

Meaningful Use Workgroup
Draft Transcript
October 12, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to the Meaningful Use Workgroup. This is a federal advisory committee, so there will be opportunity at the end of the call for the public to make comment. Let me do a quick role call. Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

George Hripcsak?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Neil Calman? Art Davidson?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Lansky? Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Latanya Sweeney? Michael Barr? James Figge? Anyone from CMS? Karen Trudel Tony Trenkle? Josh Seidman?

Josh Seidman – ONC

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anybody off? Alright, I'll turn it over to Paul Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Welcome to this final call before we present our update to the full committee on October the 20th. So this will be work in progress. The couple things we wanted to cover is, one, an update from the smaller group that's working on the patient access and copies, sort of the patient and family engagement proposal. I think it's a work in progress so we still have some more detail work to do in the smaller group.

The second thing I wanted to go over is I did have a discussion with David Blumenthal. His suggestion is that we sort of introduce the next stages in phases. Instead of going to the full committee with detailed draft of our criteria—and I don't think we're quite there yet—talk about some sort of policy or philosophy options that we've discussed along the way and get feedback from the committee on those options, talking about, for example, the outcomes measures versus the process measures. I'll go over that in the second half of this call. But I think that's where we want to, one, give the committee a sense of some of the branch points in our thinking and take feedback, and then we can go back after the 20th and work more on the details and also incorporate the philosophical decisions we make in the full committee.

Then, that would be in October, and so October through November, try to work on that and then present back to the full committee either in November or December, depending on when our final face-to-face meeting is for the calendar year before we go out for our request for comments. How does that sound?

M

Good.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Paul, on that one, one of our parking lot issues had been the timeline issue. So I don't know if it makes sense to just review those issues and some of the options with the committee in the context of how you're thinking phasing. Would that make sense so there's just an understanding of that across the workgroup or not? Because I'm not sure what you want to make a policy recommendation on it. It may be more of a CMS issue, but it currently does affect some of the thinking in terms of moving forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Are you talking about the overall timeline for releasing of the final rule in our recommendations or which timeline are you referring to?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. I'm actually referring to the fact that the way it's currently proposed, even if we meet our timeline, it's really not even viable for the people who start now and declare meaningful use to get to stage two because there's just not enough time with the current way that the rule is written. It's just to kind of heighten the awareness ... other people and there's options to get around that, but in some way that's got to be addressed. So it's clearly an issue that's been raised to CMS and Dr. Blumenthal numerous times so it's not a new issue. Would that make sense to review that with the Policy Committee?

Deven McGraw – Center for Democracy & Technology – Director

Is that an across the board comment or one related to the patient engagement stuff that you—?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

No, it's across the board

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we've covered this in full committee and in this workgroup. Let me just make sure we're talking about the same thing. The original request was to have an 18 month lead time for 2013. That's not possible with the final rule of processes that we have to go through in the final rule. So once we give our recommendations, they prepare their NPRM. The bottleneck is not so much our recommendation so much as the time they need after getting some initial response to stage one applications before they go into rulemaking process for stage two. So the agreement we had sort of with the community and the industry is that we—the Policy Committee—would do the best we can, like we did with stage one, to give solid directional recommendations from the Policy Committee, which, as you know, is an advisory

committee to ONC and CMS, so they can change things, but at least in stage one, the directions of our recommendations were fairly close to what came out.

Our plan is to produce our final recommendations in the summer of 2011. That would, in a sense, give the 18 month lead time. We all understand that that's not, by no means, final. It's just a recommendation from the Advisory Committee, but it's one way to have the industry receive a signal that this is a directional ... that the compromise, I think, we worked out. Does that summarize ...?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. Just a couple of issues on that: Number one, even if you make it in the summer and the hospitals have to be up on stage two by October 2012, so it's a year. So it's not even 18 months. So practices have to be up at the beginning of the year, the hospitals have to be up in October 2012 on stage two, so it's less than a year. Unless we get a lot better for a lot of reasons, there's still a lot of question even in terms of what the final rule is today. So even the signals really, honestly ... work. There was ... change from the point that the signal was given. The direction was given, but the details to implement those ... change between what the signal was and what the actual ... final rule, and there's still ... change. I mean, it changes day to day. ... when we get an answer from CMS.

So I just think we need to be aware—have that sensitivity as we think through this, as you look at the combination of going to outcomes as well as defining ... function. So I'm not sure that's bought into by the industry either—the people who have to implement this or the providers. It certainly ... community. We just don't see how we can do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I think we're all sensitive to the issue and we've discussed this in full committee, and as you say, you've talked about it with Dr. Blumenthal and with CMS. I think everybody's aware of this and we're trying to work within constraints of the law. The objectives of the program, which has nothing to do with just an EHR program, as we all agree. It's about moving the feet along in terms of measuring and improving outcomes. So we have a certain timeline that's dictated by the external environment, and that's the broader house reform environment, and also the constraints of statute.

