

**Health Information Technology Standards Committee
Summer Camp
ePrescribing Discharge Meds Power Team
Draft Transcript
July 5, 2011**

Judy Sparrow – Office of the National Coordinator

Thank you, operator. Good morning everybody, and welcome to the Standards Committee's ePrescribing and Discharge Meds Team call. This is a federal advisory call, so there will be opportunity at the end of the call for the public to make comment. Just a reminder for team members to please identify yourselves when speaking for attribution.

And let me do a quick roll call – Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente

Present.

Judy Sparrow – Office of the National Coordinator

Scott Robertson?

Scott Robertson – Kaiser Permanente

Present.

Judy Sparrow – Office of the National Coordinator

David Yakimischak?

David Yakimischak – SureScripts

Present.

Judy Sparrow – Office of the National Coordinator

Kevin Hutchinson and Liz Johnson could not make the call. Don Bechtel, are you there? Ken Gebhart? And Renee Rowell from ONC?

Renee Rowell – Office of the National Coordinator

Present.

Judy Sparrow – Office of the National Coordinator

Alright. With that, I'll turn it over to Jamie Ferguson.

Jamie Ferguson – Kaiser Permanente

Okay, well thanks. So, I think the first thing I'd like to do is to recap some of the summary points from our last call, in terms of both where we ended up and a few questions from the last call. But I think it would be good for us to focus in on the particular standards that we're gonna recommend and see how much we can tighten up those recommendations and prepare something for the next Standards Committee meeting on this call. So, my intention for this call is first just to summarize my understanding of the basic standards and the delineation of scope as we have it. I then – I want to turn to Renee to get the view from ONC on some of the questions that we raised in terms of our scope boundaries and alignment with CMS; things of that nature that we raised on our last call. And then I'd like to sort of test for consensus in the group on the core recommendations and on any remaining questions that we need answers to before going

forward with a set of recommendations. So that's my proposed agenda for today in a little more detail. Does that sound acceptable to everyone on the call, or is there something else that you'd like to have discussed today?

Multiple Unknown Speakers

Sounds good. Good. That's good.

Jamie Ferguson – Kaiser Permanente

So, in terms of where I think we are in the set of recommendations, I think that for the part of the Use Case that – the order to the pharmacy – the basic prescription – we aligned very strongly with Part D. And I think that that's a good direction for us to go. So basically, allowing both script and HL7 to be used exactly as they are in Part D for the different kinds of orders and pharmacy structures that are covered by these electronic orders to pharmacies. And again, just in terms of scope, these are for orders that are coming out of the EMR as the prescribing system. So, in terms of then also getting the medication history to the ordering prescriber – and I think this was part of David's email as well (that we can cover) – I think he nicely summarized the current Meaningful Use Standard of using the HL7 CCD as well as the ASTM CCR as the basic mechanism for getting the history to the ordering prescriber. Now in Stage 1 of Meaningful Use, in terms of vocabulary, it was really any of the vocabularies that are included in RxNorm or RxNorm itself could be used. And actually something I neglected to mention on my agenda rundown is: I would like to introduce the recommendations of the Vocabulary Task Force of the Standards Committee, which are the recommendations for Stage 2 vocabulary, specifically recommending requirements for some of the elements of RxNorm itself, specifically the semantic Clinical Drug and the semantic Branded Drug in the generic package and branded package components of RxNorm. So I'd like us to consider whether we can include those in our recommendation and potentially include those in the recommendation for certification criteria, but not for meaningful use measures at this point. And so, I'd like to have a little discussion on that. So it's basically the idea that was [indiscernible] in the Standards Committee was that you would put it into certification and ensure that the systems would be certified to be able to have that capability before requiring it of the EMR users. And we also had a discussion on formulary. And I think we agreed that truly standardizing formulary information was something that would be sort of a nice-to-have-for-the-future. And in fact, one of the things we can do in the group is to recommend a course of action to try to bring that together and make that happen through the Standards and Interoperability Framework and in future phases for standardizing the representation and transmission of formulary information. And then, we also had a discussion on eligibility and benefits, where again we aligned with the existing standards. And I don't think we came to complete closure on the eligibility and benefits discussion, but I think if we pick that up by aligning with the other existing standards that are used in CMS and in other regulations, I think that would probably align well with our general direction. So, that's my summary. And what do you all think of that? Do you want to throw brickbats or bouquets?

Unknown Speaker (male)

I'll throw an okay.

Renee Rowell – Office of the National Coordinator

I will too.

David Yakimischak – SureScripts

Yeah, I think from a summary level, I think that was great. I would like to go back on each one of the points and just make sure that we've got clarity on a couple of points around each one of those comments. But yeah, I think that was the scope that we discussed and seems appropriate for recommendations. David Yakimischak, by the way. Sorry.

Jamie Ferguson – Kaiser Permanente

Good, good. What I'd like to do – perhaps before we get to that slightly more detailed discussion David – is turn to Renee if we can. And Renee, do you mind going through the points of response that you got back from ONC discussions about our last call?

Renee Rowell – Office of the National Coordinator

Sure, I'd be happy to. One of the first ones that feedback was requested on or to take back to get a little more information on was the versioning regarding aligning with CMS, I believe. And I – please clarify for me if I misunderstood this – but it was focusing on the different versioning and whether or not to – where the alignment should be. And it was felt that it should definitely be in alignment in support of CMS. And I guess – Jamie, am I on the right track with that one?

