

Meaningful Use Workgroup
Draft Transcript
December 3, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good afternoon, everybody, and welcome to the HIT Policy Committee's Meaningful Use Workgroup. This is a federal advisory committee meeting, so there will be opportunity at the end of the meeting for the public to make comment. The meeting will run from 9:00 to about 2:30, and there will be a lunch break. Just a note here too that the Internet in this building is acting a little weird today, so it might be somewhat delayed over your Internet connection. Let's go around the table and introduce the members of the committee starting on my right with Dr. Tang.

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

Paul Tang, Palo Alto Medical Foundation.

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

Charlene Underwood, Kindred Healthcare.

Christine Bechtel – National Partnership for Women & Families – VP

Christine Bechtel, National Partnership for Women and Families.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

David Bates, Brigham and Women's, and Partners.

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

George Hripcsak, Columbia University.

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

Michael Barr, American College of Physicians.

Marty Fattig – Nemaha County Hospital – CEO

Marty Fattig, Nemaha County Hospital.

Marisue Cody – Veterans Administration – Rural Health Specialist

Marisue Cody, Department of Veterans Affairs.

Judy Sparrow – Office of the National Coordinator – Executive Director

On the phone, I believe we have a number of members. Judy Murphy, are you there?

Judy Murphy – Aurora Healthcare – Vice President of Applications

I am. Judy Murphy from Aurora Healthcare.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Figge, are you there?

Jim Figge – NY State DoH – Medical Director

Yes. Jim Figge, New York State Department of Health.

Judy Sparrow – Office of the National Coordinator – Executive Director

Art Davidson?

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

Yes. Art Davidson, Denver Public Health, Denver Health.

Judy Sparrow – Office of the National Coordinator – Executive Director

Anyone else on the telephone?

David Lansky – Pacific Business Group on Health – President & CEO

David Lansky

Judy Sparrow – Office of the National Coordinator – Executive Director

With that, I'll turn it over to Dr. Tang.

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

Welcome, everybody, and thank you for taking the time today to continue to work on the meaningful use criteria. Let me ask, Art, I know that you're not here the whole time. Is there a window of opportunity to talk about the population public health section?

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

Your lunch break is from when to when?

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

It's scheduled for 11:30 to 12:15.

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

I think that I'll be gone for most of that and just a little bit after that, so the morning might be better. I'll certainly be back by 1:30 at the latest, 1:00 at the latest.

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

We don't get you later in the morning; we can make sure we do it when you get back.

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

Yes.

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

Super. Thank you. To refresh our memories, we had gotten through most of category one, which is the safety, quality, efficiency, and reduce healthcare disparities. We had gotten through all of the ones that were in stage one where we've updated it to stage two and stage three with a couple that we had for future. We were working on some of the new things that were put on the table, primarily through the hearing, and we'd gotten through the progress notes, the clinical documentation, the family history. Actually, family history, there was a bit of a parking lot, and I don't know, Charlene, do you have an update on that one?

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

I do.

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

Okay. For everyone, it's record family history. I have a printout, so I don't have the row number.

M

Thirty.

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

Thirty.

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

The request was just to find out the extent to which the vendor community captures this information, and most of them do capture it in some form. The comment came back was, well, there is a lot of variation because of the different types of practices and how they capture that information in terms of their need for it. It tends to be more of an ambulatory need, primary care needs, for instance, in the hospital, so it's a had one to generalize in terms of how we might want to standardize that. Operationally, it was a challenge ... the capability being there to capture the information, and the informational variance sometimes is not pertinent.

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

And probably it's not in a standard code set.

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

Exactly.

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

So we do have an issue there, and I'm not sure how the Standards Committee would be able to help us. That's just the current state of the practice.

M

But that's one that we could ask them to work on because it would be very valuable.

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

Yes. George, are you in charge of updating the matrix again?

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

Yes, and we're just trying to get me shared here. We were shared before. We double-checked our

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

Okay. The notation here is there are essentially places to put information about this, but it is neither well defined nor standardized.

Christine Bechtel – National Partnership for Women & Families – VP

We're going to ask the Standards Committee.

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

Right. That's correct, so given that, we'll ask the Standards Committee to help us out with that. The next one was specialist report to external

M

Can you tell me what ...?

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

Sure. We had verified that family history is recordable in many, if not most, EHRs. There may be a difference in how it's recorded in the setting of care, inpatient or outpatient. There are no existing standards. There's no standard way that standard coding system that's used. So our request of the HIT Standards Committee is, can they help us out with standardized codes for family history.

W

Or data sets.

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

Data sets, something that can be used universally so that when you transmit it from one system to another, it can be understood.

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

Paul, some colleagues in public health have suggested that there's a Surgeon General's my family history ... tool. It might be something we ask the Standards Committee to look at as a source for interoperability with EHR to PHR.

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

Thank you. The next row was about specialist report to external disease registries. I think you probably recall when we worked on stage one, we actually thought about that and had it as a placeholder. Then when we asked, we had a panel of specialists. A couple things we found out, one is there are a few out there. Well, there may be many out there, but there's a few that are used in a wide scale, and that there were some issues in terms of proprietary use of the data. Actually, all of the data was entered in a separate, electronic way, not transmitted from an EHR to the registry. So it didn't seem like the opportunity that we initially thought. I think, based on that, those findings that we elected to pull it from our recommendations.

Now it's open again for a discussion if people want to propose to ... it again or

W

What row are you on, Paul?

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

It's right under care plan.

M

Thirty-two.

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

Thirty-two.

W

....

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

No, care plan we had pushed over to care coordination. One proposal could be to not include it for the same reasons that we didn't include it in stage one recommendations. Do we have any other? I'm not sure registries have advanced in the past year, but that's one proposal, and I'd entertain any other proposals to ... discussion.

W

Again, I think the feedback from the vendor community was around the fact that it's hard to report to the registries because of the variation with each one. If there was a direction to start to standardize that data, even along the lines of exchange or in some mechanism that the line was something else, that would be really helpful if you want to go this direction. It was more the diversity in terms of reporting the registries, the complexities to the community to do that because they're also different.

David Lansky – Pacific Business Group on Health – President & CEO

There is an effort at the American College of Surgeons to create the standards that would apply across multiple conditions specific to features in specific registries. That might be a place to address Charlene's ... more information about that. The other ... we are in the middle of trying to upgrade extract files from multiple hospitals ... to registries ... from replicability and uniformity in the interface so that it is uniform and ... export, whether it's ... and I guess I hope ... standard ... uniformity ... so I hope we do ... because

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

Good points. Do you think this is another proposal we can move over to HIT Standards Committee in terms of both assessing the inventory in the current state of the practice, as well as pushing forward on standards that you suggested?

David Lansky – Pacific Business Group on Health – President & CEO

I assume it won't hurt. I'm not sure it would get us ... that they have a place ... their data ... to the larger goals of HITECH health reform ... standards ... incentives ... create access to information.

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

I certainly understand, but we have a little bit of a chicken and egg problem though, right?

David Lansky – Pacific Business Group on Health – President & CEO

Right.

W

David, I think the other thing was, I mean, as we're starting to look at reporting out of the measures that you're working on too, if there could be some alignment across the space, that would make it easier too.

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

Maybe one approach for at least stage two, as it sort of was in stage one, is to have exemplar measures in the quality measures area, and at least work on some of the standards for those measurements.

David Lansky – Pacific Business Group on Health – President & CEO

Yes

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

Any other further discussion or insight into this issue?

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

Paul, we're talking about external disease registries. Are we excluding cancer registries at state health departments?

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

We are not. We could include that in the population. What do you think?

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

Well, that's something that's come up in the suggesting as well at the public health meetings. We'll come back to the current population health discussion or

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

It seems a more natural fit in the population discussion just because it has such narrow— In other words, there are only specific registries we're talking about. How does that feel?

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

That seems fine.

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

We'll note that

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

What should I note there?

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

It's the combination of the clinical quality measures that would apply to certain specialties and working in the population health category for specific registries.

David Lansky – Pacific Business Group on Health – President & CEO

Paul, I think the

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

Correct. Good. The final one in this group was to use automated med administration management and electronic MARs in the hospital setting.

M

I think this is an important one. There's a note about replacing it with an outcome criteria, and I don't see how to do that. I don't think that's possible.

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

The feedback we got on that, again, this is one that most of the vendor community, at least in the enterprise space, provides the capability for, and there was pretty strong consensus from the clinical folks that this is a really important function. Then, from the CIOs, both for this one, as well as for clinical documentation, they felt was really important to signal these things are important so that they can talk about it and have a budget item for it. So I think we got some testimony last time that—don't presume that those things will just happen, and I got some concurrence on that.

Again, I think, in some places, they do happen, but in general, they don't. I do want to add one comment on clinical documentation. When I ask them how we should think about it, they said, "Well, look at your goal and say, 'Okay. If your goal is to support reducing falls and managing skin breakdown and those types of things, it should be structured around those terms rather than saying clinical documentation,'" so that was kind of the point there around that space.

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

We've had a couple comments in favor of having eMAR, an automated med administration management, as part of the objective. Other discussion?

Judy Murphy – Aurora Healthcare – Vice President of Applications

I would absolutely agree that eMAR should be on there. I do note, however, that there's a comment related to closed loop, and that feels like a bit of a stretch for stage two, but I think to at least have eMAR there would make a lot of sense.

W

Judy, by eMAR, the piece that we would put in there is the ability to quality check that the drug was administered with a quality checking capability. Is that what you mean by eMAR?

Judy Murphy – Aurora Healthcare – Vice President of Applications

Exactly, that you're electronically documenting it with drug/drug interaction checking, and I don't know if we want to specify that, and drug allergy checking. Those closed loop part that I was specifically referencing is where we know that the CPOE goes to the pharmacy system, goes to the eMAR. That's the part that feels a bit stretched at this point.

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

It seems like a lot of consensus in terms of including this for stage two. What about the terminology? Is automated med administration management well defined? If it is, we probably should include some definition there. So you're going all the way from

W

I think ... probably got something. I brought the certification criteria. I'm sure it's in here in one of these ... if I could read it.

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

Great. Okay.

W

In terms of how to define it.

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

Okay. Meaning that's already in stage—that would be in stage one.

W

No, this is what we were certifying to way back in

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

You mean with CCHIT.

W

Yes ... levels of certification

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

Right. That's correct, so we can piggyback on some of that definition. We can bring it back later on in the day.

W

Yes, I'll look at it.

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

Okay. Then what will we do with a threshold, if any? Thinking that it's not as if you'd use it partially in a unit, but you may have some units in a hospital that use it and some don't.

W

You'd follow the path of CPOE, 36

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

So the motion on the floor for discussion would be to go 30 and then 60 for stage three.

M

Yes, I would rather go to 80 for stage three. There are some units where it's very hard to do it. Notably the NICU is really tough, and so it would be reasonable to not have them all be at the same time.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Where this would be an issue is the outpatient areas of hospitals where there's very little pharmacy assistance.

M

We should make it clear; it just refers to inpatient areas. It's problematic to do it in outpatient as well.

Marty Fattig – Nemaha County Hospital – CEO

Outpatient or ER would be extremely difficult.

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

Now ER, since their orders— ER becomes one of those gray areas, watershed areas. So the ER orders, for example, counts if they're admitted, and I think it counts if they go to an observation area. That certainly gives us room or opportunity to say that this applies to the same population groups when they're in the ER or not.

Marty Fattig – Nemaha County Hospital – CEO

Yes. Just when you're running a code, you don't worry about an eMAR.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I don't know of many instances in which it's been implemented in an ER, and there's also no evidence that it's ... benefit I think it will be, but I just think we'd be getting ahead of things.

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

So the current motion I hear so far is 30% and then 80% in stage three, and for inpatient settings only, explicitly not ER and not outpatient areas of the hospital.

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

How should we phrase it?

W

I'm working on it.

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

Right now, I just have—I can't even read my own writing—

W

I'm just trying to

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

—80% of inpatient medication orders are tracked via electronic medication administration, and recording is not quite the right word.

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

Yes, I think Charlene is going to look for the exact wording to match the—

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

Right

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

—certification criteria, but I think you have a sense of it's EH, inpatient areas only, 30% and then 80%. We'll get some of the words in terms of how to describe this function later. We're at the end of what we had put in for our placeholders for stage two and three in category one. Any other additions?

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

There's a suggestion from the public health community around healthcare acquired infections and reporting to the National Healthcare Safety Network, which ... by CMS Is that something you want to put in this section, or do you want to hold ...?

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

It's for HAI reporting, did you say?

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

That's correct.

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

That might be in the public health. Does that sound fair to people? It sounds like it's a reporting requirement. There's a lot of head nodding here, Art.

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

It's just

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

Agree, but what isn't?

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

Right.

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

Are we ready to move on then to the next category? The next category is patient and family engagement. Christine and George and Charlene and Neil and Deven have put together a proposal for us to look at. It's included in handouts here, and I think you can see it on the Web.

W

Yes.

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

It's included on the Web. Christine, do you want to walk us through that one?

Christine Bechtel – National Partnership for Women & Families – VP

Sure. The five of us, if I'm counting right on the fingers, got together and looked particularly at the access and copy requirements from stage one. As you all know, there was a fair amount of confusion in the industry amongst stakeholders around what access meant versus what copy meant, which one would be portable, and could you take a copy with you or could you have access. Anyway, at the same time that there was a lot of confusion, I think a number of us became concerned that we would end up with particularly the access information requirements generating a situation where a patient sees four different doctors and has four different portals and doesn't have a way to pull that data together. Our work was to really look over all of the constructs of access versus copy and try to redefine the terminology to be more clear and to address some of the concerns that have been raised by a number of folks.

In the piece that you see on your screen, what we did was to start with eligible professionals and suggest that access and copy really become view and download. So, for EPs, it would be the ability— And we should say here, for patients to view and download relevant information contained in the record within 24 hours of the office visit. Or for information like labs, it becomes available subsequently to be able to view and download that information within four days of being available to the practice, which is very consistent with the timelines that we find for access and clinical summary in stage one.