Let's move on in our first agenda item which is sort of to get an idea of where the smaller group is in terms of working out some kind of reconciliation between the 2011 stage one, the stage three, and some kind of ... for stage two, and trying to see one of the proposals you're working on, is there a way to reconcile the hospital and the eligible professional requirements? There may or may not be a way, but do you want to walk us through the documents you've sent out?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I'm actually going to explain the three documents and then Christine will take the lead. There's three documents that are available. One is the document, which was the original proposal that Christine drew together. The second is a document, which is a matrix of the content of what's included in the standard CCR CCD, and it's flagged with those which are currently in stage one. So it's just kind of a list to pick from, if you will. You'll see that when Christine goes through her proposal. The last document is just a piece from Christine's proposal where we tried to take the first two documents and merge them to some extent. So we'll drill down into each one of them in a little bit more detail now.

Christine Bechtel – National Partnership for Women & Families – VP

The piece that I sent out had some parameters at the top. I don't know if the Altarum folks want to get the document on the screen so the public can see it, but this is the document that Charlene sent that says, "Active Copy of Evolution Draft 10/05, October 5th." At the top of the document, what you can see is some of the summary parameters that we had discussed on the last call.

So we have agreed, at least for now, to preserve to copy requirement as it is, and to get some public comment on that. Then we're suggesting combining the access information requirement and the clinical summary requirement into a new requirement around a summary record. I think this is somewhere where

it would be appropriate for us to say “Download a Summary Record,” although it’s notable that it could still be on paper, if patients prefer that.

The goal here is to build out and expand on the clinical summary requirements for EPs to include additional data that Charlene is going to take us through with Neil and George—some of their thinking about what this data could be—and to maintain the timeliness requirement around this ability to download, so it’s 96 hours, I think, is what’s in the rule, but increase the threshold potentially to 60%. Make sure that it’s human readable when you download it, like the Blue Button feature that the VA and Medicare are doing for 2013, and that it is also machine readable by 2015. So that’s the glide path section.

So for eligible hospitals, we basically want to apply a modified EP requirement to the hospitals by building out the discharge instructions, so that they would include most of the same fields that are currently required in 2011 for eligible providers, although we would need to adapt those for hospitals, and that we would still maintain, or I guess establish, the 96 hour requirement. I actually think I have a typo here. I don’t know that we want to increase the threshold to 60% or not. I’d have to go back and remember what it is for the discharge instructions, because that is an “upon request.” What we want to do here is change this so that it is no longer just upon request. So 60% is probably a pretty high threshold for that, but we can talk about that. Again, downloadable, certainly by 2015 and including additional data by 2015, so it’s a slower walk for the hospitals than it is for the eligible practices.

The question that we sort of left with was essentially what should the additional data elements be for EPs and for hospitals so that we make the downloadable information much more usable and engaging for patients and families to facilitate care coordination and safety and all those issues that we all care about? Charlene sent the second document—for the Altarum folks, the second document is called “Access Copy Evolution Draft 10/11.” Charlene, do you want to walk us through the work that you and George and Neil went through?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I can do that, and just to caveat this, so I guess if you can bring up the document—I’m trying to merge multiple documents as we go, so we’ll just ... caveat is different.

We did two things. We tried to build out those two documents from the data ... that’s available either in CCR or in the CCD, but in our conversation, what we said was we really need to go out to practitioners, people who are providing care in practices, because Neil had provided some of his input, but validate that. So, in addition, we went out and got some additional input to the process to say okay, and that was inclusive of the concept of medical homes, care planning, and the things we’ve been saying.

So, it turned out that there may be some gaps between what’s in this proposal and what’s in the standard. Although I did have a standards person just look at it and it doesn’t seem like the gaps are that huge at this point in time. So I think we’re probably pretty good.

What we looked at was really fleshing out—as Christine said—the content of the clinical summary. The things that are highlighted in gray are those things that needed today in the clinical summary. What we listed below are some additional items that were kind of expanded upon. So, if you drill down—so this is two processes we’re automating now. One is at the end of a visit. It could be a visit to a primary care doctor or it could be a visit that maybe potentially results in a referral, but those two documents. Then the right hand column is at the point of discharge.

What we thought we would do with the committee is just kind of walk down the data content. So if you see at the top, they were the original fields that Christine proposed. If you scroll down that page a little bit more, you see allergies, adverse reactions alerts. Then you tend to see the plan. Included in there—and I think Christine had this in the same language, but—a list of agreed upon ... goals for the patient, when do I come back, referrals, what tests do I need to do, as well as what prescriptions were given. But really, it’s kind of a plan of care. Then you’ll see a list of other fields. If they have an asterisk, it indicates that those are actually included in the CCD standard or their terminology. So problems, conditions, test

results, family history, social history, surgical history is not, advanced directive, and there's probably some more below that. Additional patient education selected by the physician, care team contacts, as well as if there's a referral to a specialist, a statement of the continued relationship ... expectations for follow up.

Actually, these data fields were derived with conversations with practitioners. So that's one perspective that adds on really to what Christine was proposing. Many of these fields already are included in the CCD standard and could be built out.

