerator and threshold, it says, "If the provider to whom the referral is made or to whom the patient has transitioned has access to the medical record maintained by the referring provider, then the Summary of Care record would not need to be provided and that patient should not be included in the denominator of the measure for this objective."

Speaker

Yeah, and I would hope that would come as both numerator and denominator.

M

Exactly. So, the point, of course, is to make sure that those transitions are accompanied by the relevant information and that certainly seems to qualify.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Yes, because otherwise it's the four patients a year that I send to the cardiothoracic or neurosurgeon, if I only send the summary documents on two of those four patients I lose this objective.

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

And I think from my perspective the challenge would be similar. Our total population would be very, very large, but people who chose not to access the electronic record I guess could be small.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. But on the other hand, you want people to be able to continue the access that they're having, so this is really just an issue of the fact that you're being measured now on a smaller denominator than perhaps was anticipated that wouldn't really be representative at all of the degree of continuity of information that you're providing.

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

No, I was just wondering how can you identify that denominator clearly if you only base it upon people who chose not to access the electronic record.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. So, it seems like that goes against the spirit of sort of the strict stipulations in the 10% requirement that would have to be a different entity and a different vendor. They are saying this would have to happen across different vendor systems whereas in a, it's saying oh, if you're just sharing stuff, giving someone access to your system, that's okay. It doesn't count. I don't know if I made myself clear there.

Deven McGraw – Center for Democracy & Technology – Director

Micky, I did. This is Deven, and I'm sorry that I joined late. I agree with you, but I think that the most productive comments that we could give, if we can figure out a way to phrase them would be to meet the concerns that CMS and ONC had in making the stipulation that 10% only counts if it's being exchanged with somebody who doesn't have access to your record, i.e., is outside of your system, isn't somebody who is right next door to you and being concerned about private networks, people sort of ending up choosing to exchange only with those providers that they can access through a private network that might be established by one EMR vendor. That's what I sort of understood as the rationale for why they had those exclusions from the denominator.

So, if there's a way to figure out, well, one we should decide if their concerns are well founded. If we agree with them, is there another way to get to where they are heading without the sort of strictures that are clearly going to cause problems for some people.

Arien Malec – VP Product Management – RelayHealth

Although to be clear, Deven, we're talking right now about the 65%, the attainment of the 65%.

Deven McGraw – Center for Democracy & Technology – Director

Oh, okay, thank you.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, let's finish out the 65% and then get to the point that Deven was raising.

Peter DeVault – Project Manager – Epic Systems

What makes sense to me is that the transition should count, even if it's within an IDN, in the denominator. And then to satisfy the numerator either you produce the Care Record Summary or you give access to the electronic record. That would deal with the problem of the vanishingly small denominator for the IDNs.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

I agree.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Does anyone disagree with that?

Amy Gruber – CMS – Program Analyst

I just want make sure there's a way to measure access in terms of the reporting part, you know, if there's a way to measure the transition of the document. I'm assuming there's a way to measure giving access. Again, you can't assure that they checked it, but you can certainly measure that they have access.

Peter DeVault – Project Manager – Epic Systems

That would be true with our system.

Amy Gruber – CMS – Program Analyst

So, that's the only consideration, getting back to what Jess said to make sure it's measurable.

Jessica Kahn – Project Officer – CMS

Yeah, and I guess maybe the other thing, and I'm not sure this would matter, if you provide access to any referring or primary care physician and they have access to the system, but they may not have access to everything that would otherwise be in a summary of care record. I guess you could run afoul of the intent of this requirement.

Arien Malec – VP Product Management – RelayHealth

I assume that we would want to specify that electronic access must include the required data element. That is, you don't get around the transition requirements by virtue of providing this mechanism.

Steven Stack – American Medical Association

I feel no shame in saying this. I'm just going to admit a fair amount of befuddlement and confusion. When I practice as an emergency physician I'm having a hard time with the 65% and the 10% and parsing these different things. I mean, just kind of reality check for how medicine in the glorious United States of America works in an emergency department, I have people every day who come in with broken bones and I have on on-call orthopedist and I know they don't accept Medicaid and every single day I give patients a referral to a provider who will not see them unless they bring cash to the appointment, every single day.

And there is no workaround for this, but it's a whole different set of discussions. So, in doing this – and that's a third of my patient volume that comes to our emergency department that are Medicaid for those subset that are orthopedic referrals – we give copies of computer disks and when we have them final X-ray reports so that the patient becomes the transport mechanism for that data. I would imagine at some point we'll have a portal system so that community physicians can access that information.