We talked a lot about the formats and agreed that there are real pros and cons to both human readable and machine readable. That at least now we need to have some human readable data that patients can interpret that providers who maybe are not electronically part of meaningful use can interpret, and so we are suggesting that this particular criteria be both in human readable, particularly early on, but that also we begin moving toward more machine readable formats. We've got, as you see, a role for the Standards Committee to help figure out, for human readable, should we think about PDF or text? Many of you have seen the work that the VA has done and the Markle Foundation and Intuit and others have done around the download capability just based on straight text, and then CCR, CCD for machine readable.

We also defined the data elements. This definition is based on what was already included in stage one for the clinical summary or the visit summary, rather, in stage one. Then it is a bit expanded from that because we realize that for the access to information in stage one, we never defined what information patients should have access to, and so you see those bullets here. We're not recommending a change to the stage one objective for electronic copy of your medical record, which many of us are sort of thinking of as the full copy of the historic medical record and not all of which would be part of the electronic health record, if we're talking about historic data from ten years ago, for example.

Do you want me to dive into hospitals or start ...?

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

Just clarify that very last statement about, so the electronic copy did not include records that were based on paper. Is that correct?

Christine Bechtel – National Partnership for Women & Families – VP

No, it would, so this is the existing right that you have under HIPAA, which was clarified under ARRA to be a right to an electronic copy of your medical record. The reason we did not— George, you look like you want to say something.

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

....

Christine Bechtel – National Partnership for Women & Families – VP

So the reason that we weren't suggesting a change here was because you could either want a copy of the medical record, as it exists in an electronic health record because that's what ARRA really established was a right to copy where the data is also held electronically. But, at the same time, we know the patients will also want their full historic medical record and need to have, continue to have a right to do that. The difference with meaningful use is that it does put a three-day timeframe on that as opposed to 30 under HIPAA. Did I get that, George?

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

Yes. So stage one, which we're not changing in the explanation section says that it doesn't include paper, but you get it in three days, at least. It's the entire history, but only the electronic part. Then under HIPAA, you get the whole thing, but it takes a little longer, but you get the paper too. But under meaningful use, it's just what they have there now.

Christine Bechtel – National Partnership for Women & Families – VP

Right. Other questions on EPs or do you want me to do hospitals?

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

Let's pause for EPs. There is, download relevant information contained in the record within 24 hours. When you are seen in the office, probably the majority of records for that encounter are complete within a day, let's say, but that's not all of them, and probably not all of them or the vast majority. You wouldn't achieve that majority of them being complete within 24 hours.

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

We were actually just carrying forward stage one in this because, remember, in stage one, you wanted to give a summary of your visit within 24 hours. Then there was the issue of the lab test, and that's where the four days came from, so we kind of merged those two things, and that's how we ended up with that longer sentence.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

The clinical summary that was in stage one, that's where the 24 hours came from, and then just access to lab data. The access part, previously, that's where the four days came from.

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

I notice here it does not include progress notes because that's where a lot of it gets delayed a bit. David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I'm just getting a little concerned about asking for sort of multiple sets of data that are not all exactly the same thing. I'd like Charlene to come in, in a minute, about how easy this will be.

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

Which is the multiple, so just name them explicitly.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Say that again.

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

You said multiple copies. We tried to make it down to one, but what do you mean by multiple?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Well, there’s the CCD. There’s this. There are some other external standards for what should be exchanged when a patient’s care is transferred, which I don’t think you’re pointing to here. That one, I think, is an important thing, which is the superset of the CCD. I’m not opposed to this. I just want to point to the same things as much as we possibly can. That’s really what I’m concerned about, especially for the machine readable form part of things because the things that are not in the CCD, the marketplace will want some instructions about how to represent those.

W

I think all of these

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

So it’s ... from the CCD, so what we did is we went to the CCD and the CCR and found what was common between CCD and CCR, picked those fields, and listed them here. Now it could be that under the CCD rules, there’s something a little bit more vague, and this is a little more specific. This was picked because, in fact, for example in some cases it was already made explicit in stage one if you had requested data, so we said this is where it would go in the CCD. In effect, we’re just being a little bit more clear on what goes into the CCD, not presenting this is an alternative to the CCD.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

... that’s our intent. Now if the ... committee says no, this doesn’t quite work, we’re definitely willing to listen. We were just trying to do the right thing.

M

I had the impression that this was a superset of the CCD.

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

We measured it. I have that. I can share that spreadsheet. We actually have a spreadsheet that maps CCD, CCR in this.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

And meaningful use stage one. I may have it here somewhere, so I’ll look for it later.

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

So you want to call this list of data elements something, and maybe we can go back and keep pointing to this something. I think that’s a little bit of where David is coming from.

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

It’s the clinical summary. It’s the new version of the clinical summary. This is an expansion maybe on what was previously a clinical summary, but not an expansion on the CCD.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

Correct.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

It’s really the clinical summary for the patient, right?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

So maybe we should get the patient in there somehow, the patient clinical summary.

Christine Bechtel – National Partnership for Women & Families – VP

I see what you’re saying.

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

Patient oriented clinical summary.

Christine Bechtel – National Partnership for Women & Families – VP

... called the patient summary. I mean, I think there’s language already in the standard

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

Is there?

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

We also have to distinguish between a summary of the patient’s record in a sense and a visit summary that reflects what just happened.

Christine Bechtel – National Partnership for Women & Families – VP

Right, which this is not specific necessarily. This would include items that would be specific to a visit, but this is where we started was we got our brains wrapped around in a little bit of a pretzel because we were thinking about building off of the visit summary. But then, I think it was Neil, rightly pointed out that it’s a very specific point in time, etc. So we’ve broadened that so that they have access to a broader set of information, but would obviously include the latest visit information.

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

One of the things that could be specific are the clinical instructions.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Did you imagine this to be clinical instructions by date?

Christine Bechtel – National Partnership for Women & Families – VP

We have visit dates and locations and reasons for visit, and so at least in my head, George, I don’t know what you think, but I’m relying a little bit on the market to make this useful to patients and give them, for example, the ability to filter and sort by visit, date, location, etc. But also, at the same time, to have an aggregated list of their meds and allergies and procedures across visits.

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

It turns out it’s still hard.

Christine Bechtel – National Partnership for Women & Families – VP

It wasn’t easy to begin with.

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

No, right, so all I’m saying is it’s still hard. For each of these, there’s a state that exists at a point in time.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

That's one of the challenges, so even the problem list and medication list, two important things, exist in a state and time, and that can be pegged to a visit because that's when we got together, and we essentially looked at information that was available at that point in time. So I don't know what your thoughts there, so it was a problem list, today's problem list at the point of access, or does it have any ...?

Neil Calman – Institute for Family Health – President & Cofounder

I think that's a really important point, and also it helps to distinguish what we're trying to do here from the visit summary, so the visit summary is a snapshot, and this is more of a longitudinal view. For that, I guess, one of the things we're talking about here would be a problem list. Do you want resolved problems on the problem list? I would think that if you're looking at a picture over time, you'd want to see both the current, active problems and resolved problems. You might also want to have a medication history part that has what the past medications were in addition to the current because this is summary of the history. It's a summary of the history, the medical history. It's not really a snapshot in time. I think the more we can differentiate those things, the clearer it will be.

Christine Bechtel – National Partnership for Women & Families – VP

The piece that I struggle with though, Paul, is wanting both, and patients have real needs for both, and so at least as I look at this, I think this is something where this is about technology, and it shouldn't be particularly difficult to be tagging things active or previous prior and then allowing for a filter or a sort. So we were trying to be comprehensive because, as you note on the last sentence, this would subsume the visit summary. So you still need to have the acute specific point in time, but at the same time the patient needs to have the ability to sort of filter and look longitudinally, as Neil was describing, so this was designed to do both.

Neil Calman – Institute for Family Health – President & Cofounder

It doesn't subsume the visit summary. It's different than the visit summary because the visit summary— You want things like their next appointments, the things that you're supposed to follow up on, the referrals that are being made and other kinds of information that are not necessarily part of the history summary. It's kind of like patient instructions, patient education information. Those are things that are going on the visit summary. I think we really do clearly need to make sure that we're differentiating this from the elements of the visit summary.

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

Michael?

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

A couple of quick points: One, I think we should delink the term office visit from this because it should be any relevant encounter where there's a transaction or some exchange of information or clinical decision support. It could be for an e-mail. It could be a telephone. It could be a group visit, so I think we need to be careful about linking just to an office visit as the driver of this.

The other is when I look at my bank statements, I can choose the last five transactions. I can choose the last ten. I can choose the last 30 days. If we really want to be patient centered, we should give that type of option. Do I want the most relevant, recent five transactions, which would be more likely the visit summary, or do I want my complete history and have the patient have that latitude of choosing what information I want to view and download? That would be truly patient centered. I know that kind of bridges a couple of different other things that we're talking about, but I think that would be good functionality to start talking about.

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

David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think this is a really important discussion. They've just been having this discussion in Australia, and there was a very good editorial by Enrico Coiera in the *Medical Journal of Australia* this week about this.

In Australia, they were talking about just obtaining and circulating a very encapsulated, summarized thing that would not enable the sort of longitudinal thing that Neil is talking about. I think it's really important that we ask for both because they both are valuable. But we also just need to be very explicit about what we're asking people to provide so that the vendors know what we're talking about.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

It strikes me we've gone into the realm of defining a PHR, and it might even be easier than to figure out what's only a snapshot of something. You don't have a snapshot of an EHR, right? I think what I've heard is there's access to your full information, and there are helpful encounter documents like an encounter summary, which turned into this visit summary. They have different purposes. Yes, in the same electronic personal health record system, you can slice and dice and get these things out, but we may need to be explicit about these two "views" that have specific purposes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I think that's the question I had. I think we're all agreeing that we need both functionalities. I think the question is, do we need to say, "Here are the data elements, and these data elements must be viewable by encounter, as well as longitudinally"? Do we have two separate functional criteria, which is where we were and what we moved away from, which I'm fine to move back to because I agree; the market needs a clear signal on the intent here.

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

The patients, what's the value to the patient, right? I need to know what just happened and what do I do next. That's really important, and that definition doesn't exist, and this may be a good thing, particularly this is under the engage patients and families. That's something really important we can't necessarily just leave up to market. Marty?

Marty Fattig – Nemaha County Hospital – CEO

Yes. As you know, I'm very new to this committee, and I guess one of the questions I have is how much of this is covered in HITECH and how much is not? I'd like to see what HITECH says we have to do and then compare that with this so that I know because I know the Office of Civil Rights is holding me accountable for HITECH.

Christine Bechtel – National Partnership for Women & Families – VP

The privacy section of— that's

Marty Fattig – Nemaha County Hospital – CEO

But they also require patient access and a patient accounting and the whole works.

Christine Bechtel – National Partnership for Women & Families – VP

There's accounting of disclosures, which we're not covering here because, as you know, CR did a big RFI and was working on rulemaking.

Marty Fattig – Nemaha County Hospital – CEO

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

There's access to a copy of your medical record where the data is held electronically, which is the second objective in meaningful use that we did not change here, but that is distinct from what we're talking about now, so those are the two that I know of. But in terms of meaningful use, Congress directs the Secretary to figure it out, and that's what we're doing. Does that help?

Marty Fattig – Nemaha County Hospital – CEO

Yes.

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

Charlene?

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

A couple of comments just to align, I think, with what we were talking about. As we look at and the feedback from the vendor community is that need for consistency, so as you look at these data elements, some are relevant to the summary level. Some are level to the visit level, so there's a distinction there. I think, even in the standards world, there's a separate, if you will, document for each use case, so that's kind of one view on it. The other view, as you look across objectives, and we were talking about that, as we start to standardize or some of these elements have standards and a direction for, some don't, but as we align those things across the exchange of information with the sharing of information with the patient, the more we can start setting up. Here they are. These are the ones like the instruction We don't know what that means. For instance, this is standard. Visit dates and vital signs, we struggle with that.

As we can start to march down the path of standardizing those data elements, then they'll be able to be shared more effectively, both with the patients, the patient can do things with it, as well as across providers. I think we're almost kind of evolving to, and kind of this meaningful use data set that we start to structure and start to share. I think that's pretty powerful.

The other piece is that maybe in the definition there's a viewable, a hard copy form you can get that's in a standard format, but also rather maybe than machine readable, we start to talk in terms of structured data elements. Because what we want to do is to be able to enable the sharing of them, so it might be structured rather than machine readable. Maybe we should say structured.

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

Neil, and then I think George has

Neil Calman – Institute for Family Health – President & Cofounder

I have a question about the intent here. If the intent really is to make this a useful view of the medical history that's in the electronic health record, which is what I thought we were trying to accomplish. As opposed to giving somebody a PDF of 1,000 pages printed out of the record, but basically to give people a useful, usable, potentially transferrable view, then I think the question is, are we just capturing this snapshot, or are we capturing it over time? Are we looking at the immunization records over the last five years to look at every flu shot that they've gotten, or are we just looking at some time interval?

This is really a question: Does the CCD and CCR capture things historically and date it, so are we going to get the last three years of my blood pressures, or are we going to get just the most recent blood pressure? Are we going to get my current medication list, or am I going to get all the medications that have been started and stopped? I don't know what's in the CCD or CCR and whether or not those things are captured. Does anybody know?

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

George?

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

Actually, what I've seen of the CCR, it tends to be, it looks like an encounter summary. It's all the elements, but it's not But I don't want to go too far into defining how we use the CCD since we have a Standards Committee full of people who do this for a living. What I'd like to do is focus on the content we want, and that's why we actually left it kind of vague up there. We want a human readable form, whatever the Standards Committee thinks is best, and a machine-readable form, whatever the Standards Committee thinks best. Maybe the best way to do it is to give them the machine-readable form in a reader, but again, I don't want to get to that level right now.

Neil Calman – Institute for Family Health – President & Cofounder

... change that.

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

This is Plan B now, so take a look at what's on the screen.