Christine Bechtel – National Partnership for Women & Families – VP

So plan of care is on the spreadsheet.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

So that means that it is part of the CCD?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

There is a line item in the CCD that is in that called plan of care or there's actually two line items. One is assessment and plan and then the other one is plan of care. But I would think, again, from the standards community, this clearly would be one I think we want to put on there for 2015 because I think it needs some work, but it's really what are the next steps, what are the follow up, and that type of thing. We could just call it follow up instructions, actually, on the hospital side. We started to take out plan of care because it got to be—the whole thing is the plan of care, ultimately. So that's kind of—

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I'm just trying to get at why it didn't have an asterisk.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It is listed there. I wasn't able to validate all of that stuff was included in it.

Christine Bechtel – National Partnership for Women & Families – VP

I got it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It probably is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The title had said in NPRM. Did you mean the final rule?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that's my bad. It's final rule, not the NPRM. My bad.

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

So only those that are highlighted in this gray highlight are part of the final rule and the others— Are you proposing that all these other ones be added and in what year?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Actually, we didn't get that far, Paul. We really just—

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

Is it just other things that would be useful, you're saying?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. We did the analysis in terms of from that perspective. What is it that you as a provider thinking about medical home and everything would want or available to the patient? So it's this list of stuff.

Neil Calman – Institute for Family Health – President & Cofounder

This definitely is sort of the superset, and I think within this, there's a lot of refinement that we still need to do.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

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

Yes, remembering that clinical summaries are produced for each office—

Neil Calman – Institute for Family Health – President & Cofounder

Exactly, which is why when you have all these history things, it's not like you necessarily want to give people back copies of their history every single time they come in.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

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

As Christine mentioned, it's not an "upon request," the original measures for 50% of all encounters. So it's pretty stringent. So anyway, you're saying this is just a working document that says, "Well, here's some things that would be useful in a 'clinical summary,'" and that's separate from saying, "And it should be the clinical summary that's distributed at the end of every office visit." Correct?

Neil Calman – Institute for Family Health – President & Cofounder

Correct, from my perspective.

Christine Bechtel – National Partnership for Women & Families – VP

What we're trying to do in collapsing things is be parsimonious but also make sure that we preserve the ability to download this information. Why would it be a problem to have a more detailed summary be given out or offered up for either download or in print—right, because it's per the patient's preference—at every office visit?

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

I think there are a couple of questions imbedded there. One is you mentioned patient preference. As you know, we don't actually capture that right now, so the systems don't include a field for us to even capture that information. We need to define ... how many different ways are there. One could be shown on a patient portal, which is an integrated PHR. Another is to be transmitted to a standalone PHR, and then is there a standard to do that. A third might be printing out. Do you see what I'm saying? So one is there a number of things that we haven't defined including not even having a field for indicating this preference.

Christine Bechtel – National Partnership for Women & Families – VP

True, but that's the case in the final rule as today already. That's not a new issue.

Neil Calman – Institute for Family Health – President & Cofounder

I think from my point of view—again, at the current time, the majority of these, I think, are going to end up being printed on paper. I think, at least in 2013, we're talking about pages and pages of paper if we're basically reprinting for people the advanced directives their surgical and social history and family history. I'm not sure we want all that stuff sitting around on paper every time somebody has an office visit. But I do think that at some point, when it's electronic, it really doesn't become an issue. What you're really doing is updating information. I think then, it makes sense to update that whole spectrum of information. For right now, we need to be more stringent in terms of what we're giving people after every visit because we're going to be doing it mostly on paper, I would believe.

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

So, here are the two questions we need to answer in order to move forward, and this is what I was saying. We've got to look at this discussion from yesterday and where we got stuck. One thing is we're trying to be parsimonious and put things together, so take on the hospital side just as an example, but it's also true on the ambulatory side. There's discharge instructions, there's talk about what the patient will be doing and there's a hospital summary, which probably represents something about what occurred in the hospital. Those are two different med lists.

As we join these two things, are we giving the patients the bulk med lists and their discharge instructions? Are we giving them access to both med lists, that is what they had in the hospital as well as what they're supposed to take when they go home? Furthermore, as we add these fields, are we mandating that the doctors start collecting them or are we just saying that if this is available in the EHR, this is what they should have access to? But that's a separate leap to say that this must be collected with 80% threshold or whatever.

So it's starting to feel, from the discussion, that it's hard to merge the clinical summary that you give the patient. You want it to be short so that they read the whole thing and actually do what's instructed versus access where we feel like they should have access to as much information as you can give them. There's two different goals there. The discharge instructions, you really want it to be parsimonious because it's like you've got to take that medication and come back for your appointment and not bury them in their social history. So—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So—

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

Go ahead, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, I'll just wait until you're done.

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

Well, I'll leave it at that. Those are the two—and that's where we kind of got stuck. Larry McKnight and David Tao was on the phone. We had trouble with each of these things. Well, what do you mean by the meds? Well, what do you mean by this? So, for pending orders, do we want the doctor to sit there and actually manually list the pending results? Because they'll actually come up with a good list, and who needs to check it?