I don't even know how I would begin to follow this data, or someone who comes from a county two counties away and chooses to do their follow-up with a local clinician in their county with whom I have no knowledge or personal relationship and they're not sure until they call and they make an appointment who they might see or not see. I have a very hard time thinking across the nearly 40,000 visit emergency department per year how in the world we could ever track this.

And so now I'm thinking about the eligible hospital side of it because I would be appealing to the hospital. And I don't say that trying to resist providing the information. I try to do that every day in print form, but I

just can't even begin to fathom how we can track this for reliable numerators or denominators. And therefore I have no idea what's a reasonable threshold, 10%, 50%, 90%, I just have no way of knowing.

Arien Malec – VP Product Management – RelayHealth

There seems to be at least three scenarios here, and relating to discharge, in general. One is related to the situation, which is unfortunately all too common, where patients are discharged without even being asked where their medical home is, where they're going to be seen for follow-up care. And that does seem to me a policy that, the fact that you didn't ask should not qualify you for an exemption.

But I do think that there's a number of cases where patients don't have a medical home and despite the good intentions of the attending there's really no place to send that document. Or, in the case that you mentioned, there's a place to send it, but you don't know what it is. I do think there needs to be appropriate consideration given to that. And I would also suggest that if the appropriate mechanism is the patient, that's a reality and it should be counted.

From a policy perspective I don't want to get to that being a loophole that gets back to the our job is to process them and ship them, without the coordination of care post-discharge.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I'm just going to say, I thought that if you give it to the patient and then have the patient be the transport that that counts. So, that would count towards the 65%. So, Steve, if I understood you correctly...

Steven Stack – American Medical Association

That's fine. If that's the case; I mean, I don't know how you'd validate it unless the EMR can validate that you printed it and then they have to trust that it was handed to them. But that's fine. As long as the patient would be the transport vehicle, then for my setting that works. But you know a setting that treats 130 million people a year in the country, so it's not a small setting.

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

Do we all agree that handing it to the patient is an acceptable mechanism for transport?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Does it state that? Is that clear in the regulatory text?

Deven McGraw – Center for Democracy & Technology – Director

In paper form?

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

I didn't think it was.

Deven McGraw – Center for Democracy & Technology – Director

I didn't think it was either, Stephanie.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

We can check. I don't know, Jess, if you know off the top of your head?

Jessica Kahn – Project Officer – CMS

It says electronic. So, to me that doesn't sound like paper.

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

In fact, I thought something I read or interpreted was that it could not even be on a flash drive, that it had to be sent by Direct or something.

Arien Malec – VP Product Management – RelayHealth

We're still talking 65%. This is not the electronic.

Stephanie Reel – CIO, VP Information Systems – Johns Hopkins

No, but I thought the 65%, okay, then I misunderstood. I thought the 65% had to be electronic.

Deven McGraw – Center for Democracy & Technology – Director

As did I.

Jessica Kahn – Project Officer – CMS

In the standards it says for transitions of care it has to be electronically incorporated.

Arien Malec – VP Product Management – RelayHealth

That's the certification criterion, so that's not the associated Meaningful Use criterion.

Steven Stack – American Medical Association

So, if I can ask then, so 55% to 56% of my ER's patients are uninsured or Medicaid and so right there – who functionally have no primary care doctor, other than maybe the Health Department, which does not really count in functional terms – so, again, I'm having a hard time figuring how we'll meet the threshold, particularly if the NPRM says it has to be electronic. I have no landing place to send that to.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. If you look at the Policy Committee recommendation it was, "Record and provide by paper or electronically a Summary of Care record for more than 50% of transitions." That's what makes me think that paper does count and if you hand it to the patient that that counts.

Arien Malec – VP Product Management – RelayHealth

I agree that paper does count, but it's not clear to me that providing on transition where the patient is the mechanism, that's where I think it would be useful to clarify.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay. So, if we're able to resolve that and we have also the recommendation that providing access to one's EHR would count as well, were there any other concerns or questions that we need to resolve on the 65? Okay, maybe we should move to the 10% then.

So, having resolved that you can do it by paper and maybe or maybe not be able to hand it to the patient, now we move to having the requirement that 10% happen electronically and happen in a very particular way electronically, namely the specifications that are in the certification requirements, the EHR certification requirements.

I note again that there was this question coming out of the Meaningful Use Workgroup about the concern about having it be not only across clinical entities, but across different vendor systems where that may not be practical in certain markets where one EHR vendor may be dominant.