Neil Calman – Institute for Family Health – President & Cofounder

But it says depict CCD or CCR. It doesn't say to establish

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

I'll clarify that. I'll fix that. The ability for patients to view and download relevant information about a clinical encounter within 24 hours of that encounter. The following data elements about the encounter are included, so the encounter data and location reasons for the encounter, provider, problem list, medication list, medication allergies. Now these may not all be relevant to every encounter. It's just only there if it's relevant. Procedures, immunizations, vital signs, diagnostic test results, clinical instructions, and then gender, race, this is just demographics that come along with the encounter, preferred language, advanced directives if any exist, smoking status. These are things that come along. Now they may not be filled, so we can decide which of these we want to take out.

Then, and this objective subsumes clinical summary. It's just an explanation of what a clinical summary is. Then the second one is now this one, which is the ability for patients to view and download relevant information contained in the record within four days of the information being available to the practice. This is the longitudinal record. This is the encounter dates and locations now plural. A visit actually should be encounters now plural. Providers plural, problem lists, medication lists, allergies, the rest are more or less the same after this. So is this the way we want to do it based on what the discussion just happened?

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

I think that sounds closer. In other words, we're taking steps even higher than that is what's useful to the patients and their families? One, I'd like to bring a clinical summary to whoever. Two, I'd like to know what to do from this encounter, as a result of this encounter that just happened. I think you've enumerated those. We might still have to go back and answer some of these questions of how many, what Neil said, how many blood pressures. What's the time domain for the clinical summary? But at any rate, Michael?

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

Two quick things: One, I like this, and I'm just wondering whether we should have a clarification about usage, George, about relevant data elements. In the longitudinal one, I wonder whether you need to have within four days of it being available. It should be any time the patient wants that summary.

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

You begin the summary immediately, but the data may not be in there for four days, and that was to ... the legal lab issue.

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

Right. It's really the requirement of the practice to be able to have all that information within four days of the encounter. But the patient's access to it can happen at any time because otherwise it implied a four-day window where the patient couldn't

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

Updated within the past four days.

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

First of all, on stage one, the provider has a couple of days to give the patient access. Once the patient is defined in their system as having access, then our belief is they should have real time access. But they may have access to data that's delayed up to four days to meet the state rules.

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

Updated within four days.

Christine Bechtel – National Partnership for Women & Families – VP

Maybe we need to clarify, to Michael's point, because we all know what we're talking about, but do we know what we're talking about, which is the ability for patients to view and download relevant information on demand contained in the longitudinal record.

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

Right, with the understanding

Christine Bechtel – National Partnership for Women & Families – VP

Updated within.

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

With the understanding that information may not be updated for four days after the encounter.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, right.

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

Any particular encounter occurs.

Christine Bechtel – National Partnership for Women & Families – VP

For which is up to date.

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

Exactly, something along those lines.

Christine Bechtel – National Partnership for Women & Families – VP

Within four.

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

Is the 24 hours relevant anymore because you basically said real time access? Let's try to get as much extra stuff out of here as possible.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. No, it is because you do need. I think the thing that we've struggled with in stage one was the argument that, no, you know what, my doctors don't really do their transcribing at all

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

But they get four days.

Christine Bechtel – National Partnership for Women & Families – VP

No, not under visit summary or encounter summary. The ability, the four days is really where it's up to date with when the new data comes in. T this is already in stage one. They get an encounter summary hopefully right there, as they leave the practice, but it is no later than 24 hours.

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

Right. Well, I still think the concept of they can, the way that we described it, they can access or download it at any time the moment they walk out. Some of the information may not be completely updated until four days. The 24 hours becomes a little superfluous from that point of view.

Christine Bechtel – National Partnership for Women & Families – VP

But you're talking about the encounter summary, right?

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

So do you want to say then the ability for patients to view and download relevant information about a clinical encounter immediately after the encounter period, and it's just immediately, and it's not 24 hours, which is what I'm hearing you say.

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

Well, they always have access to, which means they can immediately do anything they want. The currency of the data may not be up to date, except within the past four days.

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

I think that what we're trying to get at is that it's incumbent upon the practice in the first case to have updated information in the chart within 24 hours, and in the second case, the information is up to date within four days. But the patient, understanding that the data may not be up to date, has in both cases the opportunity to download at any time. Isn't that what we're trying ...?

Christine Bechtel – National Partnership for Women & Families – VP

Right, but the distinction that I want to make sure that Michael is saying

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

Let's focus on the visit encounter summary.

Christine Bechtel – National Partnership for Women & Families – VP

Right, but the distinction is that the date location, the reasons, the provider, problem list, med list, allergies, all of those things need to be immediately available, not four days, and I don't want to confuse us into thinking. The four-day requirement is for labs and other information that cannot physically be in the record or maybe notes. I don't know if that's debatable. If we take the 24 hours out, I'm worried that we're going to end up with the interpretation that you've got four days to get your record about that clinical encounter up to date, and that's too long. That would be backwards off of where we are in stage one.

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

I have a question. Do we need to say four days because how it would show up in your system would be, the order would be they're pending?

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

The notion was to try to force the issue, and lab was the exemplar. One, labs ... become available immediately. Two, you would like to have a chance for the provider to review them and decide what things need to happen.

Christine Bechtel – National Partnership for Women & Families – VP

Don't open that can of worms because I don't agree with that.

Neil Calman – Institute for Family Health – President & Cofounder

The problem with the four days is it's not relevant to all labs and stuff like that. Pathology reports take a lot longer. Reference lab reports take a lot longer. Cultures take longer, so there are a lot of things. Four days is sort of arbitrary.

Christine Bechtel – National Partnership for Women & Families – VP

... being available to the practice. It's not four days after the encounter.

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

That was said too.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, that's fine.

M

... get the lab, and you get a couple days to look at it.

Neil Calman – Institute for Family Health – President & Cofounder

The second comment, I think, since we've defined two different things, I think we should focus our conversation on one and then the other because we need to sort of drill down to the elements now. I think this is incredibly helpful, and I think what we're now saying is let's figure out what it is that we think is really useful in the summary of an encounter, and then look at the history summary and think what's really useful from the patient point of view at the summary history. I would, for this, I think, one of the things that we find the most useful is having a section that tells people what's up and coming, so that the referrals that have been made, the testing that's been ordered, future appointments, and I think that stuff needs to be put into the clinical. I always think the clinical instructions as more kind of like the health education information. I would call these out much more specifically because we're trying to really say what they are.

M

Let's state them

Neil Calman – Institute for Family Health – President & Cofounder

I think future appointments, referrals

Christine Bechtel – National Partnership for Women & Families – VP

It's sort of a pending category.

Neil Calman – Institute for Family Health – President & Cofounder

... and scheduled

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

Now you're getting into the practice management system.

Neil Calman – Institute for Family Health – President & Cofounder

The what?

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

You're getting into the practice management system, so if you have an EHR, and it's not necessarily linked, you may not be getting that information. Not that it isn't helpful, but one of our principles was this is a floor. When you turn it into a meaningful use criteria, you're making everyone have to do that, and all the implications

Neil Calman – Institute for Family Health – President & Cofounder

Well, you set the— Nobody is going into the practice. A provider presumably isn't jumping over to the practice management system to suggest when the future appointment time is. You could maybe even put future appointment request because those are done through the electronic health record. When the provider sees the patient in the EHR, how do you request a future appointment?

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

Let's say you're in a small practice and refer to a specialist. How would you know that that request for the appointment was made or that the appointment is such and such with the specialist?

Neil Calman – Institute for Family Health – President & Cofounder

That's an order. I guess you could summarize all of these things as orders. We could do that, a summary of orders.

Christine Bechtel – National Partnership for Women & Families – VP

Pending orders?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, a summary of orders. I think that could be done as well because that would then say what labs were ordered. People, when they leave the encounter, they should know what's been ordered. So it would have what labs are ordered, what x-rays have been ordered, what referrals have been ordered, and any follow-up appointments that have been ordered.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

If those were in clinical instructions that would be okay too, is that right?

Neil Calman – Institute for Family Health – President & Cofounder

I think it should say clinical instructions, and I think we should say future orders or current and future orders.

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

David, do you want to say something?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think this should reference this against the CCD. Again

Neil Calman – Institute for Family Health – President & Cofounder

But I thought we said we weren't.

M

Again, the CCD

Neil Calman – Institute for Family Health – President & Cofounder

We don't want to limit....

M

... Charlene. I mean, they're categories.

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

They actually did have breakouts for, and I think they have one category, which is the care plan and interventions, which is kind of what we're talking about, and that's kind of in the space that you're talking about, so it's kind of care plans. But it's so vague. It's not standardized yet, so this discussion we're having isn't drilled down to yet.

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

I'm a little nervous about having that kind of a prescription without an ability to communicate it in a standard way.

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

... future order sits in, in the CCD, so I know that.

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

Okay.

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

This is for public comment, not for going to the thing, so I think being more clear on what we're thinking of, even if we have to back off based on the public comment may not be a bad thing.

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

Yes, but I think we

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

We could actually explicitly say David's point that this needs to— That's what I was trying to capture in the HIT SC statement is I want ... comment ... that doesn't make sense right now because it's a useful thing, but it doesn't fit in with the modern standard or something.

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

Christine?

Christine Bechtel – National Partnership for Women & Families – VP

That's exactly what I was going to say. I would just say, I think we've been trying to catalog, as we go, a list of specific questions for the RFI, and I think this is one of them.

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

This is one of them.

Christine Bechtel – National Partnership for Women & Families – VP

I agree that this is— What I like about this bullet is that it's what connects the 24 hours to the 4 days for the patient. I go okay, so this is all of my stuff from today, but I need to go back into the record in a couple of days or in a week or two weeks because I know that I've got these new pieces of information that are going to be coming to me. So I think this is a really important bullet.

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

Other comments? Where are we closing the loop with the 24 hours? Just leave it that way, because it's not clear what's 24 and what's 4 days?

Christine Bechtel – National Partnership for Women & Families – VP

One is 24 hours of the encounter, and the other is 4 days of the information being available to the practice.

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

Yes. Exactly. You don't get four days to review the lab results if you just had an encounter because if they got the lab result, they should have reviewed it during your encounter, and now you can get it. You don't need to wait four days.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

If it came back after the encounter, then that's not part of the encounter, and you still have your four days. Take a look at what I wrote for the next one, and then see how to apply that back up.

Neil Calman – Institute for Family Health – President & Cofounder

Wait a minute. Which one are you in now?

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

Now I'm going to go forward to the longitudinal one just to see the time limits I put because your question is, you want to be consistent, so just look at the blue for a second. What we're saying there is the ability for patients to view and download relevant information contained in the longitudinal record, which has been updated within four days of the information being available to the practice. Viewing and downloading is on demand. Once the patient has been defined in the system, the provider has four days to define the patient in the system on the first request. In other words, you have some lead-time because the patient who is not in your office, but is home calling you, I don't care if it's four days or not, but you

have some time to get the patient an ID and a password. There has to be something. That's not on demand, but once you're in, then it's on demand. So that's the complexity of the thing.

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

To reduce the complexity, can we separate that whole enrollment out of this ... basically want to? Let's go back to

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

Ability ... enroll

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

It's a separate step.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Yes, because otherwise how are we ever going to measure this?

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

... separate it out.

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

That's what I was trying to do ... sentences.

Christine Bechtel – National Partnership for Women & Families – VP

No, but George, what I'm saying here

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

Okay, so take it out completely.

Christine Bechtel – National Partnership for Women & Families – VP

No, what I'm saying is I like having an enrollment piece because that gives you the ability to measure

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

That was the challenge that we had and why the percent for access was so low in stage one because CMS was assuming—Josh can correct me if I'm wrong—that 10% is 10% of your entire panel was actually using the functionality and that would give us the ability to address that separately. Whereas the ability to view and download either the clinical encounter information or the longitudinal information, that ability should be available to 80% of patients or whatever the threshold is, but it's for how many people are actually enrolled and using it is a separate question. So this actually gives us a third objective that allows us to address that in a more reasonable way.

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

Correct. Can we move this to a separate objective? We'll come to it later. It may be the first one because it sort of precedes everything else, but can we put a placeholder? We'll talk about it in objectives specifically about enrollment and use because it's one thing to hand out a bunch of passwords, tokens.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

It's another to actually engage. That's what this category is all about. Back to encounter summary.

Christine Bechtel – National Partnership for Women & Families – VP

Which one are we doing?

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

Which is your bullet one, you're saying that the patient has the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter, and they have the format.

Christine Bechtel – National Partnership for Women & Families – VP

Charlene is suggesting structured instead of machine-readable. I don't know what the difference is.

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

The implication is ... structured, is exchangeable data.

Christine Bechtel – National Partnership for Women & Families – VP

That's what we intended.

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

I know that was the intent.

Christine Bechtel – National Partnership for Women & Families – VP

We're not techy.

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

Right.

M

... structured.

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

Structured, or whatever word we end up as part of the—we'll hit again in care coordination.

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

Right. Now in this case, so far you have not introduced the concept of four days. Is that an omission?

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

There's no four days on the clinical summary.

M

No.

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

There's no four days on the— Well, the encounter summary does have four days because you just had lab. You just had some procedures done. You want those results, and we're trying to say the patient gets to have them within

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

Well the visit summary is the thing that happens while you're in the doctor's office, and they just reviewed all your labs. If it's a lab, that you then get ordered and it comes back in a week, that comes under the second rule

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

I don't think

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

... clinical summary.

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

But from a patient's use point of view

Christine Bechtel – National Partnership for Women & Families – VP

I'm with you, Paul. The tie is the orders, future This is a question I don't know the answer to. Is it enough to say here's the clinical—you get the clinical, I'm sorry, the encounter summary within 24 hours, and it tells you what you need to look for in the future. Then once that lab test is available, then George is right. It is under the longitudinal objective, which includes everything.

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

But I think that people look at, okay, something happened, and some questions were raised, and I had some tests done. I go back to that, and I say, and what happened? Just like a doc does this too. You go back and, what happened? So the results actually not only flow into the results section, it flows into the encounter documentation itself. Similarly, a patient would want to know, well, the doc—had this workup for X. These tests were performed. I'd want to see it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that makes sense.

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

All we're doing is we're communicating a sense of time and also creating a commitment on the part of the provider.