Jamie Ferguson – Kaiser Permanente

Yeah. No, no I think what – you know the question that we discussed was whether we could through this program introduce frankly more advanced versions while allowing backward compatibility. So, in other words, allow essentially multiple versions with the most current version of script, for example, being allowed, while also requiring the – you know, what's required in the Part D regs. And so I think the answer is just align with what CMS puts out in regs.

Renee Rowell – Office of the National Coordinator

Correct. That's correct. Yes.

Scott Robertson – Kaiser Permanente

This is Scott Robertson. The notion of pre-adoption is mentioned from time to time, and I'm not sure that we want to say that. But if there are any extensions or specializations or additions that we're – are being contemplated to a standard somehow stating that those should align with existing within the SDOs. Is that something that can be done or is that just opening up a hornet's nest?

Jamie Ferguson – Kaiser Permanente

Well, I mean my understanding of the answer from ONC is: Don't do that.

Scott Robertson – Kaiser Permanente

That's fine. I don't want to – I'm not quite sure if it could ever even be written on paper. It's just – it's a nebulous idea.

Jamie Ferguson – Kaiser Permanente

Well, I mean I – you know, and I think the reality is that a lot of us have systems that could potentially use more current versions of the standards in production, even though they are certified to the regulatory [interrupted - indiscernible] version, right?

Scott Robertson – Kaiser Permanente

Yeah, I mean – in general [indiscernible] standards, if you have a more current version you could certify to something below that. You may not – there might be some features of the new version you may not be able to use, but you certainly can support the original specification.

Jamie Ferguson – Kaiser Permanente

And so I guess one of the things, Renee, that comes to mind on this is – and so, sort of the distinction certification and measurement for purposes of the incentives. And so, I think the way a lot of things work today in that regard is that there is a particular standard to which – or that is used for certification that the systems have to show their capability of in a testing environment in order to be certified. But in terms of the actual measures of whether it's structured lab results or even e-prescribing, the incentive program

doesn't always require the use of the standard that's used in certification. And so I think – you know, I think what we're saying – perhaps back to ONC – is it would be nice if that looseness were maintained. In other words, certify rigorously but measure more liberally in terms of the measurement of e-prescribing. So, in other words, if everybody has a system that's capable of one consistent standard, but if trading partners choose to implement something that works better for them, so long as they still retain the capability of using the one standard, they shouldn't be dinged for using something more advanced if it works for them.

Renee Rowell – Office of the National Coordinator

Sure, sure. Okay. I will take that back to the table and get further clarification. It certainly sounds feasible. It sounds like a good plan – [interrupted - indiscernible]

Jamie Ferguson – Kaiser Permanente

So long as everybody has the mandated capability and really can transact on that basis if they were to want to send or receive an order using that standard, if they also have the capability of using a later version of the standard how – we would prefer that that should be acceptable by CMS for purposes of the incentive measures. David, does that sound right to you as well?

David Yakimischak – SureScripts

Yeah, I think so.

Jamie Ferguson – Kaiser Permanente

So really it would be, by trading partner agreement, acceptable to use alternatives so long as you have the standard capability.

Renee Rowell – Office of the National Coordinator

Okay. I will – [interrupted - indiscernible]

David Yakimischak – SureScripts

Yeah. Again, this is David Yakimischak. I don't think that the phrasing actually includes that sort of terminology regarding minimum version or "must at a minimum support the requirements of" or anything like that. I think it's actually written as being very specific to a version. But I think, you know, whether we say it through – you know, maybe the question is: Do we wanna say something about this point or just leave it? Because if you say you have to support, let's say 10.6; I think that everyone recognizes that if you're supporting 10.8, but during your certification time and during your implementation you're actually using 10.6 transactions, that you're within compliance of the regulation. So, I don't know whether we need to say something to that effect or whether that's just an implied outcome of supporting a particular version number of a particular standard.

Jamie Ferguson – Kaiser Permanente

Yeah.

David Yakimischak – SureScripts

I mean, I'd always rather be more precise than leap to assumption. But, on the other hand, I think there's quite a bit of sensitivity around this question of: "What version is supported? What's the named version number?" And there are some firm reasons that that's in place and that we ought not also contest that through the work that we're doing here. This isn't really the place to question whether that's an appropriate strategy or not. It's a question of whether we're going to adopt it as-is or adopt it and then add clarification or modification.

Jamie Ferguson – Kaiser Permanente

Yeah.

Renee Rowell – Office of the National Coordinator

That's correct. That sounds good.

Jamie Ferguson – Kaiser Permanente

Okay, good. So Renee, I think there was also a question about whether we needed to consider and include information that's required for Quality Measures.

Renee Rowell – Office of the National Coordinator

Right. It was decided that probably that is being accomplished through Tom Tsang's workgroup team. We probably need to verify with him if there's specific considerations that we would want to make sure that they are addressing – that we touch base to make sure that those are being done. In visiting with Dr. Fridsma, it was felt that Tom Tsang oversees the Quality Measures, and probably that should be being done over there. It would be outside of the scope of this group.

Jamie Ferguson – Kaiser Permanente

So, in other words, our standards recommendations don't have to consider any particular requirements of Quality Measures?

Renee Rowell – Office of the National Coordinator

That was my understanding. Yes. That Tom Tsang's group should be – should be viewing that. If there was – let me get further information, Jamie, on that. Just to make sure so that we don't leave anything out.

Jamie Ferguson – Kaiser Permanente

Okay, okay.

Renee Rowell – Office of the National Coordinator

But yeah, it was supposed to be just – [interrupted]

Jamie Ferguson – Kaiser Permanente

I mean I think that's right, because – but on the other hand, you know maybe there's something we could support if we heard from them what it is.

Renee Rowell – Office of the National Coordinator

Sure. Okay, okay.