M

We should call it the Wisconsin Rule.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

And the reality is that even if there is a predominance of one particular vendor in a region it doesn't mean they've actually hooked up to each other, so you'd want to include them in the denominator.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. It seems like as long as they are doing it according to those standards and not doing it with their own proprietary standard, that that ought to be okay.

Arien Malec – VP Product Management – RelayHealth

I would completely agree and I think there's a policy concern that somebody might implement the standard, but not open it up to all players and I don't know exactly how to resolve that policy concern, but I would agree that a) it's impossible to figure out via the standard what technology you're sending it to; this places a requirement on the provider to know the technology for, not just know who they're referring to, but also know what technology that they're using and keep that up to date and that seems to be wholly impractical.

The question is how to satisfy the other side of the policy concern, which is avoiding cases where maybe I use the standard, but use it in a proprietary way.

Steven Stack – American Medical Association

The standard is used in a proprietary way?

Arien Malec – VP Product Management – RelayHealth

That's right, so I could choose to use a standard, but I could also choose to hardwire it into the implementation of my technology such that it's practically usable only with other instances of my technology and that's what I understood to be the policy concern that was motivating this restriction.

M

On the other hand, that seems like an entirely hypothetical concern, right?

M

Well, and it seems to be confusing the content with the transmission somehow, too. Beyond the Wisconsin case we have the same issue here in regional markets where you will have one small EHR vendor that has dominance across a lot of practices.

Christopher Tashjian – River Falls Medical Clinics

And my question, because I live in Wisconsin and we have this dominant, but how do you make... other vendors and not just keep it within the one system?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I'm sorry, Chris, you broke up at the beginning of your comment. Would you mind just repeating it?

Christopher Tashjian – River Falls Medical Clinics

Sure. What I was trying to say was we live in this where, obviously, a single vendor dominates it, but there are other vendors and you need to make sure that the main vendor still interacts with the other vendors, that they just don't keep it proprietary among people that own their product.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. Which I think that was sort of a policy concern that Arien was noting in the reason for its being written the way it was, but I guess as long as you require that even across their own systems they have to do it according to this standard. I guess the converse concern would be that you create a certain degree of artifice of having people having to in order to meet a measure try to have cross-vendor transitions or something. I don't really know how it would completely play out, but it seems like you could some sort of perverse behaviors on the other side.

Arien Malec – VP Product Management – RelayHealth

I would prefer to have a model where you're open to innovation and I don't have any issue with the fact that in Wisconsin there's a dominant vendor who may have really, really elegant workflow to enable transitions. I think the policy interest is to make sure that there's at least a common way for them to send and receive information. I'd like to find a way to meet the policy interest of what I think is the appropriate policy interest, which is I should be able to send and receive transitions from anybody without preventing or locking down technology for innovation.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. Well, Arien, do you think that there's something more that would be needed? And if we were just to remove this one requirement is your concern that that sort of leaves too much open to the adverse results from too much proprietary behavior then?

Arien Malec – VP Product Management – RelayHealth

Well, I just think there would have to be some attestation or some appropriate measure that includes the ability to send and receive to using the standard in a common way while still preserving flexibility in how you achieve the 10% electronic.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I'm not sure I understand how that works. So, I'm in Cleveland and Cleveland Clinic and one of the other large systems out there, who are both on Epic and now we're just saying that they have to send it according to; they can't use Care Everywhere or Care Anywhere – I can't remember which is which – but what I'm saying is they'd have to do it according to one of the certification requirements here.

Arien Malec – VP Product Management – RelayHealth

What I'm proposing is the opposite. I would be proposing that they can use their chosen vendor's deep integration to same vendor technology to achieve the 10% so long as they also have available to them technology that allows them to send via the standard to anybody else, that they're doing the 10% not in a closed or proprietary way or not in an inherently closed and proprietary way.

They may accidentally, they may have chosen for good reasons to have a group in the area to do lots of referrals to each other, they may have chosen the same vendor for a very good reason because they've got elegant workflow there. But that the test would be that if somebody else wanted to send over fees, if they referred out or if they received back that they'd be able to do that.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

But wouldn't that be accomplished by just saying that at least 10% of what they do across different legal entities, even though it's Epic to Epic has to happen according to that standard and it will be measured in the same way as if they were sending it to someone who was on Allscripts?

Arien Malec – VP Product Management – RelayHealth

So, again, this leads to the artificiality rate.

Peter DeVault – Project Manager – Epic Systems

Arien, actually as the Epic guy here can I just maybe clarify this quick.

Arien Malec – VP Product Management – RelayHealth

But it's not just a particularly Epic question.