Christine Bechtel – National Partnership for Women & Families – VP

George, maybe we do need to add a second sentence that says for information that is not available during the encounter, it must be included in the clinical summary within four days of the information being available to the practice.

Neil Calman – Institute for Family Health – President & Cofounder

No, that's the second part.

M

It's the second part.

Christine Bechtel – National Partnership for Women & Families – VP

No because— Yes, but also what Paul is saying is it's basically the second part where the filter mechanism ... to make it the most easy. Tell me if I'm wrong, Paul, but to make it easy for the patient to use the information in context, which was the context of the encounter. You would want that lab data that was relevant to that encounter to actually become part of what is in effect an updated encounter summary.

Jim Figge – NY State DoH – Medical Director

Can I give an opposing point of view? I think the encounter summary should be absolutely restricted to the information that's available at the moment of the encounter. It's really important, particularly if you're taking care of patients who have other caretakers that are going to be seeing them immediately after that encounter, so what's critical to convey on the encounter summary is what the immediate care plan is, and that might include, as Neil was saying, plans to get lab work, x-rays, etc. It might include some suggestion to try a change in the diet, to do this, do that. It's whatever has to happen immediately in the care over the next day or so. That really should be the limit of the summary. If there was any data that was reviewed during that encounter, that'd be in there, but data that is expected to come in the future really doesn't belong in there because that's down the road. The patient might have been to three or four

other places. Their condition might have changed in the meantime. That's data that comes in the future, so I would strongly oppose adding anything after the fact to the encounter summary.

Christine Bechtel – National Partnership for Women & Families – VP

Even if the lab was ordered and is directly relevant to that encounter, so I went because I wasn't feeling good, and they did a strep test, but I think what Paul is raising is right, which is, the threshold question here is how is the data presented most usefully to the patient? If I have to go digging through my entire longitudinal record in hopes that I can find that lab of the strep test, it's much easier for me to be able to go to the encounter summary and see that there's a new piece of information, which is the results of that strep test. But I propose that rather than getting twisted into a pretzel that this is a question that we should ask. I would rather include both the 24 hours and the 4 days in the encounter summary and ask an explicit question about the context in which the data is most useful for patients because that should be our lens.

Jim Figge – NY State DoH – Medical Director

What's most useful for patients is to know what they have to do next as soon as they leave the office.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, but that's

Jim Figge – NY State DoH – Medical Director

They have to know that they have to go get that strep test. That's what the encounter summary needs to tell patients because otherwise they walk out of the office. They have absolutely no idea what to do. If they're under care of 24-hour care, let's say, that they're a disabled patient, their caregivers need to pick up that piece of paper almost immediately to know what has to happen next. But even very intelligent patients usually walk out of the doctor's office in a daze and don't know what they have to do. The purpose of this should be to tell people step by step what am I supposed to do next.

Christine Bechtel – National Partnership for Women & Families – VP

But that's included in here already, so what you have to do next is part of it. It's not

Jim Figge – NY State DoH – Medical Director

And that should be the purpose of it.

Christine Bechtel – National Partnership for Women & Families – VP

... not following why there's resistance. Is it data overload for the patient? Is it too hard for the practice? I'm just not tracking.

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

Jim, we have a couple people in the room: Michael, Neil, and George.

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

I agree with Jim on the phone, but I think we're misinterpreting, at least I'm having a different interpretation of what the second part of this is. It's sort of like going back to the bank analogy. I deposit five checks. I could check my balance today, but the balance will be changed in three days when the checks clear in some cases. When I want to go back and see my new balances, I can, again, say I want to have those transactions in the last three, four days. That's what I'm looking at in the second part for. I think that the snapshot is the clinical summary, as I walk out the door. That's what we really want to focus on now. We want to be able to have that same patient not have to go through 20 different encounters on the second part, but to filter. I just want the most up to date information that's been available to the practice within the past four days, click. Now I have all the labs that may have come down the road after that clinical encounter. That's how I'm viewing the two different parts of what we're discussing.

Christine Bechtel – National Partnership for Women & Families – VP

... we haven't specified a filter, a function in the longitudinal data that says you've got to be able to filter.

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

Well, I'm suggesting that that might be something we suggest.

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

That was going to be my exact suggestion too. I think, as people's electronic history expands over time, we're going to need to call out the fact that this information has got to be organized in some way that enables you to go in and look at your most recent data without having to look at all of the data for the last 20 years. I think we need to call that out. What I would call out in the summary, in the encounter summary is instructions on how to obtain results. I think that's really important so that if there are open orders and are open results, people should be directed to how they could obtain those results.

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

George?

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

I guess the concept; my concern is that it's hard to draw the line of what is part of this encounter versus the next. I'm doing a test. Does that get lumped to the back encounter or to the next encounter where the doctor is actually going to look at it and check it? If you order a procedure, is that going to ... encounter, or it's kind of an affect. The linking, so I kind of, and if I get a summary of my encounter on paper, what I get is the encounter that the doctor knew that day when he typed it up, and that's what I consider the encounter. Then I do tests, and I saw that as what our second half was trying to solve.

Theoretically, I like the idea of an aggregated thing that makes sense, and that's what you're asking for. I was hoping that the way that they'd put it together for number two was in a logical form that I could understand. But if I'm actually asking for the formal encounter, I just get what Jim was saying. But I'm not absolute on this. That's just my thought process.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I think we have to ask about it in the RFI because I think we need to specifically ask what is the most useful for patients. It's hard for me, based on my ... over here, to imagine that if I've got a strep test, and I want to know the results of that, that it's not part of – it's not connected back to the instructions and the other pieces of my care plan that are really part of the clinical encounter.

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

I think it's defining problems, so you know that you went with chest pain to the doctor. Some things were done. You had an EKG. You had some blood tests, etc. I would like to find a way to go back to figure out and what's the result of what happened in that encounter

Jim Figge – NY State DoH – Medical Director

That's too complicated

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

... rather than looking— What did you say?

Jim Figge – NY State DoH – Medical Director

I think that's what part two is.

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

But, part two, from the patient's perspective, the patient has to know all the tabs to go look for what were even relevant. The patient doesn't know what's relevant to that complaint they came in with. They know that things were done to them, and they should find it in the

Jim Figge – NY State DoH – Medical Director

Maybe you're right. I don't know. I'm thinking that it's actually hard for a human being to pull the things that occur after into a logical thing that a person can interpret. Is the doctor going to write a second note four days later to pull in the results of the tests and interpret them and everything?

Christine Bechtel – National Partnership for Women & Families – VP

But they do now, right? That's what my doc does. She goes, here's what happens on your pap test, and here's the result, so I get a note from her at the same time. That's happened in my

Jim Figge – NY State DoH – Medical Director

We may be going too far. I don't know.

Christine Bechtel – National Partnership for Women & Families – VP

We're not mandating that, but

Jim Figge – NY State DoH – Medical Director

No, but we may need to mandate. If we really want this to work, you may need to mandate that the doctor actually touches the chart and doesn't just look at the result, but actually does something and say here's my interpretation or here's

Christine Bechtel – National Partnership for Women & Families – VP

But aren't they supposed to do that already? Right? I mean, aren't they supposed to call me with the interpretations?

Jim Figge – NY State DoH – Medical Director

I don't know. How many progress notes, so every time a lab comes in

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

Our system does this automatically. When we go to view this encounter, it has all the orders and all the results every time we go back, and that's a very helpful thing for it to do.

Jim Figge – NY State DoH – Medical Director

Yes. All right.

Christine Bechtel – National Partnership for Women & Families – VP

It's part of practice today. I expect my clinician. If it's a call or an e-mail or a portal, I don't know. But I expect somebody to follow up with me and interpret the labs.

Jim Figge – NY State DoH – Medical Director

Yes.

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

And you can understand, let's say, a phone call.

Christine Bechtel – National Partnership for Women & Families – VP

Because if you're not going to follow up, I hate to be feisty, but if you're not going to follow up with me, then give me the lab data directly from the lab. I don't want to wait four days for you to figure it out if you're not going to tell me what it is. Good. Farzad is here just in time for me to be feisty. He'll be so shocked.

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

Charlene?

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

With a standard pap, because we've been talking about two different kinds of use cases, in the CCD CDA world, CDA is kind of the overall architecture. Then there are different document types. The CCD, CCR was always intended just to be that. Again, its initial purpose was truly for exchange with other providers,

but its intent was that snapshot context. When you're done, it's a snapshot of what your current state is of the key elements that you need to share. Then there's another concept that is the more holistic view in terms of sharing more information in the record. I think it's valuable to distinguish those two concepts in terms of defining, and I don't want to say use cases, but they kind of are use cases. It seems like we got those two categories of things, and I don't think we should specify what the standard is, but we want a snapshot. It seems to be a pretty clear requirement. Then we want to be able to view the whole picture and have access to this data.

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

I think we're having trouble defining what's the complete snapshot. It's not actually a snapshot. It is a different concept. It is a summary of what happened during an encounter.

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

Yes.

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

Another scenario, George, is the patient calls back and says I was in to see Dr. X a couple days ago, and I want to know what happened with my blood test. You would go to this piece right here, the encounter summary, and lo and behold, both the order and the results are there. It's very common, both for patients, doctors, and I think the patients in the future. Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I'm just going to make the case again that I think that what we really are calling out here is that that second summary of the history needs to be updated and usable because if you just look at the orders part of this, it's not just the result of the pap test that comes back in four days. It's also, you're going to go to a specialist, and they're going to generate a report, and you're going to want to have access to that, and that might be three weeks out, or a mammogram that gets scheduled, and you want access to that. There are things that are going on, and the summary of the things that were ordered on that visit are coming into the record sequentially for quite a period of time after that.

What I'm really interested in is, I want a patient to be able to go into that history summary, the second summary that we've defined, and see a summary of their history updated by all of the information that I've updated the medical record with. I think just sort of saying, just sort of looking at the lab test is really a short-sided view, and I think people want to know their x-ray results. I think they want to know their referral results. I think they want to know a lot more than that, and so rather than say labs are going to go into this summary, but in terms of updating the referrals and other stuff, people are going to have to go into the other summary. I would just say, this is a snapshot of stuff that's available at the time of the visit, and everything else needs to be updated within four days of receipt and is available within the history download that we're providing you. We should call out that that needs to be organized in a way that highlights and makes accessible the most recent information for patients in a way that's easily accessible. I think that would sort of solve our kind of dilemma.

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

Are you saying an up to date— I mean, the focus is of the encounter summary and it's up to date when it's asked for. Right? That's kind of what you're just saying.

Neil Calman – Institute for Family Health – President & Cofounder

It's updated. It's an encounter summary.

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

Because it's up to date if new results are there. New results are there. It's just an up to date encounter summary.

Neil Calman – Institute for Family Health – President & Cofounder

No, I'm saying that about the second summary, the history summary that we

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

I think we're

Neil Calman – Institute for Family Health – President & Cofounder

The encounter summary basically is something that says here's what I know about you and what we've ordered at the time of this visit, and you walk out of the office visit. Everything that flows into the record after that is getting updated in the history summary that is available. If we call it out that people that that needs to be organized in a way to be specified so that the most recent data is readily accessible. I think we've accomplished both of the things that we're trying to do.

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

I think the thing that's missing from what you just described is the context. The patient doesn't have a notion of here's a test result that's come in two weeks later. Why was that relevant? In the encounter summary, it provides the context and the relevance. I can go to one place, the encounter summary, and know everything, and know all the results that pertain

Jim Figge – NY State DoH – Medical Director

Why wouldn't that be in number two?

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

Because you have to go search for it.

Jim Figge – NY State DoH – Medical Director

No, number two could be structured

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

You're saying you don't have to structure for it.

Jim Figge – NY State DoH – Medical Director

You could organize number two by lab test, by data type, or you could organize number two by the encounter.

Marty Fattig – Nemaha County Hospital – CEO

And not only that, the encounter date and locations might also include any communication that may have occurred since the initial encounter, such as Christine's doctor letting her know the results of her test. There's another documentation, so it's going to give a little more information.

Jim Figge – NY State DoH – Medical Director

I would say that what you're doing is you're adding another item, so there's one thing, which is, I just went to the doctor. Give me my counter, which was originally in stage one was, give me a piece of paper, which says what just happened. That's what this guy was up here. Then now what you're saying is a reasonable thing, which is, now I want the follow-up to that, which is a little bit, it's like it's longitudinal, but it's organized by the problem. Then I also want to look at my longitudinal record. Then, fourth, I want to have a copy of my complete record for courts, so forget the fourth one for now. The question is that middle, the second one I just said, which is the one that you're proposing now. Should we shove that into number one, or what's currently number two, in effect? The way to shove it into number two up there would be to say, here's how it has to be organized. You're saying we should overload number one and say, well, it's one day if it just happened, but four days, so you're overloading it too. That's why we have two different timelines.

Jim Figge – NY State DoH – Medical Director

... limits.

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

Kind of from a design perspective, this dimension is really important because from the designer system, I've got to be able to track the data elements by encounter, so I know which one they're tagged to, as well

as longitudinally because I've got to store that data. In any case, I'm going to keep the system up to date, when new data comes in. However you view it, you're going to get the most recent, up to date information. I think that just goes without saying. Keeping this encounter dimension as a view, I think, is important. I don't know. I can't discern why you'd want one more, like if I get it today versus four days. Why do I have to have another variation in terms of do you have to have a snapshot of exactly what happened in the encounter as a dimension here?

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

Let me get the queue. Farzad and then Art.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

We have to be thinking a little bit about how the technology and the kind of environment may evolve over the next few years. There may be developments like processors or readers or apps that patients might want to then use to present the data to them or provide them with advice or sharing or whatever on top of once the data becomes liquid, on top of that. I think we're seeing a lot of that already with Blue Button and the work that many other folks, and I think Adobe has a really nice example of that where they take a very simple text file, and then they process it on behalf of the patient in different views.

I think we should maybe worry a little bit less about specifying the exact format of whether the human readable part of the display should be by encounter or chronologic by category and not potentially the risk of over-specifying according to the use case that we're naively, I think, thinking about now of patients going to look at it right then and there without intermediation of other applications. I guess the implication is, let's not worry too much about the format of how it is. As long as the information is there, it could be presented any number of ways.