Jamie Ferguson – Kaiser Permanente

And that – you know – so for example, that could be potentially things like the Vocabulary Standards for History or for Allergies, whether at the package level or the ingredient level or whatever.

Renee Rowell – Office of the National Coordinator

Okay. Alright. I will follow up with Tom Tsang and then get back with you. Would that work?

Jamie Ferguson – Kaiser Permanente

Okay, sure.

Renee Rowell – Office of the National Coordinator

Okay.

Jamie Ferguson – Kaiser Permanente

Okay, so let's see – so then Renee, I guess the other question was about Prescriber Directories.

Renee Rowell – Office of the National Coordinator

Right. And that was not – that does not need to be included. There is other workgroups that would be addressing those.

Jamie Ferguson – Kaiser Permanente

Also out of scope for us.

Renee Rowell – Office of the National Coordinator

Correct.

Jamie Ferguson – Kaiser Permanente

Okay. Was there anything else that you wanted to relate from the ONC discussions on this?

Renee Rowell – Office of the National Coordinator

I don't think – not at this time. I am very pleased with the direction that the group is pursuing. I think it's right on track.

Jamie Ferguson – Kaiser Permanente

Okay, great. Well then, let's go back – if it's okay with everybody at this point – and go through a slightly more detailed discussion about the recommendations that we're contemplating at this point. So in terms of – [interrupted]

David Yakimischak – SureScripts

I'm sorry. Actually, could I just go back on one point just before we close the door on that one? This is David Yakimischak again. The question of directories being out of scope: Is there another group, subgroup, or effort that's going to be outlining requirements for directories, be it provider or pharmacy directories, that would be relevant to the work that we're doing here that we need to reference or be aware of?

Jamie Ferguson – Kaiser Permanente

Well, there is – I know there is the Provider Directory Workgroup of the – which is – Is that one that's joint between the Policy and Standards Committees?

Renee Rowell – Office of the National Coordinator

Yeah. That's the Information Exchange Workgroup, Jamie. And they did put forth some recommendations. And then Dixie Baker's Standards Team took it over.

Jamie Ferguson – Kaiser Permanente

So yeah, I think there are – you know, there is a good stream of work, David, in terms of the provider directories that's in the process of making recommendations.

David Yakimischak – SureScripts

Okay.

Jamie Ferguson – Kaiser Permanente

But I think what I'm hearing from ONC is not for us to worry about.

David Yakimischak – SureScripts

Clearly. I guess also on the pharmacy side, one question that would come up is that – One thing we, for instance at SureScripts, try to promote or require is a neutrality in terms of maintaining patient choice of pharmacy. And so one of the certification requirements we have, for instance for e-prescribing, is that: You can't limit the pharmacies that are visible and accessible to a provider when you're sending, for instance discharge meds. You can't just only show, for instance your in-house Pharmacy. If you have access and make available the range of pharmacies, you have to show all pharmacies and show them equally so that you can promote patient choice around their choice of pharmacy, as opposed to directing business to a particular pharmacy. And it's to avoid any kind conflicts or negotiated deals or anything along those lines. And so, while the directory itself may be out of scope, is the concept of maintaining prescriber choice of therapy or patient choice of pharmacy and requiring that that be enforced through the standards or through the certification or the implementation or the Quality Measures -- is that whole concept out of scope for what we're doing here?

Jamie Ferguson – Kaiser Permanente

Well, frankly I think it is because it's not part of Meaningful Use at this point. So that's not – to my knowledge, that's not either a functional or standards requirement for either certification or measurement. And frankly, I don't know that that concept has even been discussed. So the Policy Committee would be the place for that.

David Yakimischak – SureScripts

Okay, so clearly out of scope for us. I just wanted to ask the question. Thanks.

Jamie Ferguson – Kaiser Permanente

Yeah.

Jamie Ferguson – Kaiser Permanente

Scott or Renee, are you aware of any discussions about that in the context of Meaningful Use?

Renee Rowell – Office of the National Coordinator

I'm not. This is the first time that I've heard this brought to the table. It's certainly an excellent consideration that I think is really in the early phases of that being considered. Yes.

David Yakimischak – SureScripts

Okay, fair enough. I just thought I'd raise the question. Thank you.

Jamie Ferguson – Kaiser Permanente

Yeah, you know I also think – sorry go ahead, Scott.

Scott Robertson – Kaiser Permanente

Well, there are not discussions in terms of Meaningful Use; but the requirement for patient choice in the selection of the pharmacy has been mentioned. But nothing – I don't recall anything as part of Meaningful Use or to be written in the regulation. So – that I've heard.

Jamie Ferguson – Kaiser Permanente

Right. And you know I think what we're talking about here, particularly in terms of Discharge Meds, that may not be a good fit – where the order essentially may go just to the internal hospital pharmacy, right? For the initial or – right?

David Yakimischak – SureScripts

Right. Okay. Yeah, I realize it was kind of out of scope; certainly, for this group. But I was just sort of more interested if it's become a topic of discussion in other areas – you know, maintaining choice or enforcing or requiring choice as opposed to anything – that's a pretty high-level policy question. And if it's not been addressed, we're certainly not gonna go anywhere near it. Okay.

Jamie Ferguson – Kaiser Permanente

Okay, so then onto our basic recommendations then. Is there really – in terms of the standards for the order to the pharmacy and aligning with Part D – is there really anything to discuss there?