Peter DeVault – Project Manager – Epic Systems

Although it seems to be the dominant example. So, our deep integration also uses the standards. So, I think it's entirely appropriate to specify that this be done in a standards-based way and that's really where the cut-off should be.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

The artificiality you're concerned about, Arien, is that their deep proprietary solution, let's assume that it's not standards-based so it's another vendor, is actually very elegant and is something that might be preferable and now we've forced them to have 10% be through another path when that may not be the best solution for everyone and really what we would like them to do is attest to the fact that if they had to do it with another vendor they could, but not force them to have 10% of a sub-optimal solution.

Arien Malec – VP Product Management – RelayHealth

That's exactly right and the analogy that I often use is the e-mail analogy where 90% of my e-mail volume maybe within the corporation and I might be using BlackBerry and Exchange and both of those don't use

SMTP as their core underlying transport. The test that I'm using e-mail is that if I choose to e-mail you outside of my corporate environment or you choose to e-mail me across corporate entities, that we can do so regardless of the technology that we happen to be using during the integration.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Isn't the hoped for goal what Peter has suggested that his company does, which is you take those standards and you embed them deeply and I just worry that if we go down the path that you're suggesting that we actually create a disincentive to that.

Arien Malec – VP Product Management – RelayHealth

Good point.

Amy Zimmerman - Rhode Island Office of Health & Human Services

But could we then just remove the phrase different certified EHR vendor? Because if you're complying with the standards even if you're between an Allscripts shop and an Allscripts doc or an Allscripts shop and an Allscripts shop, shouldn't you be able to do that as long as you're complying with the standards, it shouldn't be a different vendor?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, that's what we were talking about is remove that and the question was do we need to put anything back essentially or do we need to put any other qualifying words or can we just remove that sentence completely or that requirement completely.

Peter DeVault – Project Manager – Epic Systems

I think as long as the standards compliance is highlighted enough then we don't need to put anything back.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right, agreed. Are you comfortable with that, Arien?

Arien Malec – VP Product Management – RelayHealth

I am convinced.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay. And I think as a part of the documentation we'll sort of note parts of this conversation and the concerns that we have.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

I have a similar related concern to this one, because it does talk about having to be outside of your organization in order to be in the numerator and I think that's in part why the 10% number is so low, so in my organization – I'm a multi-specialty group practice – about 80% of my referrals are done internally.

Now, I can imagine that you can have IDNs that have their own nursing facility and emergency rooms and home health agencies and probably over 90% of their referrals are internal, so that means they automatically fail on this because the denominator says that you have to include all transitions, but the numerator is only the ones that are outside of your organization.

So, I think what it should be is both numerator and denominator are only looking at the transitions outside your organization.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

That certainly seems to make sense that it should be invoked. I'm surprised it's not.

Amy Zimmerman - Rhode Island Office of Health & Human Services

I think that's part of what the Meaningful Use Workgroup was getting at as well.

Christopher Tashjian – River Falls Medical Clinics

That makes sense to me. And also just the fact that you can do it, that the EHR vendors will allow you to even I think at the beginning just to be able to work with other vendors.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. So, Larry, are you reading from the – just to get back to Larry’s comment for a second – are you reading from the NPRM itself or is that off the grid here?

Larry Garber – Medical Director for Informatics – Reliant Medical Group

No, the NPRM page, 112. It says, “In the denominator number of transitions of care and referrals during the EHR reporting period for which the EP hospital was the transferring or referring provider.” It doesn’t mention anything about organizational affiliation.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay, because on the grid here it does say, “Number of transitions of care using to recipient with no organization affiliation.” So, that’s your point is that it says a numerator, but not the denominator. That was your point, okay.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

So, now the question then is if you indeed make this exclusively for outside referrals, is the 10% too low?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay. Jess, not to put you on the spot here, but is there any clarification you can give us on this point?

Jessica Kahn – Project Officer – CMS

No, I’d rather talk to Charles and get back to you guys.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, all right. This one I think we need to flag and just think about a little bit more it sounds like. And it sounds like the Meaningful Use Workgroup, if I’m understanding Amy correctly, had a parallel conversation on the same thing.

Amy Zimmerman - Rhode Island Office of Health & Human Services

That’s my recall and if Deven is on she can attest to that, too, or agree with that. Listen to me, I’m already in this language here.

Deven McGraw – Center for Democracy & Technology – Director

Yes, I will attest to that, Amy.

Amy Zimmerman - Rhode Island Office of Health & Human Services

Too many calls today, what can I say? Four hours of this is a lot.