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

Art?

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

Yes. Thank you. I think I agree with what Farzad just said, and I wanted to focus more on If I understood Jim Figge's earlier comment, let's limit the encounter view to the content that occurred or was observed or notated during a visit. I like the idea that Michael Barr mentioned about having this filter on dates, and it seems like you should be able to get your encounter as soon as you leave the office, just like Neil and Jim were saying. There's value to that patient and their caregivers. Then, after that, if we need to get the lab result, the mammogram, the pap smear, whatever it is that would come in afterwards, you just filter it down and say I want it since my last visit. That way you could say I want the entire 20-year record, but that would be putting the concept of a filter, as Michael suggested, on that longitudinal record and not worrying about trying to push the content from subsequent labs into that first view, that encounter view.

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

Right now, it's listed as a question, so I say, question, should follow-up tests that are not ready during the encounter be included in future summaries of that encounter with a four-day lag? One approach would be to leave it as a question instead of specifying one or the other and would be an approach because it doesn't affect what we do in two. We either add here or don't add here.

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

What you just suggested was to ask the question of what

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

To literally ask the question in the

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

Right. That seems reasonable to me. How do others feel?

Christine Bechtel – National Partnership for Women & Families – VP

I think that's good.

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

Okay.

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

Good. Now that that's settled.

M

What was settled?

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

... for the ... meeting, so now we've got to double-check the longitudinal record.

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

Yes.

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

Paul, the question about the filter, is that going to be something we come back to later, or is that ...?

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

You want to word how you want to phrase it?

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

I think Art did a good summary of what I was trying to explain. I think that that or try to suggest. I think truly from a patient centered perspective, if you want to be able to collect the information from a specified time period. Now we have to be careful obviously, because you don't want to—for referrals and those things, there's some information that might flow outside the window of the patient picks. So there's some physician or clinician responsibility to make sure that an adequate amount of information goes to wherever the patient is and the patient not picking a window that doesn't include their EKG that was terrible two years ago.

Christine Bechtel – National Partnership for Women & Families – VP

... 30, 60, 90 days plus.

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

I think what the patient sees is going to be different than what the physician might send, but I think that's the option. I mean, to narrowly focus it just on the last clinical encounter and everything fits or to go back for the last whoever long we think is reasonable from the technical perspective.

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

Let's see. I think there are three things maybe. Farzad basically said let's make sure they're data elements that are available, and then let the market decide how to render them in useful ways. Then there is the other side, which says, we think the following kinds of information should be presented to everyone. That's sort of the other extreme. Then there's the in the middle, which is, well, maybe not because, Michael, that's similar to what Farzad said in a sense, unless what you're adding in the middle is to say, and there must be 30, 60, 90 days views. You know what I'm saying?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

If I were to take a bit of what Michael is suggesting, it would be to say that it's really one function. It's an ability to access your information and that there might be the ability for the patient to filter that request on the basis of date, encounters, conditions, type of data, so that you would have—basically it's one function. It's, I want to get my information, but then the ability to be able to filter the request in some ways.

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

Right, so that is in the middle where it says not only must you make these data elements available, you must implement these filters, and I don't know whether you'd enumerate these filters versus have some enumerated "encounter" documentation.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Pre

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

The thing that I agree with Farzad and it was actually, where we sort of started this conversation about what's the role of the market, and I agree there is a role. But I'm also, at the same time, cognizant of the fact that not every patient is going to be savvy enough or have the time to sort through the mobile application marketplace and pick the one that they want and figure out how to do all of that. I think there ought to be sort of a basic level of, as a data holder, I'm opening up the ability to view and download your data, and I'm going to give you a platform to do it. If you want to use your own platform, that's absolutely fine, but here is a platform to do it, and as long as that platform includes the ability to download it, and I think we actually need to get to upload in a second, then we go from there. So if we agree with that approach that there are probably a lot of patients who want to just use the portal that they're given or the PHR that they're given or pointed to or whatever, then I think it is useful. It's a little bit of a rabbit hole, I agree, but I think it is useful to have this filter ability just as a minimum basis sort of functional criteria.

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

George, the two questions to pose to the public, so that we can get information and then figure out where they lie.

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

I was thinking, instead of a question on this one, we could ask it as a question. What I did is I said, well, maybe what we could do is signal what we expect to happen without mandating it because we don't know exactly how it will come out. So I'd say who we—now who "we" is, I don't know, so I have to fix this a little bit, but—we expect patients to be able to filter or organize information by date and counter diagnosis, etc. Is it enough to just signal what we want to happen without mandating what the vendors actually supply or is that too—or CMS won't know what to do with that?

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

I'm not sure. Neil?

Neil Calman – Institute for Family Health – President & Cofounder

For one thing, I would take out diagnosis. We can't even do that now. Human beings can't even do that now. Medications are prescribed for more than one condition. I don't know how people would attribute a medication to one condition or another when they could be used for any one of six different things, and I just don't think we should call things out that are going to be impossible. And I think, if we want to simplify the call out to do this, we could basically say, in the most simple frame, we could just say that there should be two views, one that says the most recent information in every category, and one that has the complete history. Rather than making people sort through date ranges and encounter ranges and stuff like that, maybe the first cut is just to say there's one view, which is just the most recent information available. So at your last chest x-ray, your last labs, your last medication list, your last everything, and the other that basically has the full range in it because I think, if we get into all of the different ways you can sort the data and stuff like that, and I agree. I don't think we can depend upon third party applications. If we're calling this out, we need to say we believe this needs to be done by vendors in this context now because we don't know whether people are going to – those applications are going to develop. I think they will, but I agree, I don't think we should be putting the burden on the patients to try to figure out how to get access to the stuff that's in there.

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

Could the two things that we offer for comment, one is essentially what Neil just offered, which is, there's a set of data, and then there's an enumerated e.g. filtering by states and providers, etc. Then there's something that maybe Christine and I work on to say here might be what you call an encounter summary, and we'll just spell it out, and we'll just ask for comments because that can flush out some of the public sentiment. Does that sound fair?

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

When we want to ask a question, is the proper way to do it is to be we're thinking...?

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

We're thinking of two

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

... another way to do it is to include it with the idea that it can always be stripped out because, if don't include it, then you're not asking the question. You're not opening this thing for comments. So the way to, another way to ask a question is to just include it.

Christine Bechtel – National Partnership for Women & Families – VP

But strategically it's usually better

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

Rather than ask.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

We could talk about an alternative that was discussed in the workgroup was the following, and that gives them the ability to react to that. The more restrictive would be something like we originally started out with, which is, there is an encounter summary, and it looks like this. There was an alternative discussed, which is just to have data available with filters. How does that sound?

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

I'm trying to decide. Is Neil's version this version, or is it two different things? Neil is going for the simple button.

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

It's a data with filters.

Neil Calman – Institute for Family Health – President & Cofounder

Most recent.

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

No, most recent, that's what Neil's is, which is different than this.

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

That's part of the e.g., right?

Christine Bechtel – National Partnership for Women & Families – VP

... most recent ...?

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

Paul?

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

Yes.

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

Did Neil say that there would be a filter or not?

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

He's proposing that there are filters, and

Neil Calman – Institute for Family Health – President & Cofounder

I'm proposing one simple filter. You either ask for the most recent information, or you ask for all the information.

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

But ... organized by encounter or date.

Christine Bechtel – National Partnership for Women & Families – VP

That I think we're going ... too far down

Neil Calman – Institute for Family Health – President & Cofounder

Yes. Then I think we're really getting too far. I think it deals with, Christine, hopefully her issue that we don't want this to be so complex that people can't find what just happened to them, and that also....

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

Remember, they may have multiple visits with multiple providers, and so how do you chase down did the cardiology ...?

Neil Calman – Institute for Family Health – President & Cofounder

Yes

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

I mean, we sort of really take the patient's point of view of this. All right, so we'll work on the wordsmithing in terms of the two kinds of things we'll offer for comments is sort of the pre-formatted version of the encounter summary and this filtering approach.

David Lansky – Pacific Business Group on Health – President & CEO

And maybe one of the questions to the public is, well, what kind of filters would be the most useful? I don't ... can of worms, but this is an important

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

I think that's going to be way

David Lansky – Pacific Business Group on Health – President & CEO

If it's really going to be patient engagement, that's something we probably ought to ask.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I agree.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

You've got to remember who the public is that comments. It's not mostly people who are on the street going like, gee, what would be most useful for me is this. It's really, David, you know, vendors and people deeply in this space.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

And I feel like we should be describing what the providers should provide, and that other entities will be doing some of the filtering and making it available, as Farzad suggested. I just don’t think we should get in....

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

To filtering at all?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

I mean, it should be filterable, but I think that’s not what we’re talking about here....

Christine Bechtel – National Partnership for Women & Families – VP

The easy fix is go back and include the updated info in the encounter summary because I think that’s how we got down this can of worms was how do you get the most recent. So if you have it in the encounter summary, and I still haven’t totally heard a compelling reason why we wouldn’t do that, then you wouldn’t need to specify the functionality of the longitudinal presentation. I’m just saying.

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

That’s why we have two options....

Jim Figge – NY State DoH – Medical Director

But the problem with that approach is that, let’s say in the initial encounter with the primary care, you order lab work for somebody’s diabetes. You send them to an endocrinologist. In the meantime, they land in the ER. Then there’s going to be a whole chain of data that links in some logical way, but branches off in many different directions. And a month later, the patient wants a summary of everything that’s happened to them since that encounter about their diabetes. You can’t just link it back to that one encounter because there were many intervening events. It would be more useful for the patient at that point to be able to get a logical summary of what’s going on with their diabetes. They may date it back to that first encounter, but it’s not all part of that encounter.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

But who is going to provide that? Who is going to curate it?

Jim Figge – NY State DoH – Medical Director

There needs to be some logic in the system that can provide a reasonable data flow of what happened with their diabetes. Maybe they also had a mammogram done at that visit, and they also want to know what happened to my mammogram, so it does relate back to the initial visit because that’s where the whole chain of events started, but that chain has taken a very circuitous route, and it branched off into many different branches in the meantime.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

I think that would be nice. It goes far beyond the capabilities of the current systems. Right now there’s nobody. You need a person really to curate that.

Jim Figge – NY State DoH – Medical Director

You can do it if you specify the starting date. You say I want to see my information back to this date. And you could probably sort it by problem, if you have a problem list, active problems, mammogram, diabetes. It wouldn’t be that hard to sort the information.

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

Let me take this opportunity to create a bridge. I think we’re not going to close on this issue, and we do have a couple of options to present to the public. I think we’re actually going into the second one, which is the clinical summary, your overall health summary, so why don’t we take that opportunity to move into number two, George, which is the overall clinical summary?

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

Yes. I think we're in there.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

We're in there.

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

Just remember, there's 2013 and 2015 is another concept we have and reminded ourselves in the last couple minutes, so there is a concept of what we envision should be the neatest summary in the world for 2015. 2013 is just getting the data and see how it goes. That's another alternative. That is, just to say that the data should be filterable and leave it at that for now and not worry about how it gets filtered for 2013, as an alternative anyway.

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

I also wanted to make a comment relevant to the currency of the information as it relates to the encounter. As you have all those events occur, and kind of what David was saying, if the data comes in, and you don't know who to map it to, the system has to figure out, do I map it to an encounter, or do I map it to an order. Then you don't want to necessarily always have a human intervention every single time you get a piece of data, so it gets really complex to figure out what encounter. Is this associated to this encounter, or is it associated over here to this result? And then it's going to require a provider to look at the data and map it. You don't want to go there....

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

Let me comment on that. That may be one of the reasons to try to pin this down. If you generate an order, and in the 2015 world and beyond, it should have a couple of things that identify the results to that order. That just helps everyone.

Christine Bechtel – National Partnership for Women & Families – VP

That helps a lot.

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

That helps everyone, and that's why it may be important to start making the distinction now that goes into the Standards Committee that goes into certification. It's really important to be able to – and so the accompanying thing is tied to this encounter. Let me just put that on the table. It seems like the goals, which turn into technical criteria, technical specs, is to be able to map each order and is to associate each result with an order and an encounter and a provider. Does that make sense? I think there are lots of downstream benefits to that.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

What we're saying is if we do start tying things to encounters, that's one of the things that goes along with the order so that it can come back and be matched. I just think that's very important.

Neil Calman – Institute for Family Health – President & Cofounder

And if we're looking downstream, then we add back in diagnosis and other things, and we should start calling that in because that way people can then filter things to look ... by condition, but right now we don't have that capability.

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

That's right.

Neil Calman – Institute for Family Health – President & Cofounder

But downstream, we'd want that capability.

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

And you know what, I think – so if we agree to this principle, we'll probably fold it back up to CPOE because that's probably where it belongs. I'm seeing—for the people on the phone—a whole lot of nods in room. Is everybody agreeing with that?

Christine Bechtel – National Partnership for Women & Families – VP

Comes back....

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

It comes back to CPOE. Then that gives us at least a capability, if the public would rather just have given me the data and we'll filter, sort, and make applications versus having it laid out in a specific way.

Christine Bechtel – National Partnership for Women & Families – VP

Should we do hospitals?

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

Yes. We're ready. Yes.

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

I would suggest that we just do this and say, in one, just say that future summaries, and this could be struck out by the public, but future summaries of encounter should include tests that are linked to orders in this encounter with a four-day lag, recognizing that we may be told that's going too far, and then get rid of the filtering on number two. No?

Christine Bechtel – National Partnership for Women & Families – VP

You can't just say....

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

No, but I have to put it in for 2013.

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

I didn't understand that, George. In bullet two, that's the clinical summary. It seems like, why would you want to eliminate filtering?

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

Because I think it's....

Neil Calman – Institute for Family Health – President & Cofounder

You need it more there because there's more data and....

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

Yes, you need....

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

I know I need a lot of stuff. I just, you know....

Neil Calman – Institute for Family Health – President & Cofounder

Well, we're trying to....