So, for example, the pathology report: It's pending. Who's going to check it? The MRI reading: ... pending is going to check it? There's a post to every CBC that didn't happen to be finished yet, which we could generate automatically from the EHR but is a less useful thing for the patient, potentially. You really want both lists. Here's the list of important things, and here's everything else. The patient's welcome to look at it because they may someday find something that wasn't checked that wasn't on the doctor's list.

That's why it became a very complicated discussion. For instance, plan of care: Do you mean really the instructions for the patient? Do you mean the inter-doctor plan of care?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, one of the comments that's going to make is ... a comment that I attributed to Einstein of saying, "Things should be as simple as possible, but no simpler." I think we have created actually worse of a problem by trying— In this interpretation of parsimonious, which is to lump everything together— hospitals, outpatient, office visit, discharge—those aren't the right concepts. So we have to understand what's the problem to solve for. What kind of information does each patient need at each transition? So a transition can be from the exam room and seeing a physician and what do I do afterwards, or transition can be from hospital to outpatient care. I think they have different purposes. So, I think the exercise was good in the sense that, well, when you try to combine them, you find out the details, and I wonder if we've

actually created more confusion. We've certainly created confusion even amongst the folks who worked on this stuff by trying to lump it all together. So that's—

Christine Bechtel – National Partnership for Women & Families – VP

Another construct then would be to preserve a distinction between the visit summary and discharge instructions and access and copy, but we could think about merging, on the EP side, access and copy into download where the greater list of information that we have in the document from Charlene is specified and more detail so that we're clearer about what we're really able to do with access. By re-naming it as download, then we clear up the what's—

I think most of the confusion around access versus copy was what's portable and not and people had different interpretations of— Copy to them meant portability, and it didn't really to us in our first go around. That was where access had it. It was just very confusing.

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

Are you suggesting three levels in effect? There's the instructions where you're telling the patient what to do. That's the most ... one. Then there's the access where the patient wants to log online and figure out what's been going on in their health that has more detailed. Then is there a third one which is I want my entire record, everything, every little bit of information? Is that a third one or is that combined with the second one?

Christine Bechtel – National Partnership for Women & Families – VP

Well, I think that's the question. From a parsimony perspective, I'm not sure that all patients need that. They already have a right to their full medical record under HIPAA. Now 20 years from now, this question will be irrelevant because you'll be able to have 20 years of back data, but if you need your record and you've been seeing a doc for 20 years, then that's what the copy piece gets you is more historic data. Whereas at least for 2011, 2013, 2015, it's only going to have a year or two of back data depending on when your doc implemented, right?

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

So then maybe, as you point out, there'll be paper from either before they had electronic health record and there may be some paper filing in that—I don't know if they're going to scan it all. So the full, complete chart is really a separate thing as a function, which could be part of meaningful use or might be just part of HIPAA. Access may not be the full thing, but it's really a pretty full reflection of the care encounter, whereas a discharge instruction or clinical summary are pointing to the patient to what the doctor thinks they need to see right now.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

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

We don't want to—

Christine Bechtel – National Partnership for Women & Families – VP

I think that ... makes sense. The only reservation I have is that there is not any kind of a downloadable access requirement for hospitals. They only have the discharge instructions.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right, and Christine, on that one, the concept came up in our conversation, if you listen to the ... what the gap was, was let's flesh out the content of discharge instructions rather than create a new concept of hospital summary because when the docs talk about discharge instructions, they put all this content in it. So rather than adding a new concept here, let's flesh out the content of the piece that we've got in there, which is discharge instructions and say it needs to have the procedures and the allergies and the follow

up plan and those kind of things as part of that rather than a new concept. Because this is the piece that the patient takes home and we don't introduce a new thing, because we add confusion to say, "Okay, there's a hospital summary." Well, what's a hospital summary to the discharge instructions? But when the doc talk, they talk about the elements that ... hospital summary as part of the discharge instructions.

Neil Calman – Institute for Family Health – President & Cofounder

Right, but I think that we're forgetting the who's using it piece. So, you're talking about discharge instructions, and from our conversation there were two kinds of uses here. One is what the patients need to do to know about their next appointment, the medications they're supposed to be taking, etc. The other is that right now, it's a document that transports information from the hospital, in the hands of the patient, to the follow up providers because we don't really have a mechanism to that at the current time. So I think that that's what we were trying to create is an appropriate document. We originally called it a discharge summary, but we didn't want to confuse it with the legal document that doctors dictate sometimes days later. What we're talking about is what's available to the patient. The first part of it could be what's for their use, which is this was your diagnosis in the hospital and these are your medications you're supposed to be taking and these are the appointments that have been made for you to follow up.