Deven McGraw – Center for Democracy & Technology – Director

It is, it is and I haven’t made most of it, so kudos to you.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Well, you need to electronically submit.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

One more little detail is there was an exclusion I remember reading somewhere in here that said that if you don’t do any referrals or transfers of patients then you’re excluded. And it seems to me that the number probably shouldn’t be zero. It should probably be a low number, but it probably shouldn’t be zero because I can imagine radiologists being eligible professionals may do one referral a year and they would

now be obligated to meet this requirement and I would think that there's probably some reasonably low number that should be put in here instead of zero.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. That's a good point. Otherwise you could never hit the measure, right. Okay. Have we beaten this one into submission? This last one point, I don't know if anyone has thoughts on this, which was the countable number versus the percent, which is something from the Meaningful Use Workgroup.

I know my own personal thought on that, which I felt at the time as well, was that a percent is better than an absolute number, but I don't know what other people's thoughts are on this.

Amy Zimmerman - Rhode Island Office of Health & Human Services

Micky, this is Amy. I'm with you. And I can't remember if it was in this group or that group that we had the conversation that a countable number gives no perspective relative to the size of the practice. It could be 50% for one entity and 5% for another and I don't think we achieved what we wanted to achieve, which is why I would absolutely agree with getting the percentage right, but using a percentage basis.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right, okay. Any other concerns or questions? Any other thought that we should...

Peter DeVault – Project Manager – Epic Systems

This is Peter DeVault with a completely different topic, which is that this criterion leaves on the table the other very important kinds of transitions that are not planned. So, for example, the patient arriving in the emergency department where typically what you would do is do a query response exchange type model where you would get the Care Record Summary from the patient's PCP. So, rather than a push to a known endpoint you're querying the patient's medical home, for example.

And I do worry that the focus purely on the known transitions is going to leave a lot of important activity that's already going on in the market kind of off to the side.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Peter, I actually was thinking just the opposite. I had the opposite concern, which is if someone is going to the emergency room, how in the world am I going to be, as the primary care physician, obligated to send them a Summary document because the pull may not be available and I don't know to push it.

Amy Zimmerman - Rhode Island Office of Health & Human Services

I think you're actually saying the same thing, which is not every community has the ability to pull, but especially where their Health Information Exchange has the ability to that, I mean, HIE in more of a noun versus a verb, would help with that, but I'm not sure how to make that work for all use cases.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

That's why the 10% is low.

Arien Malec – VP Product Management – RelayHealth

It seems to me there's a preference if you know where the information is going to, there's a workflow preference to push it in the sense that it actually shows up at the practice that you are pushing it to in ways that are more useful for follow-up.

So, if I have a pull only solution I'm really reliant on either some other mechanism to tell the primary care provider or whomever that the patient has just been discharged.

Peter DeVault – Project Manager – Epic Systems

Actually, I'm talking about a slightly different case from that. So, what I'm talking about is the patient arrives at the emergency department, unplanned, so clearly the patient's PCP did not send the ED a document. But in that case the ED staff would ideally query the patient's PCP and pull the document.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Peter, it sounds like your comment is more, while it's specific to this, it's more of an overarching comment related to Stage 2 interoperability, in general, which is that it's still focused on push and isn't getting us to the next level.

Peter DeVault – Project Manager – Epic Systems

It's not clear to me that an unplanned ED visit is a transition in any case.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Well, it's not excluded here.

Amy Zimmerman - Rhode Island Office of Health & Human Services

I think the question is if you're sending a patient or receiving a patient. If you're receiving a patient and the patient comes to you and nobody knows the patient has gotten to you, nobody can push you the data and I think you're asking is are you responsible then for going out and getting it and pulling it in some electronic fashion.

Peter DeVault – Project Manager – Epic Systems

Well, what I'm suggesting is that people are today going and pulling those documents. Our customers, for example, have quite a high volume of that kind of activity and I'm suggesting that it's at least unfortunate that that doesn't count as activity underneath this criterion.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right, which is fair enough. So, Larry was getting at the one particular scenario here, which is that your patient shows up in the ED. You don't really have a reasonable way of pushing information to them, yet that's counting in some way against you. Although I'm not sure how that would even count, how it even is measured.

Peter DeVault – Project Manager – Epic Systems

I guess what I would suggest is that in that case if the hospital pulls, so queries the PCP system and pulls over the document that that should count as a transition so it's in the denominator, but it should also count as part of the 10% numerator.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

What do others think about it? I can understand the spirit. It feels to me like it's going into a whole different realm that I'm not sure we want to enter.