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

The question isn't what we need. It's what we should specify for meaningful use for 2013, so I'm trying to make it feasible. I'm trying to think if we put vague things like filtering, and we have three alternatives, four alternatives now, it kind of shows that we're kind of....

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

It seems like what we need to do, and it may be very helpful, are some of these things we need to specify that they are coded in standard form, and that automatically means, well, you'd be able to filter on those things.

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

Right, so do we need to say anything but that?

Christine Bechtel – National Partnership for Women & Families – VP

George, I don't get your logic, George, but I think it's subtle, and I think it's easier to have it in both places ... get public comment on it.

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

What should I put here then? This is not good, so what should go here instead?

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

It seems like it's more prescriptive than you need--

Christine Bechtel – National Partnership for Women & Families – VP

Alternatives, yes.

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

--because if we have date in standardized form, which we have to, you'll be able to filter on them, as an example.

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

So I should put a question, which says should patients be able to filter or organize by date encounter, etc.?

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

I think we decide we say what should be encoded in standard format, and then we say that there'll be filters.

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

The vendor will supply filters for the patient. I'm not going to say this literally in there, but the thought is that the vendor will supply....

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

Exactly. I think it's very natural. What we're doing is to help them is to declare that everyone has certain things in standardized format so that when you go across vendors, and even customers of one vendor, it'll be filterable in a consistent way.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

So the suggestion is, patients should be able to filter or organize information by structured data?

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

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Coded data elements?

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

Yes. Do we need to enumerate which of these data elements should be standardized? We've already commented on, I hope ... is already there. Do we have dates in stage one?

Christine Bechtel – National Partnership for Women & Families – VP

...dates.

Neil Calman – Institute for Family Health – President & Cofounder

Encounter date?

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

Certification criteria for dates?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

There's got to be a date.

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

I hope so. Does anybody at ONC know if that's true?

Christine Bechtel – National Partnership for Women & Families – VP

The visit date is part of the visit summary.

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

Yes, but there needs to be a consistent way to represent dates.

Christine Bechtel – National Partnership for Women & Families – VP

It should be in the certification....

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

Farzad is still smiling....

Christine Bechtel – National Partnership for Women & Families – VP

Because it was ... I'm making an assumption, but because it's part of the visit summary in stage one, it should be part of the certification rule, right?

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

But let's just make sure it's so.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

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

Now interestingly, reason for encounter currently does not have a standard, and there's probably not even a data set. I mean, there's nothing for the Standards Committee to point to.

Christine Bechtel – National Partnership for Women & Families – VP

But that's part of why we said human readable.

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

That's fine, so I think we don't have an option there. Problem lists we already declared ... where are we going?

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

I need a working PC and an editing....

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

That's right. Go up to....

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

This is it. This is where you're supposed to be.

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

Providers, that's the NPI, and what's the status of NPI?

Christine Bechtel – National Partnership for Women & Families – VP

Isn't that being...?

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

NPI is coming under information exchange, right, the NHIN? NPI will be a given, yes?

Neil Calman – Institute for Family Health – President & Cofounder

I don't think that's been decided that that's the way the providers are going to be identified.

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

I thought, isn't that part of the proposal for the authentication?

Christine Bechtel – National Partnership for Women & Families – VP

...provider directory....

Neil Calman – Institute for Family Health – President & Cofounder

Because not everybody has got an NPI that provides an encounter.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

I think we have to be careful not to try to do the work of the work of the Standards Committee.

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

Yes, I agree.

Christine Bechtel – National Partnership for Women & Families – VP

Right, but isn't this the care team?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

That's right.

Christine Bechtel – National Partnership for Women & Families – VP

It's your care team.

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

We're calling then we would like to have standard in this area.

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

I think all of these are coded except maybe clinical instructions.

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

I think we would like them all standardized.

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

Well, reason for...?

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

There may not be a national standard, but that's up to the Standards Committee to define, but we know there's a standard for dates.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Yes, I think you guys say what data elements you think should be there, and the Standards Committee will process it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I totally agree.

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

The other piece of input in terms of data that I think is relevant to medical home is like the concept of shared goals. I don't know where that goes. Typically it would be under the care plan, but here's the shared goal that the provider and the patient negotiates, so does that fit in? I know that there are standards for that.

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

That was ... we moved that over to the care coordination the last time we talked about it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, but you know, I think what that raises for me is we at least need a placeholder because I think that if we have a shared care plan, which I hope we will under care coordination, it should be something that's accessible to the patient, so it should actually be on the list.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We've called that a longitudinal care plan.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

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

You have a data element. Isn't there one in that group...? Is there a data element for that?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I don't know if – it's not really specified.

Christine Bechtel – National Partnership for Women & Families – VP

But the Standards Committee ought to be able to help us because some of what is in the current list ought to be in the shared care plan anyway, so I think it's really figuring out what the delta is. Even if it's a human readable PDF it's fine, but for 2013, we ought to have a reference to, George, shared care plan or care plan is.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Longitudinal care plan.

Christine Bechtel – National Partnership for Women & Families – VP

Thank you, David. Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Where...?

Christine Bechtel – National Partnership for Women & Families – VP

And it gets stated with that list.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, you could put it after language or something.

Jim Figge – NY State DoH – Medical Director

Question: Is the longitudinal care plan, the shared care plan is part of the longitudinal care plan.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

...for the same thing. I mean, I think it's....

Jim Figge – NY State DoH – Medical Director

I don't know. Christine, is it, because I thought that what you were talking about is the agreement between the patient, family, and the clinical team in terms of what that plan for their self-management, engagement, goals are versus the larger, longitudinal plan. But I could be wrong. That's why I'm asking for clarification.

Christine Bechtel – National Partnership for Women & Families – VP

I don't know the answer. I thought it was part of the longitudinal.

Jim Figge – NY State DoH – Medical Director

Part of, but it's not, I mean, the question is, are you asking Christine for it to be as specific, as George has put up, shared care plan documented in the longitudinal summary as opposed to just calling apart the longitudinal...? I mean, I'm interpreting it differently perhaps than others. That's why I'm seeking clarification.

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

This is Charlene. The shared care plan encompassing things like orders and the instructions, what you have to do next because I'm self-managing these conditions. So it's a higher level, so at a minimum I think you want at this level, at least what the goals are, you know.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I think that the difference in approach, shared care plan or care plan or longitudinal care plan in my brain right now is a placeholder on this list because, if we take the same approach, which I think we probably should, with the care plan, as we are with you and download, then we ought to define the minimum data elements or the minimum data elements, but not necessarily data specifications, but data elements that should constitute the longitudinal care plan. Then what we need to do is come back to this single bullet and figure out, based on the overlap and differences, what needs to be added into the list.

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

George, would you mind annotating that particular item, like square bracket, see care coordination or something because we have to come back to it because no one would know what a longitudinal care plan data element would be?

Christine Bechtel – National Partnership for Women & Families – VP

Right. That's a good call, Charlene. I forgot that.

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

Thank you.

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

Okay. Good.

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

Moving on to hospital—

Christine Bechtel – National Partnership for Women & Families – VP

It's very exciting. All right. We've done two things here, and then based on this conversation, as I'm thinking about it, there is an explicit assumption that we've made or one that I believe is implicit anyway that I want to make explicit. The first thing is that we want to – we're suggesting that we change the – you

get discharge instructions upon request to 80% of patients who are offered. In other words, would you like your discharge instructions electronically? That's the first piece.

Then the second piece is the ability to view and download relevant information that is contained in the hospital record within 36 hours of discharge. Then what we've done is, similar to what we did above, but we based this data list again on CCR and CCD, but what's going to be most relevant to the patient from the perspective of somebody who is being discharged from a hospital. That's the new objective. There's no change, again, to the stage one objective for copy for hospitals.

Let me call out the implicit assumption that I think is here, and George and Neil and Charlene can correct me if they think I'm wrong. I think our assumption was, there wasn't as much of a need for ongoing, what we used to call access to information, in the longitudinal way because the hospital presents an acute event. A hospitalization is a specific acute event at a point in time. But if that's our assumption, then I think what we do need is not only do patients need access to the core information that's coming out of a hospital, which is the bulleted list here, but then I think the piece that we're missing is the ability for the patients not just to download that, but potentially to upload that to other providers. I want to parking lot that because I think it's complicated, but I want to make sure we talk about it today. So there's a change in the stage one objective with respect to on request versus offered to everybody. Then there is this new, reformulated objective around view and download the hospital information, which would include discharge instructions.

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

Comments? Offered now becomes a new requirement. When you change the word "offer," now how are you going to measure this?

Christine Bechtel – National Partnership for Women & Families – VP

It's attestation, the same way that everything is in this.

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

But 2013 is electronic.

Christine Bechtel – National Partnership for Women & Families – VP

I don't think so.

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

I don't know.

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

This is Charlene. I think the same feedback came from the vendors. How are we going to measure it? And if it's there, it's there.

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

Yes.

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

When you say the ability to do it, now again, if it's used meaningfully, I think, is what you're trying to push for.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. That they've offered to 80% of the patients who are being discharged, would you like your discharge instructions electronically? But I don't see, for much of the criteria that we've already agreed to, how you're going to measure beyond attestation anyway, so let's leave that one aside.

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I guess the meaningful use part of it for me is the ability to take the information that's in the hospital record electronically and produce this document. But I don't think the meaningful part to me is whether or not it's produced electronically for the patient because I think it's more useful at this point for somebody to walk out with a piece of paper than with a disk or a thumb drive with this information. And so I think that I would want 100% of the people to be given discharge instructions, and what I'm afraid of is if we call it out as having to be 80% of them have to get it electronically that we actually run the risk of sort of impeding a process because I know 80% of my patients can't take this electronically.

Christine Bechtel – National Partnership for Women & Families – VP

But the last line says consumers who have a paper could still have a printed copy of what we'll now say the encounter summary or....

Neil Calman – Institute for Family Health – President & Cofounder

So they're not doing the 80% then. That's where I think we have....

Christine Bechtel – National Partnership for Women & Families – VP

No, they've been offered. They've been offered electronically.

Neil Calman – Institute for Family Health – President & Cofounder

I know, but....

Christine Bechtel – National Partnership for Women & Families – VP

And they can say no; I don't want it. I want it on paper. But I'm a little bit nervous about mandating a paper process in a meaningful use context.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Maybe you could move it up to – right next to....

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Because I was thinking the same thing.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. For sure. George, we can move the last sentence down to be part of – basically copy and paste and just focus on discharge instructions.

Neil Calman – Institute for Family Health – President & Cofounder

But if the threshold is just offering it, then we should make it 100% because why should we – do you know what I'm saying? Basically you say to people, we'd like to give you a discharge....

Jim Figge – NY State DoH – Medical Director

Because they left against medical advice or some weird thing why you couldn't offer it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, or we can see how it plays out, and then in 2015 look at 98% or something, but for 2013, that....

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

Is there a reason, Christine, why it isn't just the ability to view and download like for EPs?

Christine Bechtel – National Partnership for Women & Families – VP

You mean, why did we call it a data element?

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

No, upon request because...?

Christine Bechtel – National Partnership for Women & Families – VP

This is actually another piece that we need to be aware of, and we may not have taken the right approach here. The first bullet is specific to discharge instructions. The second bullet is a much larger set of information.

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

Yes. I guess I'm commenting on the first one. Why isn't it an analogous to EPs, the ability to view and download?

Christine Bechtel – National Partnership for Women & Families – VP

Discharge instructions.

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

Yes, to Neil's, I would think most people, including myself, would want the paper and someone to review it across, going out. But, later one, I'd want the ability to view and download.

Christine Bechtel – National Partnership for Women & Families – VP

The discharge instructions.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I think that's great.

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

Marty?

Marty Fattig – Nemaha County Hospital – CEO

As a hospital, I would much prefer to have upon request rather than offered. I don't know how I'm going to measure, document, substantiate the offered piece. And if we can't do it, why require it?

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

When a patient leaves ... I've not been hospitalized, so what do I know, but when a patient leaves the hospital, is there a standard set of documents you have to give them ... sign something?

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

So why wouldn't you have a big orange piece of paper in there that says if you want your discharge instructions electronically, and then you've just done it for 100% of your patients.

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

Farzad?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

I guess the question I would ask is, do we have strong reason to believe that people having it electronically is superior in terms of their health than them having it on paper?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Is the offer is getting, driving, creating a new workflow and a new standard of care essentially that drives the receipt of the discharge instructions in electronic format a public good, social good?

Christine Bechtel – National Partnership for Women & Families – VP

We acknowledged obviously that it was in stage one since everybody has to have that capability to give every patient their discharge instructions electronically.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

It's a little bit different. Having....

Christine Bechtel – National Partnership for Women & Families – VP

How they get it is different. It's upon request versus their being offered to, but the public good is still the discharge instructions, which is what I hear your question asked.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

My question is, it is clearly important for patients who want it electronically to be able to get it electronically, and that's what we covered in stage one. I think the discussion now is, is there a compelling reason to push on this issue to push for electronic over paper on the discharge instructions?

Christine Bechtel – National Partnership for Women & Families – VP

I'm still not understanding your question because we already have done that under stage one. Maybe I'm not getting it, but let me tell you what the goal was.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

On stage one, we say you could do it either paper or electronic.

Christine Bechtel – National Partnership for Women & Families – VP

But for people who know to ask for it, which is the big problem, they can get it electronically. But let me speak for myself. What I think certainly in the National Partnership and our coalition of consumer groups have talked about is the culture in healthcare that we have where, A, patients always have to ask for something, and they may not feel comfortable. B, they don't know that they can get it electronically. There's no consumer education campaign that says, by the way, you can get your discharge instructions electronically, and the culture of healthcare needs to shift so that it is electronic as the default and that every patient gets told. By the way, you have this option. Now if we preserve the second objective, then I think we have to have the same discussion. And if the second objective is going to be that the ability to view and download is offered to 80% of patients, and the view and download is all of that, I think there's more value in that, and we probably don't need the first objective because it's included, discharge instructions under the second.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Yes. I'm, I think, like Marty. I'm questioning the setting a metric for number of people or percent of people who are offered.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. It's simply an education. I don't see any education initiative to tell patients today, oh, by the way, you could now get discharge instructions electronically, or to tell, more importantly, their caregivers. I don't see how it's going to happen, and I think, if it's not going to be taken advantage of because people don't know about it, then why do we include it in stage one. So it's really a culture change that's designed to actually get people to use it.