But then there's a larger set of information that's required when they hand that to the doctor that they're getting follow up care for. That includes last labs, diagnostic tests that were done. Not that we want to hide that from the patients. They can see that too, but I think it should be one document, the front of which is meant for their discharge instructions, and the subsequent part of it is the information that's available and important to transport back to the primary care physician at the time of discharge.

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

So, Neil, I would say that what you're describing and what Christine is describing as the new access copy could be the same thing. That's where we can be parsimonious.

Neil Calman – Institute for Family Health – President & Cofounder

I just don't think it makes sense to do the same thing for eligible providers and hospitals. Those records are completely different, their contents are different. I just don't think it makes sense.

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

Right, but it may not be the same thing, but ... we still have to define. So we need to figure out what the access, and I think Charlene's bringing in the CCD document is a nice laundry list of ... to choose from. So I think what we do is we just define the CCD. So I think I'm implementing, Neil, what you're suggesting. Number one, there's a discharge instruction—

Neil Calman – Institute for Family Health – President & Cofounder

Are we talking about hospital or EP now?

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

For the EP, there's a summary that you may want to give the patient that says, "Here's what I need you to do."

Neil Calman – Institute for Family Health – President & Cofounder

Well, we'll call that the visit summary. Because it's after each visit, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It is ... summary.

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

Well, wait—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Just don't put new words in yet but for concept wise, let's talk

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

Well, whatever. What would you want to call the thing that's analogous to discharge instructions, Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I guess, if we're talking about one, we would call it the visit summary and instructions or visit—yes, visit summary and instructions.

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

Okay. So then, now, we probably confuse people because clinical summary may have been interpreted as this visit summary, but let's go with that. Then besides that, which is a pithy thing—fits on one side of a page, you give it to the patient, the whole point is for them to read the whole thing—is access to a summary of either the hospitalization or a summary of the visit that goes into more detail. That could probably be assembled by looking at the CCD field, and that could be the access. The thing that you want them to access is probably the thing you want the next doctor to read anyway. So I think that's maybe where we could be parsimonious.

Then there's a different issue, which is giving them the whole legal record. Whether we address that in meaningful use or not, I don't know. So what we can do is take Charlene's CCD list, pick off what goes in what we're calling for now just access, keep the discharge instructions and visit summary ..., and that's defined clinically, and whether we have to actually enumerate the parts or not, we could discuss that. I could see arguments either way, whether we should enumerate what belongs in the discharge belongs in there. But aside from that, then there's the thing we will enumerate which is access. I think that we probably, in this section, cannot make every field we check off as mandatory. I mean, I think ... available at the present.

Christine Bechtel – National Partnership for Women & Families – VP

George, can we back up before you dive into the—

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

Sure.

Christine Bechtel – National Partnership for Women & Families – VP

I think I'm hearing three concepts. I might put slightly different language to clarify them, but I want to make sure that I'm tracking because I think that this is akin to what I mentioned earlier. What we would do is for EPs, we would maintain the visit summary. We might look at it and see if there's maybe one or two things that get added, but it's a short, sweet, point in time after your visit, what do you have to do next, what just happened. That's the visit summary.

Then the second piece is access to downloadable information, which is the piece that we would define with greater clarity based on the list that we've got from Charlene on CCRs, CCDs, blah, blah, blah. That's EP.

Then the third piece is on the hospital side. It's something like access to downloadable discharge instructions, which we would also then go through an exercise of doing some more specifying over what's at least in the final rule. So there's three categories. Is that correct?

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

Well, the discharge is—

Deven McGraw – Center for Democracy & Technology – Director

That's not what I heard.

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

Visit summary and discharge instructions are analogous. We have to define them because one's inpatient, one's outpatient, but they're analogous to each other. They're ... instructions. You could look at

that as one thing with ... two things. So, that's kind of one in my mind. The other is the access defined by the CCD.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, one, I think there's probably some detailed work that can be best done in the smaller group. So from here, I'm wondering if we can go try to identify the attributes. I'd like to make a contribution over what Christine said.

First, I think we are fairly in agreement that there's two settings: an office visit and hospitalization. Are two different settings and they have fairly different requirements. The other dimension is—I'm going to say them a little bit differently—three kinds of, I'm sorry to use the word access, but one is access, copy, and specific use document. So access is really a real time. When you have access, as information changes, you continuously have access to the updated information. That, I think, is a good thing and is our longer term goal. So everybody should have access and from access they can download or they can have a moment in time snapshot at any point.

Before we reach that point, there will be times when we want to go, "Give me all the information at a moment in time," and I think the word we've used there is copy. So that's analogous to walking up to an HIM department and asking for copy of my medical record. In the electronic world, it can be downloaded to USB or it can be in some other electronic format. That's the "download" function, but in the future when we have true access, then we won't even need that.

The third kind, of which there are two instances we've described, is the specific use document. We've described two times when that's of use. One is when you're in the office and you're going to walk out and you have instructions and a concise summary of what happened and what do I do next. That's been labeled the visit summary.

In the hospital setting, that specific use document is when you leave the hospital, in which case you have a very concise summary of what happened while you were in the hospital and what do you do next. That's independent of what gets transferred, in care coordination terms, from a provider in the hospital to providers in the outpatient setting.