Amy Zimmerman - Rhode Island Office of Health & Human Services

I think sort of that whole realm began with you. I think it may not be out there universally enough. It may be something to really think about Stage 3, how to get some pull criteria or query-based retrieve, however we want to frame it, but I think we're mixing up too much here and we're going to have difficulty sorting it out if we get too complicated.

Deven McGraw – Center for Democracy & Technology – Director

I just wonder; I'm intrigued by it, if only because the fact that we don't think pull models are as ubiquitous as we want them to be doesn't necessarily mean that we shouldn't allow people to count it where they actually have the capability to take advantage of it. I think it's just a matter of figuring out. If we were going to comment in that regard I think we'd have to be very specific about how that would get measured and included in numerators and denominators for that to make sense. How would you count it?

But I guess I'm sort of where Peter is, which is, look, if where it's happening it really does count as a care transition whether it's push or pull shouldn't matter. People should get credit for it if they're able to do it that way. I guess I'm struggling why that would be complicated unless we can't figure out how to numerically count it.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, I don't know either, just wrapping my head around it. In the case where a patient just shows up in the ED and you haven't pushed something because you couldn't possibly have known they were going to show up in the ED, that doesn't count against you anyway, right? I mean, how would that even get counted in the denominator?

Peter DeVault – Project Manager – Epic Systems

So, we're talking about counting it in the denominator of the emergency department because they went and pulled the document from the PCP system. So, it wouldn't count for the eligible provider either in the denominator or the numerator, but it would count for both for the hospital.

Ted Kremer – Cal eConnect

I think that piece, though, where you're querying a PCP system is a unique kind of HIE implementation where you do that in a fairly tightly coupled environment and I don't know that most HIEs are really doing that.

Peter DeVault – Project Manager – Epic Systems

That's actually not true. So, NwHIN Exchange is based on exactly that model.

Amy Zimmerman - Rhode Island Office of Health & Human Services

Deven, I think you make a good point. I mean there are a lot of different models. You could be pulling from a centralized HIE, too, within that count and why should that not count if you're getting some information? It may not be everything you need, but it's better than nothing in treating the patient. That's the whole point of doing this.

But that goes to show the complexity of the model. I think if you're saying if there's an easy way to define, a way to measure it and count it for the entity or the organization that has taken the time to try to do the transition right by getting information, regardless of whether it comes from a physician's EHR or some other type of HIE centralized system or whatever. I think what you're saying is it should count and rethinking that, perhaps it should.

I would want to make sure it's not held against you if you didn't do it because there is nothing to go to and do it.

Deven McGraw – Center for Democracy & Technology – Director

That's right.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

So, I have a suggestion. It sounds like, so for the purposes of the Policy Committee meeting it sounds like where we're headed is to say that at least some consideration should be given to this at a minimum, so we can certainly articulate that and then in the set of meetings that we have between this next meeting and the main meeting perhaps we can devote more time to it in a separate meeting and try to think through all the implications.

And maybe the recommendation ends up being that consideration should be given to this and flag the areas that would need to be sort of further specified in order to be able to truly count it, if we're going to make that a part of the final recommendation. Does that make sense?

Peter DeVault – Project Manager – Epic Systems

Yeah, I think that Epic can help out with the language when it comes time to do that.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay, so for the Wednesday meeting I can just flag that it seems like we've got a consensus that at least some consideration should be given to this and that we ourselves as a Workgroup will spend some more time thinking about it before the May meeting and we'll get back to them.

Peter DeVault – Project Manager – Epic Systems

Sounds good.

Amy Zimmerman - Rhode Island Office of Health & Human Services

Micky, before I forget. And this may be completely loaded and off-base here, but maybe some sort of menu option on a pull is a way to go. You can either include it or separate it, and we'll get back to it in May. So, I agree with your premise for later this week for the Policy Committee, but I just wanted to throw out thinking about whether that would even make sense to be another candidate for an optional, for a menu type of...

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, there could be various ways to incorporate it that allow some flexibility and recognize that not all places will have this type of capability and menu set would be one way of doing that, but I agree with that.

Michelle Nelson – Office of the National Coordinator

Micky, this is Michelle Nelson. I just wanted to bring up, maybe after the Policy Committee meeting part of what the Meaningful Use Workgroup was concerned about was how will you know who to send it to? Other Meaningful users, what about long-term care, things like that? I know that was part of their concern, so just something to put out there.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

How will you know who to send it to, right.