Marty Fattig – Nemaha County Hospital – CEO

Just to be fair, I tend to be conservative on these things, but just to be fair, upon request, I'm not sure how I'm going to document that one either. How do I document the ones that were requested and I said no? The ones I gave, I have, but the ones that were requested, and they said no, I don't know what to do.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

No, I agree. It's not so much the data collection burden because, unless you go with something like we did with 10% had it done, like we did in stage one.

Marty Fattig – Nemaha County Hospital – CEO

Right.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

The on request and the offered both provide a manual data collection burden, which is new to document within the system some process. But what I'm more asking about is creating a new standard of practice around this new process of offering things to people.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, and I'm okay with that in healthcare. I think we ought to be offering more to patients, and so this to me was a pretty small step to say here's the discharge instructions, and do you want them electronically.

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

It's a small step, so I get your education piece, but could that be decoupled from this? What we're trying to do is get, one, the capability and, two – well, the capability and the reuse of data in these powerful ways. But is education a separate kind of thing we should be doing?

Christine Bechtel – National Partnership for Women & Families – VP

I guess, yes.

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

Your education creates an administrative burden. That's....

Christine Bechtel – National Partnership for Women & Families – VP

I actually think we should put this discussion aside for a second and have the same discussion under the new objective that we're proposing because, again, we can eliminate the stage one objective of upon request entirely if it's included here, and that is really where I think the most meaningful discussion occurs around do you let people know that they can actually have access to some kind of a mechanism that allows them to not just view what just happened to them in a hospital event, but actually move it around and give it to their primary care provider because I think that's where I'm much more inclined to insist that absolutely you have to offer that and not just hope that people ask for it, and that would include discharge instructions.

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

Paul?

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

Yes, Art, and then Neil.

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

I wonder if maybe we should just let this be something that happens at the point of informed consent, that the information can be shared. It could be shared with other providers. It could be shared with them electronically or on paper. That would be the metric.

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I think it's really important that we call out the educational piece. I think we can do that in the next objective that we're going to talk about. But what I don't want is another thing for people to have to sign off and say that they've been informed about. What I'm worried about is when we create this, you end up with another thing just like advanced directives and everything else. You end up with a 12th piece of paper that people have to sign that say I was informed of my ability to get this electronically, and I have denied it or whatever. I think there's an endless stream of those kinds of things we could do. I think we should call out in the strongest possible way that people should be educated about the ability and informed, but not do it in a way where they're going to have to attest by having people sign some document that says that they've been informed.

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

Charlene?

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

You had mentioned earlier we talked about this enrollment engagement function.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I just remembered that.

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

Maybe it could be linked in too.

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

Yes.

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

If you enroll and engage, just like when we enroll, you have to make those decisions on things.

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

Thank you. Farzad?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

I think maybe, Christine, this is what you were referring to. People don't know. At the time of discharge necessarily is not the best time for them to take possession of the electronic copy anyway. What's more important is at any time in the future then being able to have the same kind of online access to download those discharge summaries. I think, as long as we have it in the next step that they can, they have the ability to at any time go in and download the copy, I think that, similar to on the EP side.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

We didn't have the 80% of the people in the outpatient have to be offered with some periodicity. It's just what really counts is whenever they want it, that patients are able to go and download it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. We actually have to come back to that threshold question on the EPs, and Charlene was just flagging that as well, which is the enrollment piece, and which approach do you take? When we have that discussion, it will cover this, I think, as well.

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

Yes. Good. David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Two things, just one friendly suggestion, which is to the discharge instructions, maybe add, including their follow-up appointment. That's the most important thing.

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

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

That presumably will be there, but it should be there. The second thing, I don’t know when we want to talk about this, but I’m going to want to bring up something about the care transition summary in which we ask for some additional things beyond what’s in the CCD. I don’t know whether I should be doing that now or later.

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

Let’s have the discussion later and then retro because....

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Sounds good.

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

...care plans and stuff like that. Yes.

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

So we’ve got to decide....

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

Look at this list again. Has there been any other mods to this list, which is fairly similar to the above list?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, including follow-up....

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

And follow-up appointments are actually some of our, what do we call them? In fact, that’s a better term, whatever Michael said, if we talk about follow-up orders or whatever.

Christine Bechtel – National Partnership for Women & Families – VP

Then, George, can you add a placeholder for care transition summary and put a C?

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

Or is that the shared care, the same language as above?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

The shared care plan is slightly different.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

It’s two different things.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, but I think it is a new bullet, George, on care transition summary. Is that right...?

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

Where?

Christine Bechtel – National Partnership for Women & Families – VP

Under the – yes, so anywhere in there. Just hit the enter button.

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

No, but there's no....

Christine Bechtel – National Partnership for Women & Families – VP

It's a new bullet.

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

Which would be what?

Christine Bechtel – National Partnership for Women & Families – VP

Care transition summary with a reference to say, see care coordination, because we need to come back to it.

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

Care transition summary?

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

Yes, you could just put square bracket, care coordination.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes. I wasn't thinking of necessarily giving this to the patients, but this is really more between providers part of things. There might be some things within it that would be valuable to the patient.

Christine Bechtel – National Partnership for Women & Families – VP

Maybe we just put care transition summary elements, and know we need to go back.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Sure. That'd be good.

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

And you probably are going to add some care plan elements too.

Christine Bechtel – National Partnership for Women & Families – VP

Correct.

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

Just RE care coordination....

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

There's a summary of hospitalization, remember. This is not....

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

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

Right.

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

This ... section, otherwise we would....

Christine Bechtel – National Partnership for Women & Families – VP

...positioning....

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

What do I want to put here?

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

RE care coordination is our marker.

Christine Bechtel – National Partnership for Women & Families – VP

C, care coordination.

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

But we didn't....

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

We haven't discussed it yet.

Christine Bechtel – National Partnership for Women & Families – VP

That's the summary section, I think, is what we meant.

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

Discharge is also, I think the plan too because there are going to be elements there that you're managing diabetes, so whatever your shared goal is, it's going also just need to be a touch point in terms of the....

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

All right. I've got to see what it looks like, but I'll put it there.

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

Marty and then Michael.

Marty Fattig – Nemaha County Hospital – CEO

I assume, for the sake of arguments, that this includes only inpatient versus outpatients versus emergency patients.

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

Yes. This whole section actually is hospital.

Marty Fattig – Nemaha County Hospital – CEO

Okay.

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

Michael?

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

A quick question: Even on the care coordination and care ... is that where pending results would be documented, or should that be part of this basic set?

W

The orders piece....

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

Yes, so outstanding orders.

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

...outstanding results, or those types of things.

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

Right.

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

Yes, from a hospitalization, or is that in the care transition summary?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

I think that usually gets left out, frankly.

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

Yes. No, that's a good point. The whole notion of follow-up plans maybe. I'm trying to come up with some terminology that would work both in ambulatory and outpatient. Go ahead.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Follow-up plans are different than pending.

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

I know, so I'm trying to find something.

Christine Bechtel – National Partnership for Women & Families – VP

We had that bullet in EPs.

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

I know.

Christine Bechtel – National Partnership for Women & Families – VP

It worked.

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

I'm just giving it a name. I'm trying to find a name that will go in both places.

Christine Bechtel – National Partnership for Women & Families – VP

I think we called it orders. We didn't say....

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

The concept is....

Christine Bechtel – National Partnership for Women & Families – VP

You're right.

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

...outstanding orders.

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

Yes, it is outstanding. You don't want all the orders.

Christine Bechtel – National Partnership for Women & Families – VP

Orders ... I knew it was somewhere.

Neil Calman – Institute for Family Health – President & Cofounder

Documents going back to the primary, to let's say to a primary care provider, they need to know, which they don't know how to get the results of the tests that were done in the hospital that were pending upon discharge. So I just want to be specific about that, but I don't know how you want to label it.

Christine Bechtel – National Partnership for Women & Families – VP

Pending orders....

Neil Calman – Institute for Family Health – President & Cofounder

We talked about that the last time. That's a critically important part, so there are things that went on that are not yet available, and people need to know how to obtain those.

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

Did you take orders out because it was really pending orders.

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

Yes. Pending.

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

Or some kind....

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

This is what we had under the outpatient summary. Now we weren't initially putting all the patients in patient orders. We didn't want to put orders because....

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

We don't want all orders, right.

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

Right, definitely not.

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

That's part of the discharge instructions.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I would say pending diagnostic results.

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

Yes, you're right.

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

You could do diagnostic tests, orders, and results. Well, we also had referrals. That's the whole PCP appointment or, in the EP side, the referral appointments.

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

Again, this is a case where like the kinds of questions we get is like diagnostic test results. Do you want all the test results that happened while they were in the hospital? Do you want just the most recent?

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

No. You're killing too many trees.

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

Right, so again, that's the kind of thing where we've got to filter it. It's those things that are relevant for that discharge state that you'd want.

Christine Bechtel – National Partnership for Women & Families – VP

We don't want orders. We want pending test results.

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

Is that what you're saying...?

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

Well, you've got diagnostic test results early. You probably might want the most recent or the last state or not.

Christine Bechtel – National Partnership for Women & Families – VP

I see.

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

You don't want all the tests....

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

There are two different issues here. One is the ability to determine what went on during a hospitalization, which I think is important if you're picking up the care of the patient who has been hospitalized, and that's more than just knowing what their hematocrit was on the day that they were discharged. You need to know what they came in with, what was done, what happened, so a summary of what went on is what you're looking for here in this sort of expanded view so that somebody can intelligently pick up on the care of the patient. That's different than what gets done in the fourth generation NCR paper now where you just get like the six meds that are there and the fact that they have a follow-up appointment. You do need to know something about what went on in the hospital, and I also think it's important that patients know what went on in the hospital, that they received three blood transfusions and all of that stuff because you ask people later, and they have no idea what happened to them in the hospital.

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

We've got David, Farzad, Christine.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I thought the audience was explicitly patients here.

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

Right.

M

It is.

Christine Bechtel – National Partnership for Women & Families – VP

And I want, that was actually my point.

Neil Calman – Institute for Family Health – President & Cofounder

And that's why I say that's why it's important for the patients to know all of the things that we're talking about because they're going to go someplace, and somebody is going to say, what happened to you when you were in the hospital, and they're not going to have a clue.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Right, but there are some different things that the provider would want to know. That's what I'm....

Neil Calman – Institute for Family Health – President & Cofounder

Which is what you're putting under the care transition summary, right?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Farzad?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Right now what happens is that in every hospital, the patient is discharged, someone dictates the discharge and highlights the most relevant facts, if the person had the three blood transfusions. What filters all that massive information to extract and that's only something you can do with the clinical knowledge, extract the most relevant information to communicate to another provider, so they don't have to leaf through all that stuff. I see the advantage from the data point of view if we're going to have people download it and be able to upload it to somebody else or be able to trend what happened with X, Y, or Z, or drill down into the details of their records for having the different elements. But in terms of having a human readable format, it's not just the format ... human readable content. What people really need to be able to read is a discharge summary that is dictated by a human being. No?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes. The problem with this is, there are two problems with the discharge summary. They come two weeks later, and the audience is the compliance officer.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Really?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Usually, yes. That's why you do a dictation. You do a dictation because you can't bill unless you do your discharge summary, at least in New York. You're driven by why are there people running around making sure you sign your discharge summary?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Well, that's....

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

They did one and signed it. Did one and signed it. In the old days, the old discharge summaries before this kind of thing, you could read them. They were like two sentences long in our records from like 50 years ago. Then it became longer when it became a billing issue. Actually, that's not true. It became much longer in the early '90s when we shared them to other doctors. This supports your argument because then people started using them as a summary of a record because they knew the hospital record was lost, and they were using the doctors to say what happened. Human beings did the right thing. And now that we have access to the record, they don't need to do that so much because they can actually see an electronic one, which would argue that this would be okay.

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

We've ran into some problems trying to include the discharge summary though. Charlene, do you want to...?

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

I think that the challenge with the discharge summary now is exactly the time window because the current model is the dictation piece, and it's just not available. And even CCD right now or, I'm sorry, the transition of care document, when your discharge requires that you put a discharge summary in, yet it's not dictated yet, so there's a lot of struggle by our customers certainly in what do you mean by discharge summary. We do have customers who are actually, when a patient is discharged, dictating a real quick note to make available to support this process, but it's not conceptually the discharge summary because then you run into all those legal requirements, so it's a struggle right now in terms of, as you use that word, because of the other aspects of its use, to make it kind of happen in this context.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

I would think it's more important to include it, even if we have to annotate the time within that element needs to be provide than to exclude it. I think it's a really important piece of human readable context.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We would have to make it then if available because it's not available most of the time.

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

Yes. I'll write that.

Jim Figge – NY State DoH – Medical Director

This is Jim. Can I make a comment? I think, as a clinician, the dictated discharge summary is the single most valuable piece of information for another clinician to receive because you don't have any idea what happened during that hospitalization unless somebody puts all the little pieces of information into context, as Farzad said. And, yes, you could get a data dump of everything, but without knowing the day-to-day thinking and process, you don't really know what happened. So when you're receiving a patient from a hospital without that discharge summary, it could take you literally days to reconstruct what happened. I think the most important thing would be to set a standard that the discharge summary needs to be dictated and transcribed within X amount of time from the discharge and available electronically.

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

David, I think this is probably covered in your care coordination, right, the discharge summary?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We didn't talk about discharge summaries explicitly. No. We tried to keep it relatively simple. I think the medication list is actually the single most important thing. The discharge summary is valuable too. It's just that there are all these issues around actually getting it.

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

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Here again we're talking about the patient, not the provider.