So, let me summarize. One: There are two settings: the ambulatory care setting and the hospital. The second dimension is access, copy and specific use documents. Is that kind of segregation or categorization useful?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

No. I get what you're saying and I think we're saying the same thing, but it's the language—

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... because you've got a specific use in your first category but also in your last—I think it's short summaries available for both settings. Whether that's a visit or a discharge, there's a short summary of here's what just happened; here's what you've got to do. Then there's the ongoing access to downloadable information, which is the subset or set of CCR/CCD, more detailed stuff that you can grab. At any moment in time, you could build a subscribe feature on later. Then the third piece, I think, is the question that we haven't really addressed yet, which is your ability to get a copy of your record under HIPAA and what happens, which over time, if we focus on the first two pieces—short summaries that are downloadable and access to a bigger set of downloadable information—you won't really have as much of a need for.

Neil Calman – Institute for Family Health – President & Cofounder

Right, that's what I thought I heard Paul say, exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. ... the exact same thing.

Christine Bechtel – National Partnership for Women & Families – VP

There's one other comment, and this is ... under care coordination, we have a requirement to demonstrate the exchange of a CCD or CCR, which would seem to have to fit into this picture some way. Obviously we would want— We already have to export that, and so the intent would be at discharge, I would send a copy to the patient plus the additional data that Neil talked about, on this expanded CCD to the primary care doc, so they would have access, ultimately, electronically. Then patient would still take home their discharge instructions with their relevant information on it. So I always thought it was two things we would have to generate.

Neil Calman – Institute for Family Health – President & Cofounder

But I think that that's got to be a 2015 issue. The reality right now is the patient is the communication between the hospital and the follow up provider. That is the communication link. Except for places that are linked electronically, they become the major link. There's no reason why the patient shouldn't be able to carry something useful with them instead of a fifth generation NCR copy, which is what they do right now, that's got all of the information.

I think that we could call that ladder document the discharge instructions. It's a discharge from a patient visit as well as from the hospital. Discharge instructions and visit summary. Basically, it summarizes what happened during that either hospitalization or visit. It gives the patient, probably on the front side of it, the exact instructions as to what they need to do, what medicines they should be taking, and what appointments they have to follow up and any kind of self care instructions.

I think the rest of it is falling out really well. I mean, I think that record summary from the CCD or CCR makes a lot of sense for access. I think we already know people have access to their entire record and every system's going to need to have a way of dumping what that complete record is in some manner, either on paper or electronically, so that the patient can have a complete record of everything that happened in the hospital or a complete record of everything I have in my records here in the office. So I think we're there. We just need to flesh out the details.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I want to save the last ten minutes to go over the branch points so that we're on the same page when we present next week. So I think we do— Well, let me check. The kinds of segregation in terms of the kinds of "documents" that are made available to the patient, we have those categories. I think Christine and I were saying the same thing. I think Neil agrees. Can that be something that the small group works on and returns with at the next meaningful use workgroup call?

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

Well, I think the proposal is done. I can say it in one minute, so let me just propose it. Number one: We define what we mean by discharge instructions and visit instructions, just so people understand, when we're talking about it, what it means. I don't think at this point we actually enumerate the components, but I could be convinced otherwise.

Number two: Access and copy we combine in the way that Paul described, which is real-time access to the full record. They can download a copy at any time. That's how they get combined. Furthermore, what's required in that CCD is anything that we require elsewhere in meaningful use. The other fields that are in the CCD or the CCR, we say that if it's in the EHR, it has to be pulled over into the CCD, but we don't make those fields mandatory otherwise. In other words, I don't think we can mandate every last field to get checked off. So anything that is defined in CCD and CCR and the document that Charlene sent around, we put as what should be sent, but we only mandate it if either meaningful use mandates it or it happens to be in the EHR. That's our second level, and we can decide to make more things mandatory.

Then the third level: We don't touch yet because it's not really meaningful use, which is the legal thing about doing the full record. We could make a comment that that's part of HIPAA and can be worked out further. So that would be my proposal, and Charlene's already defined it by giving us the CCD. I think those checkmarks are it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think there's a lot more to be worked— I don't think we can include all these things. Could we take this to the smaller group because I just don't think we can have all these things in there? I do think you have to specify it—that would have to be specified in the rule.

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

So you don't want to include anything that's not mandatory to collect?

Christine Bechtel – National Partnership for Women & Families – VP

That's already mandatory under meaningful use?

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

Yes, that we make mandatory. That's a philosophical question the group has to decide before we do all this work.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I don't agree with that.

Neil Calman – Institute for Family Health – President & Cofounder

Me neither.

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

With what? What do say we should do?

Christine Bechtel – National Partnership for Women & Families – VP

I don't agree that we should be limited to what's in 2011 meaningful use from the CCR or CCD because I'm looking at the blue checkmarks, which indicate that. There are some big, important pieces, really important pieces that are missing if the frame is—

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

Well, we can make them mandatory in 2013.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Which is fine by me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So I'll just add this to my list of things to ask the committee. I don't think Neil and I are comfortable with that one yet.