Michelle Nelson – Office of the National Coordinator

Is it other Meaningful users and how will you know who other Meaningful users are?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Why would it be other Meaningful users?

Michelle Nelson – Office of the National Coordinator

Well, that was the question. How do you define who can receive it?

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Actually, that's an interesting point. I was looking at the Stage 1 definitions for transitions of care. It talks about hospitals, ambulatory care providers, long-term care facilities, home health agencies, rehab facilities. Yet realistically half of those can't receive the document that you're sending electronically to them.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. So, I assume that's partly why the threshold is so low at 10%.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Agreed.

Amy Zimmerman - Rhode Island Office of Health & Human Services

I vote we have enough on this topic and we move on.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah. Thank you. We're actually getting to the end here of our time. Let me just see, and I'm just going to throw this out there and see if we can get a quick win on Med Reconciliation. If we can't, we can't.

And then where that will leave us is that we have the two patient ones that we'll have to do, which is the View and Download and the Secure Messaging, which we'll have to do after the Wednesday meeting.

But on the Med Reconciliation, which is on page 12 of the grid, really just the Policy Committee recommended taking the Stage 1, which was that it covers 50% of the transitions of care and moving that to core. And the NPRM, if I'm understanding it correctly, basically says, yeah, but increase that to 65% rather than 50%. And there's no interoperability requirement associated with that. It basically says, in the preamble it basically says we don't think that systems are well developed enough to automate med reconciliation so it is going to be by necessity for a long time a human process that also takes information from the patient as a fundamental piece of the information, but let's push this forward and go to 65% instead of 50% and move it to core.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

Do we have statistics on how people did as a menu item?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

I thought that it was higher, but I may be confusing it with the Transitions of Care. Jess, are you still on? Do you know? Okay, she may have had to drop off. So, I think the point of this one, at least to me, was that it's not automating anything and it's reflecting and even recognizing that a whole bunch of the information is going to come from the patient and all it's doing is saying let's keep the pressure on to get more of this done and not making any requirement on the interoperability side of it.

Arien Malec – VP Product Management – RelayHealth

Were there exclusions for this one?

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

The only one that I know of was the one that you can see there with the double stars, which EPU was not the recipient of any transitions of care during the EHR reporting period.

Arien Malec – VP Product Management – RelayHealth

There are certainly specialties where either prescribing is; I'm just wondering whether there are specialties where it's not clinical practice or clinically needed to perform medication reconciliation.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Yeah, and I don't know. I would think that that's not changing from Stage 1 to this, but I don't know the details of it.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, but you don't have to worry about it as much when it's optional.

Arien Malec – VP Product Management – RelayHealth

That's right. When it's menu, it's okay.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Oh, that's fair, yes.

Arien Malec – VP Product Management – RelayHealth

So, I'm thinking about, okay, I'm a dermatologist. I generally don't prescribe systemic medications. If I prescribe Accutane, boy, I'd better doing med reconciliation. It's situational in that context whether it's clinically appropriate or not. I'm not a physician, but I can think of a number of other examples where the clinical appropriateness of med reconciliation is situational.

Steven Stack – American Medical Association

I'll give you a better example, though. Orthopedic surgeon, person breaks their wrist, they're 30 years old and they're otherwise healthy. I mean, there's not much to be done or they're on a blood pressure pill.

They're not going to change blood pressure pills. All they're going to do is they're going to rely on the anesthesiologist to go over that stuff and make sure they're safe for anesthesia, but it won't change their intervention.

Or, an 80-year-old woman falls and breaks her wrist, is in the hospital to get surgery. They're going to rely on the general internist to do the medication reconciliation. The orthopedist is not going to do it because, quite frankly, they're not; I mean, they're physicians, but they're really mechanics in that instance.

So, there are situational examples where a number of specialties would probably say another member of the healthcare team performs that function on behalf of the patient for the team.

M

But as long as it's being performed it doesn't seem like that's a carve-out.

Steven Stack – Chair, ER Department – St. Joseph Hospital East

Right, but what happens if you have five physicians? I can see the other side of this argument. I mean part of the problem in healthcare in this country is you have so many people in the kitchen and nobody communicating. So, you've got to be careful on the carve-outs. On the other hand, having every physician member of the team; because there's no exclusion to say another member of the team has done this.

Arien Malec – VP Product Management – RelayHealth

Well, I'm wondering if there's an appropriate exclusion that says as a specialty I am not primarily responsible for or accountable for the medication therapy for the patient.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Right. So, it sounds like there are two things with this one that we need more information on. One is to Larry's point what were people attesting to, the ones who did choose this one, to give us a better sense of the 65%. And the second is Arien's point of in moving it from menu to core we want to just take a good, hard look at the exclusion criteria to make sure that they reflect what would be appropriate exclusions to make this practicable. Is that fair? Okay.