David Yakimischak – SureScripts

Just one point that came up briefly in our conversation last time. And again, this is David Yakimischak. Sorry. I think by now you're getting used to my voice. [laughter] We had a brief discussion I think, in regards to the possibility that a prescription will get routed to a long-term care facility as opposed to a retail or mail-order type of a facility. Now, I kind of forget: Did we say out of scope? And so, the need to support Long-Term Care types of transactions or routing to Long-Term Care is in or out of scope?

Jamie Ferguson – Kaiser Permanente

Well, you know, that's a good question. I mean I don't think that we really discussed anything that would prohibit that. And certainly that seems like it is a type of discharge order that we would want to facilitate.

David Yakimischak – SureScripts

Or is that more of a Transition of Care, where you're talking about the transmission of a whole lot of other discharge information and patient records and summaries, etc., that might include an active Med List and possibly even the recommendation for continued med, but not necessarily sending a live prescription to a long-term care facility.

Jamie Ferguson – Kaiser Permanente

Right, exactly. Exactly. I think that's exactly right. But you know in this case, what we're talking about and really our scope here is the Discharge Prescription Order. And so, are there cases where that order would go to a pharmacy in a long-term care facility? And if it did, would that be any different from any other retail pharmacy from the perspective of the Prescription Standard?

Scott Robertson – Kaiser Permanente

This is Scott Robertson. In terms of the Prescription Standard, there isn't really a difference. It actually is an active point of discussion with NCPDP to make sure that the standards support everything that's needed. There is a slight workflow variation. But from the prescriber's perspective, I don't think they really see a whole lot of difference.

David Yakimischak – SureScripts

Yeah, I tend to agree. And then it's only the question of whether we're gonna document whether we've sort of included it as a concept. From my understanding, the majority of long-term care facility pharmacies are not sort of actively receiving live electronic prescriptions from Ambulatory Care or Discharge Care. That they are more like an in-house type of a pharmacy – [interrupted]

Jamie Ferguson – Kaiser Permanente

But if they did, it would be the same standard right?

Scott Robertson – Kaiser Permanente

Yes it would.

David Yakimischak – SureScripts

Yeah, that's a good point. Right.

Scott Robertson – Kaiser Permanente

And actually the relationship is a little different. The pharmacies typically are not part of the long-term care facility. So if it's introducing another layer in the overall workflow, the prescription that's going to the long-term care facility may need to augment that order with facility-specific information. Send it out to the pharmacy that serves that long-term care facility and then it proceeds from there. But from an ordering perspective, most of that doesn't really impact the prescriber too much or it would be involved in like formulary benefits kind of questions. If we notice in the workflow, we could still say whether or not it's in scope now. But I don't think it's going to impact our work significantly, so we should at least – [pause]

Jamie Ferguson – Kaiser Permanente

Well, it seems to me that we can – this is Jamie – seems to me that we can include that in the description of our scope, but that it does not require a different standard.

David Yakimischak – SureScripts

Correct.

Renee Rowell – Office of the National Coordinator

I would agree.

Jamie Ferguson – Kaiser Permanente

Okay, now let's talk next about getting the Medication History to the ordering prescriber when needed. So as David's note pointed out, there are existing standards that are specified for that purpose within Meaningful Use Stage 1. And so I guess the only question is whether there is any reason to deviate from those standards. Or Renee, is that another case where – and I'm just hypothesizing here. I know one of the comments that you made was that ONC has a preference for single standards, but in this case there's a dual standard.

Renee Rowell – Office of the National Coordinator

Okay. Well, I need a little bit more information – exactly what you're – I think the dual standard needs to be brought forward as far as further discussion. Let me hear a little bit more about where you're going with this.

Jamie Ferguson – Kaiser Permanente

So, well in terms of getting the history to the ordering prescriber, the mechanism for that is to use the Summary Record formats of the C32 in the HL7 CCD or the ASTM CCR. So either CCD or CCR are allowed; and so that "or" from a vendor perspective really is an "and", meaning that the EMRs that are getting certified have to support both mechanisms. And so I guess the question is whether there is any desire to converge that to a single standard versus that dual standard. You know, that's a different question than just Discharge Prescriptions, right? I mean that would be – that's a – so maybe that's out of scope for us.

Renee Rowell – Office of the National Coordinator

Okay, okay. Alright, I'll run that past our team and get some further information and feedback as well.

Jamie Ferguson – Kaiser Permanente

So what I'm gonna propose is that unless we hear anything back to the contrary that we would support the existing standards that are specified for Stage 1 of meaningful use.

David Yakimischak – SureScripts

Well, this is David Yakimischak. I actually have a little different twist on this. So in the email that I sent out, what I indicated was that the Meaningful Use Stage 1 Standards that have been defined are actually defined for a somewhat different purpose. It's not really intended to define standards around the use of Medication History as we know it in the Ambulatory world. And so I outlined sort of what they were intended for and what the CCR/CCD could be used for. But the point in the last paragraph around CMS mandate for Prescription-Related Medication History support either NCPDP Script 8.1 or 10.6. And then there is an exception to that if the information is transmitted internally, where if the sender and recipient are part of the same legal entity, then HL7 may be utilized, which I think mirror identically what we said for Prescription Routing. And so, that's the standard that I would suggest we recommend as being used for Discharge Medications, because that's what's being mandated by CMS for Part D. As well, the current Stage 1 and potentially even the proposed Stage 2 don't really address the question of these consolidated Medication Histories that are aggregated from many different sources, including payers and retail pharmacy, that would be used in a Discharge Med kind of situation. So, you know, that's my take on the situation as it relates to Medication Histories.