Neil Calman – Institute for Family Health – President & Cofounder

No, not yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So let me move on to some of the questions on philosophical approaches that have come up over the discussion period. This is what we're going to present on the 20th for additional guidance, and as George mentioned so with this guidance, we can apply ourselves more on the details.

The first one: I think we had an opinion on, which was how do we position stage two? Is it an incremental change over stage one or is it a stepping stone to stage three? I think this group has agreed that it makes more sense and I think the industry and community would find it more helpful if we used stage two as a stepping stone to stage three.

The next question we had was migration to outcomes. We've always said the entire program is focused on how do we measure and improve outcomes, so that's been our target for stage three. What can we do in stage two to start orienting ourselves to that? We've put out a couple of examples, such as use of clinical ... support. We want to use that, but here's some of the things, the kinds of tools that should be incorporated in the EHR that certify stage two, but were not prescribing well the provider has to use this number of this kind and this number— It's more outcomes. Get the job done. That's what we're interested in most.

The third kind of philosophical approach is the recording, the measures. We started out with our example of quality measures that we thought were "HIT sensitive." That means measures that there's some evidence based on the informatic ... if you use EHRs, you can improve these quality measures. That's what we mean by HIT sensitive, versus let's come up with all the measures for all the specialties. That would take exemplar versus the 500 measures approach. We'd always been favoring sort of the exemplars where we can use something that applied to as large a scope of practice as possible and are based on evidence in terms of what can an EHR influence. So that's another kind of a ... question.

The fourth one is this whole notion of can you qualify, in a sense, for not having to go through all these process steps? So, the reason to have structural criteria or process criteria is because we don't yet have the ability to measure outcomes from using an EHR, for example.

Neil Calman – Institute for Family Health – President & Cofounder

But that's not the only reason, Paul. Just to jump in. It was also because we're using it to show that these outcomes are achieved with the EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, you're right. That's why it's sort of a question. So once someone is achieving a certain level of outcome—some threshold of reduced medication errors or achieved certain outcomes in terms of use of clinical decision support—do we really want to continue to have them measure the structural qualification of their EHR and the process things that they've done to achieve that? That's a question, considering that in the end, we're moving towards measuring and improving outcomes, and one of its uses is for value-based purchasing. How does that work for you, Neil? The question?

Neil Calman – Institute for Family Health – President & Cofounder

Yes. I mean, the tricky part because we've been working on this a lot, the tricky part to me is that we want the outcomes to be achieved. Right now, I think we're trying to get outcomes that are achieved through the EHR, so one is to pick measures that we think do that. But I think if you move totally to outcomes, then you create sort of a bypass where people go, "Well, let me just do this the old way. I can get the A1Cs to that ... without even having an EHR, without even putting that information in it."

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, of course, they always do that. First of all, by stage three, you will pass through stage one and two, which means you'll have all these tools accessible to you. You can choose to very laboriously and very costly doing it on paper or you can choose the much easier way. That's always a choice people make. But to reinforce the point we're moving towards outcomes measures, better outcomes measures, I think that— So that's the question to put in—and you can argue that same point in full committee—but that is the question.

Another question was this whole deeming question. So should external criteria, whether it's PCMH or whatever other external criteria, be used to deem qualification for meaningful use, or should it actually be the other way around? I'm just hypothetically saying if, to qualify for an ACO—you all know those rules are not out, but let's pretend one of them was some kind of HIT qualification, could you be deemed to

qualify for that component of ACO by being a meaningful user stage X? That's just the question to ask before the full committee.

Christine Bechtel – National Partnership for Women & Families – VP

I have an issue with that question. I mean, you mentioned ACOs and the rules aren't out, but the rules are out for medical home. I haven't seen anybody do a detailed crosswalk, which I think is really needed, between meaningful use stage one and where we're trying to get to and the specifics of level one, two, or three—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's not a rule from the CMS. That is somebody's private certification criteria.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I know. But, number one, those are likely to be used by CMS, very highly likely. In fact, they are in some of the existing demos that are going on, not under the meaningful use construct, but you're posing a question that a lot of folks are pushing for that and I have some real nervousness about because people have always said you can do medical home without health IT, and that defeats the purpose.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I share your nerves, but that's why this is a question for the group—to have this very discussion.

Christine Bechtel – National Partnership for Women & Families – VP

Can I ask why are we having the discussion at this point if we don't have a real context for medical home or ACO at CMS?

Neil Calman – Institute for Family Health – President & Cofounder

... anticipate that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. I'm trying to say, just like you said, you've heard people trying to push for this, that, and the other. Let's have that discussion in the open and see what the committee members feel about that, because that's sort of a policy issue. We should probably incorporate that thinking into our policy work.