Okay, well rather than dive into View and Download, which would not be accomplished in the two minutes that we have, we'll put the two patient-facing ones on the agenda for the first meeting after the Policy Committee meeting on Wednesday. And I had a quick and dirty grid. Maybe we can toss it up just for a second.

That was the PowerPoint, if we could just toss that up onto the screen. I think it was sent out to all of you as well. That just gives a very high level view of – it doesn't include today, obviously – but it gives a high level view of on the ones where prior to this meeting where I think we are, and we don't have to go through all of this in detail right now, but basically we had a whole bunch that were still waiting on some information so we've been chasing down the information. I think we'll come back right after the Policy Committee as well to try to maybe quickly go through some of the ones where we just had a couple of pieces of information that we needed to be able to do a check-on that will then get us to a decision.

That includes the e-prescribing one, the incorporating lab results, and with public health, I'll just put that in a separate category for a second. With the cancer registries there was some information back on how state is defined for the cancer registries and then for non-cancer, if there was any information or specificity around which registries might qualify I think we want to get more information back on what kinds of registries might one be talking about as we think about that, which is both informational as well as a question, which may not have sort of an informational response, but would require more policy specificity.

With respect to public health we had a number of questions I think that were, if you think about the three categories that we had looked at where I think there was a general sense of the Workgroup there seemed

to be not enough top down direction and too much discretion being given to local definitions of the key objectives, the measures, the definition of successful ongoing.

We had a conversation about the transport standards, that it didn't specify transport standards, whether that would mean that we ought to align with the EHR certification standards, as we just described, what's being required for the 10% and/or allow the grandfathering of legacy approaches that are already in production. There are public health connections already in production, do we want to grandfather those in?

With immunizations there were some questions about, and I think this may be informational or it may be just a genuine policy question that we ask; I don't know, we have to dig into it and see whether that specificity is there about what immunizations would be covered, which immunizations would be covered in the reporting requirement.

In terms of areas where we reached decisions, having hospitals send lab results, I believe that was a consensus decision. The performing test of HIE, I believe we reached a decision as well to remove that to go for Option 1. I would note that the Meaningful Use Workgroup, I believe, settled on Option 4, which I think was to replace it with a Summary of Care test or something, but I'm not sure exactly what Option 4 is. I just noted that they had said Option 4 and if someone can give us – Michelle or Amy or Deven?

Michelle Nelson – Office of the National Coordinator

Actual account and transmission of a Summary of Care document.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Sorry?

Michelle Nelson – Office of the National Coordinator

Actual electronic transmission of a Summary of Care document.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay, so this is a Stage 1 requirement. So, instead of saying have it be a test, they're saying have one of your 50% be a real electronic transmission, right, if I read that right. Okay.

So, unless anyone has any quick thought about whether we might want to consider Option 4, I think we did unanimously agree to Option 1, which is basically saying get rid of it and it'll be taken care of with all the other things that are being required, both in Stage 1 and really coming up in Stage 2.

And then we also reached a decision on the Syndromic Surveillance requirement, agreeing with CMS that the eligible professional requirement should be menu set rather than core, but that the hospital requirement should be core.

So, we've got decisions.

Deven McGraw – Center for Democracy & Technology – Director

It's a good list, actually.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay, well, so what I propose we'll do a similar sort of just a quick bullet point summary of where we landed on the ones today, which I think was really just we have questions, obviously, and we have some recommended thoughts or avenues to pursue and then I will put those into a couple of slides for presentation at the Policy Committee. Really, just as I said, it's an interim sort of snapshot view of where we are in the process and not definitive in any way.

So, if people feel comfortable with that, I think that there may not be enough time given that this has to go to Mary Jo tomorrow for the Wednesday meeting to do a quick Workgroup review. Are people comfortable with my summarizing and presenting that on Wednesday?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Larry Garber – Medical Director for Informatics – Reliant Medical Group

I'm fine with that.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Great. All right. Well, thank you, everyone. Let's now turn to the public comment, Mary Jo.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Okay, Operator, would you open the lines please for public comment?

Operator

We do not have any comment at this time.

Mary Jo Deering – Senior Policy Advisor – Office of the National Coordinator

Thank you.

Micky Tripathi – President & CEO – Massachusetts eHealth Collaborative

Okay, great. Well, thank you, everyone. Really appreciate your participation today.