Jamie Ferguson – Kaiser Permanente

So let me understand what's – so I understand that if the prescription-related information can include a Medication History in that case, I guess my question is that: Since the Comprehensive Active Med List as well as Medication History and Medication Allergies really are all, according to Meaningful Use, supposed to be sent in these other Summary Record Standards, what's the scope of that prescription-related information in Part D compared to what I think is a broader scope of the other Summary Standards? And I don't know – Scott, can you provide any insight on this?

Scott Robertson – Kaiser Permanente

All of Medication History and Medication Allergies – all of these are present in the – as you mentioned, they are present in the various Summary of Care documents. There is no – I do not recall one right now that is specifically just Medication; although, it's been discussed a little bit. In addition to that, there is some transaction work in NCPDP, but that's not gonna fit into what already is established in Meaningful Use that you would comment in a CCD or possibly a CCR.

Jamie Ferguson – Kaiser Permanente

So what is the Medication History that's in the Script Standard. Because I'm just – [interrupted]

Scott Robertson – Kaiser Permanente

In the Script Standard, you can request the Medication History. It's a history of dispenses.

David Yakimischak – SureScripts

It's dispenses and claims typically. And I think the distinguishing factor here is that what's contemplated in the CCR/CCD is more what's referred to as the active Med List, as opposed to the NCPDP Standard which transmits I guess a broader range of external claims and pharmacy information. Here's what's happening in practice today, independent of Meaningful Use, is that the EMR is gonna maintain an active Med List and that active Med List is what's being used when patient's summary information is being exchanged, say within the institution using say a CDA release to CCD format. The external Medication History that's delivered by NCPDP 10.6 or for internal exchange using HL7 is typically gonna be that broader net of claims information and pharmacy dispense information. And that information is brought into the EMR but not accepted into the record yet. What has to happen is the provider typically goes through and looks at the medications that's coming in from that external Medication History and reviews that with the patient and says, "Oh, it shows that you made a claim for this particular medication six months ago. I don't show that on your active Med List. You must have gotten that somewhat else. Did you, in fact, get it? Is it currently still an active med?" And if so, then they'll import that and add that

into the Med List. Often they'll find, "Hey, I just took that once and I don't take it anymore. It's no longer an active med. Or hey, it was a claim for my son. It mistakenly got put onto my account cause I'm the beneficiary. That's not my medication." So there's – that's the workflow that's going on today in practice with EMRs. And that's sort of a distinguishing trait between the active Med List and the external Med History. And I think there's different standards that govern those two things.

Jamie Ferguson – Kaiser Permanente

Yeah. So that's interesting. So I think, you know, you're right obviously that the Dispensed and Claims History is gonna be broader in terms of the financial transactions and what was dispensed. I think that at the same time, the EMR Medication History is gonna be broader in a different dimension because it's also gonna include patient-reported items and it's also gonna include OTCs. So one of the things that's actually – it's a big point of discussion right now in the Stage 2 Meaningful Use Vocabulary is the inclusion – not only the inclusion of RxNorm but the addition to RxNorm of OTC – basically OTC products that are prescribed, and so where those would not be things that would have a Claims History. So I think what I'm leaning towards on this is actually that both may be needed. So I think you absolutely have a great point that the – rather the Medication History request that Scott described and the ability to pull that from the Claims History and so forth is an important component. But I also think the ability to get the patient-reported information that's in the EMR and the OTCs and so forth that are gonna be on the Summary Record and/or the active Med List – I think it may be important to get both. And so, what I'm gonna suggest is that a recommendation would include both of those components.

Scott Robertson – Kaiser Permanente

That sounds right to me. You know, the question then comes up is: Do you require that both models – and then there's actually two standards within each of the models, right? In the case of the EMR, there is – [interrupted] Right.

Jamie Ferguson – Kaiser Permanente

Yeah. That's exactly right. But I think, you know, the context for this recommendation – let's remember – is the EMR as the ordering system. And so, what are the capabilities that a prescriber should have in their system? And so one capability would be the ability to request and to pull in the Dispensed History and the Claims History; and another capability would be the ability to pull in and represent active Med Lists from other sources from other EMRs, as well as including the patient-reported history and the OTCs. I think that's also the mechanism that would be used for the PHR, which I guess is another version of the patient-reported stuff.

David Yakimischak – SureScripts

Yeah. I was really just wondering: Do we need to require that an EMR would support all four or at least one of each of the two models or – ? I think it would become quite an onerous – not onerous – but it's quite a lengthy set of standards to support just for Med History.

Jamie Ferguson – Kaiser Permanente

Well, that's true. But any time we have an "or", it's an "and" from a vendor perspective. So – right? So I think by having any flavor of those alternatives, which I think probably are all correct because they're really – they are for different things. I think we're saying that: "Yes, the system has to have all of those capabilities." Now the – so yeah, it's all four.

David Yakimischak – SureScripts

Yeah. Well, they're already gonna need to support the two that are within Meaningful Use Stage 1. And if they're – well I was gonna say if they're – and the CMS Standards require – [interrupted]

Jamie Ferguson – Kaiser Permanente

Yeah, they already have to support all four. Don't they?

David Yakimischak – SureScripts

Yeah, yeah.

Jamie Ferguson – Kaiser Permanente

So we're just saying support all four for this purpose. Seriously.

David Yakimischak – SureScripts

Yeah.

Jamie Ferguson – Kaiser Permanente

Okay, so that was – yeah. No, thank you for bring that up because I had forgotten frankly about that part of the Script Standard.

David Yakimischak – SureScripts

Right. And since that's a CMS requirement, I think we better make sure we include it as a standard that's necessary for Discharge Meds.