The one that you just brought up is the mandatory—whether some of these things— Are we looking for sort of a “minimal set,” or a threshold set or are we trying to prescribe an entire, everything that's possible kind of an approach? So does that sound like the kinds of issues that have come up and which we'd appreciate further committee discussion? Not that it would be that brief. The challenge would be managing the time, really.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I think it gets to my question about why are we asking the question about ACO and medical home. I mean, if this is a discussion that has 20 minutes on the agenda and we're trying to both present our thinking and ask 6 or 7 philosophical questions, I don't think we're going to get meaningful discussion. How much time do we have for this piece?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We have up to two hours for our whole presentation, I think. I think this is the majority of that.

Christine Bechtel – National Partnership for Women & Families – VP

The committee, do you think, is looking for guidance from us on these issues or are we looking for guidance from them? Because it sounds like we're looking for guidance from them without having done some of the discussion on our own

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's a bit of what you mentioned, which is this discussions seem to be going on, either in private or in various pairs. Let's have the discussion in the open and let people weigh in and that can be input to

this group's deliberations, but if there's strong feelings on one or another, then that certainly will influence this. It's almost like the question we just ended on, as far as the earlier discussion, which is how much should we make mandatory. Well, there's a lot of work would go in if people say no.

We want to drill down and present some concrete recommendations—drafts, initial drafts—for people to react to. At this point, there are a number of these questions that have come up in our discussion and having a full discussion amongst people with other diverse perspectives would be helpful. Does that make sense, Christine?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Any other comments about raising those issues for discussion in the full committee?

Neil Calman – Institute for Family Health – President & Cofounder

Well, I think it's a great discussion. I think it's important because people that are moving forward in these areas are going to be involved in all of these concepts. They're going to be involved in medical home. They're going to be involved in meaningful use. The extent to which we can help people understand the synergies and the extent to which we can actually facilitate that, I think, is an important piece of our parsimony idea. That we should send out the clear signals because it's all about healthcare transformation. We should all be marching in the same direction.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That is the major point, Neil. For every new program, CMS or otherwise, we don't want to have yet more rules. To the extent that we can at least reconcile if not almost converge, that would be good for all concerned, I think.

Neil Calman – Institute for Family Health – President & Cofounder

The ACO piece fits in with the care coordination the most. So I think there's different pieces of this to pick up different aspects of meaningful use.

Christine Bechtel – National Partnership for Women & Families – VP

Just to be clear, I completely agree with that philosophically. Where I struggle is okay, I'm not sure we're going to get any disagreement, philosophically, that we ought to be aligned with the ACO, medical home, and other kinds of models of care. Really, we should be thinking about payment reform, too, and bundling and what capabilities do you have to have electronically to facilitate episode of care reporting.

But on the other hand, I have trouble getting to, "Well, how do we operationalize that?" Well, we don't know yet what any of those criteria are. So I think it's great to have a philosophical discussion. I thought we were trying to get farther, in which case I was going to struggle. So, it makes sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, we're not doing anything detailed. It's just sort of the point that Neil raised. Okay, we're at the end of our hour. Judy, do we need a public comment period or—

Judy Sparrow – Office of the National Coordinator – Executive Director

We do need one, so let's ask the operator to ask the public if anyone has a comment for the workgroup.

Operator

We do have a public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Would you please identify your name and organization?

Chantal Worzala – American Hospital Association – Sr. Associate Dir. of Policy

Hi. This is Chantal Worzala at the American Hospital Association. Thanks so much for having this call. Just wanted to comment a little bit on what is obviously a challenging issue of how do you both give summary information to patients, but also maintain the structure of documentation that is operational today. I guess I would challenge the notion of having to specify what is in discharge instructions for meaningful use. These are documents with a long history and have evolved over time and will continue to evolve in the future. I wouldn't like to see a sort of freezing of what they are. I think it's a fairly well known document.

If you do decide that you need to specify discharge instructions, I would certainly encourage you to work with ONC staff to first of all identify how many different variations of discharge instructions there are today. Convene both clinical experts and medical records experts who can tell you what is needed and what is done today and what might be anticipated for the future.

I understand that your taking of your model the clinical summary in the final rule. I would note that that clinical summary on the inpatient side in the final rule was manufactured by CMS in the final rule. There's considerable confusion in the medical community today about what this is and how it works and how to do it. So I don't think that it actually serves as a guide, that is something that is real and used and operational today. This was, again, something that CMS put together. In fact, in the final rule that CMS does indicate, that it is up to the clinical judgment of the professional to determine which information needs to be in the clinical summary. Thank you.

Operator

We do not have any other comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, and back to you, Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. This has been a very productive conversation and it looks like we still have some more additional work to drill down on some of the details, so I think we'll benefit from the committee's additional Thanks a lot and see you, what, next week?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you.

Public Comment Received During the Meeting

1. It is difficult to envision how the EP Summary of Care record envisioned by the Workgroup will be applicable to non-primary care specialists (i.e., most EPs). Shouldn't the summary of care record for radiologists be the radiologist report; and shouldn't summary of care record for pathologists be the pathology report?