Jamie Ferguson – Kaiser Permanente

Yeah. And I think, you know, our write-up can explain that these are for different parts – [interrupted]

David Yakimischak – SureScripts

Different purposes.

Jamie Ferguson – Kaiser Permanente

Yeah, for different parts of that Comprehensive Patient History.

David Yakimischak – SureScripts

Yeah.

Jamie Ferguson – Kaiser Permanente

Yeah. Good, thank you. Okay, now let's move on to Eligibility and Benefits. And I'm missing my notes on this right now. I don't have them in front of me. So what do we want to say about Eligibility and Benefits Standards? I mean is there – [interrupted]

David Yakimischak – SureScripts

This is David Yakimischak. So there's an existing set of standards that are supported and I recommend that we support or require support for these as already defined in – [interrupted]

Jamie Ferguson – Kaiser Permanente

Yeah, basically support the HIPAA Standards right?

David Yakimischak – SureScripts

It's HIPAA 5010 using the X12, specifically 270/271 which is Eligibility Benefit Inquiry Response.

Jamie Ferguson – Kaiser Permanente

Yeah.

Scott Robertson – Kaiser Permanente

Do they – they do have the 5010 – I don't recall if – does it specifically call out that NCPDP has another set of benefit transactions that are specific to pharmacy? I thought those were called out as well.

David Yakimischak – SureScripts

Yeah. I mean that's D.O, which is the Pharmacy Claim. But I think we said that we're gonna leave the administrative transactions of what a pharmacy would need to do to adjudicate the discharge prescription out of scope.

Scott Robertson – Kaiser Permanente

I'm talking about the physician at this point. So, I'm sorry.

David Yakimischak – SureScripts

Right. So we're just talking about HIPAA X12 version 5010, and specifically 270/271.

Jamie Ferguson – Kaiser Permanente

Right. Okay.

David Yakimischak – SureScripts

Now is there – I'm sorry to maybe take this off track – but a quick question: Are there any Drug Benefits that might accrue to the patient as a result of their stay at the institution – at the hospital – prior to discharge that might impact the Eligibility and Benefits for those Discharge Medications? Or once they're discharged is it always the case that their private plan or employer plan or Medicare/Medi-, whatever health benefit they have kicks in for Discharge Meds.

Jamie Ferguson – Kaiser Permanente

Oh, that the Discharge Meds being included as part of the inpatient stay?

David Yakimischak – SureScripts

I'm just wondering if there's any benefit accrual to the patient on discharge or does it all turn over to their external provider insurance coverage at that point.

Jamie Ferguson – Kaiser Permanente

I don't know. And I wonder – I really don't know. I wonder if that also depends on where and when it's filled exactly. So if it's filled before by the hospital pharmacy, before the moment of discharge according to the discharge order, then it would be part of the inpatient stay it seems to me.

David Yakimischak – SureScripts

Right. It may not be relevant here. Maybe we should make the assumption that it all accrues or that nothing accrues and that this is now a new clean prescription benefit request that's being made on behalf of the patient.

Scott Robertson – Kaiser Permanente

Back when I actually acted as a pharmacist in the hospital pharmacy – this is Scott Robertson – there was a transition going on where we would give people a week or two supply or whatever of the medications that they were on as part of the discharge. And increasingly, that was not being covered by the inpatient benefit. So we were getting to a point where we had to start doing the claims processing for these things that we weren't set up for. And so it was a transition during that time. And I think the majority of it now is that Discharge Medication is not considered part of the stay or is not covered in the benefit. However, having that down as a decision point is probably a valid thing to include.

Jamie Ferguson – Kaiser Permanente

Okay. We should at least assume that it's not at all involved with the hospital stay benefit?

Scott Robertson – Kaiser Permanente

Yeah. Because if it is part of the hospital stay, then in a way it's not really a Discharge Medication. It's part of the inpatient stay/inpatient care and would be reported to anybody else in like a Care Summary document, so that information would be followed on in that case. But if it is actually a Discharge Medication and noted as such and processed as such, then it's going to be a separate indistinct thing and require specific transactions. So I think the assumption is that the Discharge Medications are not accrued in the inpatient stay benefit.

David Yakimischak – SureScripts

Right. Yeah and it should be maybe termed a Discharge – [interrupted]

Jamie Ferguson – Kaiser Permanente

Yeah. And so, as long as we're explicit about that, that's fine.

Scott Robertson – Kaiser Permanente

Okay.

David Yakimischak – SureScripts

Okay.

Jamie Ferguson – Kaiser Permanente

Alright good.

David Yakimischak – SureScripts

So yeah, I don't think there's anything else on the Eligibility side of things. And I think your discussion of Formulary was accurate. Oh no, I'm sorry. We're not on Formulary.

Jamie Ferguson – Kaiser Permanente

No, no that's a perfect [indiscernible] because I was just gonna go there and I was gonna ask the question: Well, what do we want to say about the need for standardizing Formulary? What do we expect -- If standards magically appeared today, what do we expect the timeline would be? Or is that even a consideration? I mean is this something -- Is there value in standardizing representation and transmission of Formulary information?

Scott Robertson – Kaiser Permanente

David, in the practical use of formulating benefit in NCPDP, is NCPDP actually sending like full formulary files or -- ?

David Yakimischak – SureScripts

Yeah. There is no standard today, and I'm really not aware of any effort that's got enough traction for that to be even mentioned by us. Today, the mechanism is really crude and there's a lot of flat files that are being sent around. Yeah. You know, there was some effort to establish standards. And what we ended up adopting was something that was based on those models. But obviously, there wasn't a standard that we could pen and say, "Just follow this standard." So, you know, and frankly there are all kinds of different Formulary products and services out there. And whether there is any standardization possible is not something I'm aware of. I mean I could maybe do some research before we have our final report as to whether there is something there, but there is certainly nothing today and nothing of substance

that I'm aware of that has enough evidence of momentum or possibility that we would even say that that's a future.

Jamie Ferguson – Kaiser Permanente

Well, you know, if there were a standard, where would it be used? I mean, what – I'm thinking about – [interrupted]

David Yakimischak – SureScripts

Well, there's a couple of different levels of standards too. There's also the concept of Formulary Terminology, such as definitions and standards around Bioequivalents or Therapeutic Equivalents and just all the different terminologies that's used to represent a formulary. That alone, there could be an effort around standardization of it, as well as Data Structure and then Transactional type of model. Today, there isn't a Transactional Model. There is no Formulary Request/Formulary Response type of a transaction. The formularies themselves aren't just in one format either. I mean, there is the list of Alternative Medications – there is the list of – not the list of, but there is structure around Alternative Medications. So when a doctor picks this, it provides a list of the alternatives that are available based on the Formulary as to which levels and tiers and copays are involved. So the whole concept of copays is another idea. So what's the structure around the copay model of the different tiers that are available and the pricing rate, so that you can say this drug is a Tier 3 which means it has a copay of X – of 27, and 27 stands for this patient's thirty-dollar copay. There is also the flags that are related to prior authorization that's required, so this medication is not available without prior authorization from insurance; and those kinds of things. So there is a whole room for – there is room for all that kind of standardization, but there is really so much diversity in the industry that I really don't see any traction on that.

Scott Robertson – Kaiser Permanente

You know, it would really be – it'd be very inefficient for that capability to be programmed into all the various e-prescribing systems. It would seem a lot – I mean because you'd end up duplicating the entire formulary and benefit structure and copay structures for all the different possible providers – or payers inside of each e-prescribing system.

Jamie Ferguson – Kaiser Permanente

Yeah.

Scott Robertson – Kaiser Permanente

So it would seem to be more efficient for a transaction to say – potentially, a transaction could be sent from the prescriber asking, “Okay, I need to know if this is covered and what will be the copay?” And they would get a preliminary result back based upon that preliminary request. Maybe it may not be exactly what the pharmacies are seeing because the pharmacy has to make some [indiscernible] decisions along the way. But that might be a better way to approach that rather than the idea of replicating the entire formulary.

Jamie Ferguson – Kaiser Permanente

Yeah. Okay. But you know one of the things, David, that you mentioned really intrigues me, which is standardizing the representation of Therapeutic Equivalents.

David Yakimischak – SureScripts

I mean, that's another one of the sort of categories of standardization that could occur. But like I said, I'm not aware of efforts in that area yet. There is discussion around it but no standardization efforts that I'm aware of.

Jamie Ferguson – Kaiser Permanente

Yeah. Well is that an area where we think there should be standardization efforts?

David Yakimischak – SureScripts

Well, I think similar to what we said about RxNorm, etc., you know that's where the industry's moving. And if RxNorm is gonna be required or an RxNorm vocabulary required, for instance for prescribing, it probably should be required for Formulary and for History and for all of the Transaction Sets.

Jamie Ferguson – Kaiser Permanente

So, okay. So I think – let me say I think that closes out our discussion on Formulary. But I want to pick up that thread on RxNorm, if that's okay. And I – cause I do want to come back to what I mentioned earlier, which is the current recommendations of the Vocabulary Task Force that were accepted by the Standards Committee for Stage 2, which is a requirement for certification purposes that certified systems had to have the ability to use four particular components of RxNorm which is the Semantic Clinical Drug, Semantic Branded Drug, the General Package, and Branded Package. So the actual RxNorm codes for those four things are currently recommended to be required for certification in Stage 2. And so, it would seem to me there might be some synergy or some additional benefit from us making the same recommendations. I want to raise that for consideration.

David Yakimischak – SureScripts

So what would that recommendation sound like? That would be that we would adopt RxNorm or recommend that RxNorm be adopted as a standard for –

Jamie Ferguson – Kaiser Permanente

For certification of EMRs that are used as prescribing systems for Discharge Meds. And actually, this particular recommendation came in a letter from NCPDP. So this is actually the NCPDP recommendation for the implementation of RxNorm. And what that would say is that the prescribing systems have to have that capability to be certified for Stage 2, but there is not a requirement to actually use the RxNorm for the CMS Incentive Measure.

David Yakimischak – SureScripts

So RxNorm – so how would that compare then to NDC numbers? So RxNorm could be used, national drug codes numbers could be used –

Jamie Ferguson – Kaiser Permanente

So basically, the requirement to use those requirements of RxNorm would be part of the certification process. But then in practice, in terms of the measurement of ePrescribing, there would be no standard required. In other words, you could continue to use NDC, but the ordering systems would have the RxNorm capability. And then presumably for Stage 3, a couple years later, the requirement to actually use those RxNorm codes could potentially be introduced into the ePrescribing Incentive requirement.

David Yakimischak – SureScripts

That sound good to me. I mean that allows RxNorm to be used but doesn't require it immediately. And that's where we're at today. RxNorm is optional. NDC, by the way, is optional. But one of the two is required. When you get to Controlled Substances, one of the two is required by the DEA. So I think that's – that approach is pretty consistent with where things at.

Jamie Ferguson – Kaiser Permanente

So Scott, what do you think of that?

Scott Robertson – Kaiser Permanente

I think this is a good approach. We need to move away from NDC numbers as part of the prescription order because there's issues about the – how it represents the intent of the prescriber.

David Yakimischak – SureScripts

Right.

Scott Robertson – Kaiser Permanente

And it's just been an ongoing problem that RxNorm is probably the best solution for. And there are just a lot of advantages. So anything we can do to facilitate transition to RxNorm codes is a good thing in my mind.

David Yakimischak – SureScripts

Yeah, I agree. I mean the “manufacturer-specific/package size-specific” is not actually typically the prescriber's intent. One thing: I would just want to be cautious that we don't push for something that's not yet really doable in industry. I mean RxNorm is not widely deployed and has not been – you know, it's been tested but it hasn't been deployed. And I think we're gonna see that over the next year or two. I think – yeah, I agree with your statement.

Scott Robertson – Kaiser Permanente

Well, the Drug Knowledge vendors have been working at both in terms of incorporating into their systems and feedback to NLM to improve RxNorm. So, I mean that process has been working well. But, you're right. Getting it actually deployed and in use is another step.

David Yakimischak – SureScripts

And, you know the Drug Database companies are all stepping up to including RxNorm into their products and it's just gonna take just a little bit of time.

Scott Robertson – Kaiser Permanente

You know, it's just moving forward as well as these things can.

Jamie Ferguson – Kaiser Permanente

Yeah. Okay, so you know – I mean I know we'll get feedback if we include this as a recommendation, basically saying that the EMR vendors have to include the capability first is essentially what we're saying. Then I'm sure we will hear from the EHR Vendor Association on the feasibility and so forth. But it seems to me that that's a recommendation consistent with the other recommendations of the Standards Committee. [pause]

Okay, I think in terms of my agenda for this meeting, we're done.

David Yakimischak – SureScripts

I don't have anything else.

Renee Rowell – Office of the National Coordinator

I don't either.

Scott Robertson – Kaiser Permanente

Neither do I.

Jamie Ferguson – Kaiser Permanente

Just to recap though: So I think Scott, one of the things that you were gonna do – you took away from our last meeting – was to do a Use Case Scenario scoping write-up. And so, if you could get that to me, I will take a crack at doing a first draft of writing up what we've discussed today in the letter format that's required for these recommendations. And I'm gonna try to get that back out to the team this week – by the end of this week, so that we can circulate it for consideration and for editing and hopefully be ready to make recommendations to the Standards Committee meeting, which I can't recall the date, but I think it's in about two weeks.

Judy Sparrow – Office of the National Coordinator

The 20th Jamie.

Jamie Ferguson – Kaiser Permanente

Okay. Sound good. Any desire for anything different?

David Yakimischak – SureScripts

Just to be clear: There's gonna be something written that we can review before that's presented to the Standards Committee.

Jamie Ferguson – Kaiser Permanente

Absolutely. So my intention is to draft a letter, send it out in draft to the Committee – let me see, are we a Committee or a Task Force [laughter] or whatever we are – our team – send it out to this team for review and editing. And so we can just circulate it by email to refine that first rough draft. And then through that process, I think we ought to be able to come up with a letter to present to the Standards Committee in a couple weeks. Now Judy, you are out next week, right?

Judy Sparrow – Office of the National Coordinator

Yeah, but somebody will be minding the store here.

Jamie Ferguson – Kaiser Permanente

Okay. Okay, is that good for everybody.

Renee Rowell – Office of the National Coordinator

Sounds good.

Unknown Speaker (male)

Yeah.

Jamie Ferguson – Kaiser Permanente

Alright.

Judy Sparrow – Office of the National Coordinator

Okay.

Jamie Ferguson – Kaiser Permanente

So Judy, I think we're ready for any public comment.

Judy Sparrow – Office of the National Coordinator

Yes, Operator can you check and see if anybody does which to make a comment please?

Operator

Yes. If you're 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. [Pause] And we do have a public comment.

Judy Sparrow – Office of the National Coordinator

Okay, thank you. Could you please identify yourself?

Carol Bickford – American Nurses Association

Carol Bickford from the American Nurses Association. As this conversation was proceeding to raise the question about incorporation of a recommendation to assure that clinical preparation to use RxNorm be encompassed, not only at the reg level or the implementation arena but incorporated into the educational program for preparing clinicians. Has that been accomplished?

Jamie Ferguson – Kaiser Permanente

So, that's a great point. I don't know that there have been specific recommendations about including education on RxNorm, but we can certainly include that in our recommendations. And I thank you for the comment.

Carol Bickford – American Nurses Association

It's more than just for physicians. It includes the whole prescribing spectrum.

Jamie Ferguson – Kaiser Permanente

Yeah.

Judy Sparrow – Office of the National Coordinator

Thank you, Carol.

Jamie Ferguson – Kaiser Permanente

Thank you. And I agree that here we're talking about – and I think we were pretty careful to talk about the prescribers not just physicians.

Judy Sparrow – Office of the National Coordinator

Right. Okay, anybody else from the public?

Operator

We have no more comments at this time.

Judy Sparrow – Office of the National Coordinator

Thank you, Jamie. Very productive call.

Jamie Ferguson – Kaiser Permanente

Okay, thanks everybody.

Judy Sparrow – Office of the National Coordinator

Thank you.

Unknown Speaker (male)

See ya.

Public Comment Received During the Meeting

1. Single-ingredient compounds (e.g. solid dosage forms compounded into liquid formulations - common in pediatrics) has presented a challenge with regard to the external medication history based on NDC number - would the same issue exist for data based on rxnorm? Hi - in case my question isn't clear or if more detail or use-case is necessary - please feel free to provide my contact email of brenda.dodson@childrens.harvard.edu