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

Right. That's why I was trying to move it over to the provider side. Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I want to just make sure we don't lose the patient side of it. I think it's important that patients read the discharge, have a discharge summary in a readable fashion. To me, that means indicating that it's done without abbreviations because people need to know what happened to them when they're in the hospital. The most common experience we have is I went in the hospital. I was there for four days. They gave me a bunch of medications, and I got better, and that's all people know when they leave the hospital. And I think if we want – if we're trying to involve people more in their own healthcare, they have to have a better understanding of that, and I think the discharge summary is valuable, but I think we should say more about it, including the fact that it should be dictated without abbreviation so that it's more likely that people can actually comprehend what's in it.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Absolutely. The other side of this is that documents have to be produced at different levels, and I don't think we can mandate the discharge summary be dictated at an eighth grade level.

Neil Calman – Institute for Family Health – President & Cofounder

I didn't say eighth grade level. I just said without abbreviations.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

For patients that don't understand them, you have to produce things that are a relatively low level, and I just don't think that's really going to work. I'm fine with making them available to people, but that's not really the purpose that they're intended for. They're intended right now for exchanging care between professionals, which is different than communicating to patients....

Neil Calman – Institute for Family Health – President & Cofounder

Well then I don't think we have anything in here that speaks to the issue of patients understanding what went on in the hospital.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think it's discharge instructions.

Neil Calman – Institute for Family Health – President & Cofounder

It doesn't say that. That says what happens after you come out of the hospital.

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

There are two different things. The things that should be handed to you, that's your fourth copy NCR, that's discharge instructions.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

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

And you must even, and so most people are writing them. The really brief, hopefully understandable summary of what happened to you in the hospital, and that leaves with you. That's a mandate from Jayco, I believe, and there are certain elements, certain sections that have to be filled out. That is contemporaneous with leaving the hospital. Then we're also, in bullet two, describing other things that must be available about the hospitalization for the patient. There you could have discharge summary if you want, and that doesn't have the same contemporaneous, that stricter timeline. Does that help?

Neil Calman – Institute for Family Health – President & Cofounder

A little. It helps enough to move on.

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

The point here, I think, in both of these cases, there is not a set standard, standards to which both discharge instruction, and I'm not sure we'll sort it out in this conversation, as well as discharge summary. What does that look like, and how can we move towards standardization of that? I think that's the gap that you'll hear from the vendor community because ultimately you'd like to share those elements of those two documents or processes.

Neil Calman – Institute for Family Health – President & Cofounder

There's so much to this that we need to pay attention to, so we're not saying that it's got to be generated in the language that the patient can actually read and understand. We're not talking about reading levels. We're not talking about any of this stuff yet. But I think it's all got to be – if we're not going to call it out for 2013, we'd better put something in there that says our ultimate goal is to be able to deal with those issues. We can't be handing people something in English when they don't read or speak English, and assume that we've met the requirements. We have other requirements from OCR to deal with those things.

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

We can put that under comments, right, for this particular one. That's a different sheet. George, do you want to maybe put a notation ... spreadsheet under comments for ... discharge instructions, right?

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

Where...?

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

That's funny. I can't find the discharge instructions.

Christine Bechtel – National Partnership for Women & Families – VP

Underneath the ... where it's a low copy.

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

Yes. Right.

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

What's that?

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

Underneath copy, under the patient and families.

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

...what one?

Christine Bechtel – National Partnership for Women & Families – VP

We don't....

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

I don't....

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

What section?

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

Patients and families, and under electronic copy, so move – yes. Wait a minute. Up one.

Christine Bechtel – National Partnership for Women & Families – VP

Up, 43, there you go ... discharge.

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

Okay. The comment is.... This is discharge instructions.

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

Right. That's what we want.

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

What comment do you want there?

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

The comment has to do with health literacy.

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

That's the whole point. That's the standard in the field that the discharge instructions have to be ... by patients.

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

Okay.

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

That's known. What Neil was saying is the other stuff should be also understandable. This one we know has to be ... that's exactly what that means.

Neil Calman – Institute for Family Health – President & Cofounder

Discharge instructions are only one line in that.

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

No, I understand. There's not enough information, so it doesn't cover....

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

Yes, but you're kind of rolling out the discharge instructions, so....

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

Well....

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

Are we done with the new objective, which is essentially hospital summary?

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

The ability ... download ... eligible ... 36 hours of discharge.

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

Thirty-six sounds pretty constraining.

Christine Bechtel – National Partnership for Women & Families – VP

Pretty what?

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

Constraining. I don't know that discharge dictations would get in here for that.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

That's why I said when available.

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

That's why we have to say when available.

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

The instructions....

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

Where it's when available.

Christine Bechtel – National Partnership for Women & Families – VP

...discharge summary.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Discharge summary.

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

Okay.

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

And I think the following elements are included where relevant.

Christine Bechtel – National Partnership for Women & Families – VP

And do we talk about do they need to be most recent? I'm cognizant of Charlene's point that there may have been--

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

Lots of lab tests. Lots of...

Christine Bechtel – National Partnership for Women & Families – VP

--lots of stuff that you don't need to know.

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

So your concept is this is like a clinical summary in the ambulatory world.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

If we actually didn't, we turfed it to the filtering functionality in the ambulatory world. You might want to be more precise because it's just so....

Christine Bechtel – National Partnership for Women & Families – VP

We turfed the filtering in the context of longitudinal.

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

Correct.

Christine Bechtel – National Partnership for Women & Families – VP

Which is, this is not. This is acute episode more akin to the encounter.

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

A single encounter almost, a single episode.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

So if you want to add modifiers to that.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I guess one thing that wasn't clear to me in the parallel to the EP side is, I'll call it, the sideman use case pursuant to his blog about how it's very helpful to the patient's family to be able to follow along the course of hospitalization when their family member is in the hospital. So the online access and download, the analogy to the after visit might not be the entire hospitalization. It might be what happened today. What's new? My dad's hospitalized a thousand miles away. What happened in his care today? I don't know if we're addressing that at all here.

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

There are actually some of our customers who print this type of thing out, probably not to this extent, and review it with the patient while they're in the hospital.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

But I'm talking about a different use case, and I'm just wondering whether online access that's not triggered following discharge is something we're considering or not. It's not clear to me.

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

Should we put that's brand new, and some of us are trying to go there. We might want to put that in one of our future columns so that we start working on how we could specify what it would look like, and could you even get there by 2015. That we'll have to figure out.

Christine Bechtel – National Partnership for Women & Families – VP

Yes....

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

But the idea is that we need a navigator in the hospital. That's for sure.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I agree.

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

For everybody.

Christine Bechtel – National Partnership for Women & Families – VP

That's good. George, can you put a placeholder....

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

But in the future, and we'll work backwards.

Christine Bechtel – National Partnership for Women & Families – VP

...back.

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

It's really....

Christine Bechtel – National Partnership for Women & Families – VP

A sideman use case.

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

This would be under--?

Christine Bechtel – National Partnership for Women & Families – VP

Future.

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

Maybe contemporaneous.

Christine Bechtel – National Partnership for Women & Families – VP

There's going to be a new row anyway.

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

Contemporaneous summaries.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, I'd make it a new row.

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

Yes. It's a new row. It's a new row. Put it in future.

Christine Bechtel – National Partnership for Women & Families – VP

I think what we can do is make the row for view and download, hospital summary, and then that goes in that row under 2015. Then under 2013 is a reference to this that we're looking at now.

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

Yes.

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

All right. So I am putting for 2015 ... ability to track....

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

Right.

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

Or usability....

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

You might put future....

Christine Bechtel – National Partnership for Women & Families – VP

On demand. I think the distinction we need to convey here is during the hospitalization.

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

That's what he said, hospital....

Christine Bechtel – National Partnership for Women & Families – VP

...discharge being ... okay.

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

He said track hospital course. That's how I read that anyway.

Christine Bechtel – National Partnership for Women & Families – VP

Can we use English though?

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

What do you want to call it?

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

Track?

Christine Bechtel – National Partnership for Women & Families – VP

Hospitalization in progress, I don't know.

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

Ability to do what with the hospitalization?

Christine Bechtel – National Partnership for Women & Families – VP

Track it, fine, follow, whatever.

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

Track hospital—

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

Course.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, my problem....

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

Course. You don't want....

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I don't understand that.

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

You're not tracking ... progress....

M

Everyone knows hospital ... no?

Christine Bechtel – National Partnership for Women & Families – VP

...course is a problem.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

...on demand.

Christine Bechtel – National Partnership for Women & Families – VP

In real time, I think we need, it's really in real time too.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

It's really online access to patient information.

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

During hospitalization, yes. Great.

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

This is kind of a brand new one. Conceptually we would think it might be menu in 2013 and move to core in 2015, and then this one just jumps the bar even higher.

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

You're saying this could be menu?

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

Well, I would think for 2013 because it's a brand new feature capability.

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

Pretty hard....

Christine Bechtel – National Partnership for Women & Families – VP

No, for 2013.

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

No, she's saying....

Christine Bechtel – National Partnership for Women & Families – VP

You're talking about the new objectives.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Charlene is talking about the new objectives.

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

Yes. Fine. Right.

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

The new objectives.

Christine Bechtel – National Partnership for Women & Families – VP

We need to have – I think there are two more things that we need to talk about. One is, is it menu or core because if it is menu, we cannot eliminate the first objective, and we have to change it.

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

Yes. Time out. What did we decide to do on the first objective? I'm still not clear.

Christine Bechtel – National Partnership for Women & Families – VP

In my view, it depends on what we do with the second objective. If it is core, which I would like to see, then I think we can eliminate it. But if the second objective is menu, then we have to go back to the fight of do you offer it, or do you hope people know to ask for it.

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

Yes ... part of us, I think, when we were defining discharge instructions, we were forcing a clinical goal independent of meaningful use of electronic health records. We were just saying patients should get this, and this is a way to accomplish this across the nation. And that's why it'd have the short turnaround, but it wasn't strictly speaking meaningful use necessarily, so we could get rid of this if it undoes that original goal.

Christine Bechtel – National Partnership for Women & Families – VP

If the new objective core.

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

The hospitals are forced to do that anyway. If the new objective is core, then you'd think that covers it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Because remember, this one is while you're walking out the door, you get something. And you should be getting discharge instructions on paper or electronic as you go out the door, but that's standard of care. I don't know that meaningful use has to be the one to define that.

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

So I have acute....

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

If that's the case, then I would agree with Christine, based on that.

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

Michael, do you still have a comment?

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

I'll hold it for a while.

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

David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I don't think we've talked yet about how we would handle, for example, authentication of family members and delegation of who would look at things. This opens a whole lot of issues that are kind of problematic, and need to be dealt with to make this work. I would make it a menu for 2015 if we're going to include it.

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

For which one?

Christine Bechtel – National Partnership for Women & Families – VP

But have we done the same thing for EHRs and clinicians? We haven't, so why would we, in meaningful use, define those requirements around authentication, etc. when we have not done the same thing for clinicians under meaningful use using EHRs?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We would be requiring hospitals to come up with something totally new that they do not do today, do not have today. We haven't defined the set of elements that somebody might like to look at. I can understand the rationale for wanting to do it, but while this is something that would be nice, nobody has done it that I know of.

Christine Bechtel – National Partnership for Women & Families – VP

What about portals though?

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

David, do you mean for this? For which one, do you mean one, two, or a new thing for 2015?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

New thing for 2015.

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

Yes, I agree with you.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I'm sorry. I thought you were talking about the middle....

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

I agree with David on that.

Christine Bechtel – National Partnership for Women & Families – VP

We're good.

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

Farzad?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

I'm thinking about how the objective we have is implemented.

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

Which one? Is that bullet one?

Christine Bechtel – National Partnership for Women & Families – VP

...number...?

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

Bullet one, the discharge instructions?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

No.

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

You mean to put it in the final rule....

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

So the new objective.

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

What do you mean?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Would you let me talk? We say the ability to view and download relevant information about inpatient encounters contained in the record. Then we say within 36 hours of discharge. That to me is a special case of a general capability of providing online access to this information.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

Similar to the – I see a lot of parallels between – on the EP side and the EH side where the ability to do the comprehensive, all bundled together, total summary is the unfiltered instance or the one instance of the generalizable ability to provide online access to the information. It seems – I'm thinking through my head about how hospitals would actually implement this requirement, and I'm thinking, this new thing we're talking about wouldn't be that different in terms of how they actually implement it other than the timing of when it's made available. There are two factors that are added, two complexities that are added. One is around what's the information that is available and the timeline and the workflows of making that information, like discharge instructions obviously wouldn't be relevant. And the second is this issue of proxy to access where here we're just saying it's very clear. It's the ability for the – I guess it's not clear, but it's the ability for the patient and, in this extension, we're saying that patients should be able to grant proxy access to others. But I don't see this as being, David, fundamentally very different capabilities to enable the viewing during the hospitalization versus following the hospitalization.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Let's just look at things from the hospital side. When somebody is discharged from the hospital, there are a whole bunch of things that get checked and get done. From the hospital's perspective, they can make sure that when somebody is discharged, a lot of these things are available. At other times when somebody is just, say, in the hospital, they're just not used to doing that today. Now they could be asked to do that potentially, but I'm not sure that we want to ask them to do that.

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

Michael?

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

Are we talking about making this information, Farzad, available to proxy family members and others, as you were saying earlier? Is this a set of information that I, as a patient, would want somebody else to see? If not, do we then have to start putting filters and saying I don't want the family to see this while I'm in the hospital getting care. I'm having a hard time. This is the time when sometimes it's hard to find out whether your family is actually in the hospital or not or where they are, so I'm having a hard time kind of making this seem realistic, understanding the rationale.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

We're actually doing this project, and what they want to know is who is on the team, like who is the patient's nurse, what tests are they going for today, what's the schedule, so I know when they're going off the floor. When is the doctor going to show up? It's a bunch of things that are a little bit different than....

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

...information.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

And it is still research, but I agree with the concept. We definitely want to do this for patients. It's just, I don't know that this is a 2013, we're ready to do it.

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

Right, so could you just, instead of 2013, just for our placeholder, use the word future, because I just really think it is so unclear? We're into the concept, but I think we need to flush it out more. I wouldn't want people to get too scared because there are a lot of details here. Let's see where we are because we are at lunchtime, so where are we from a process check? It looks like we're in agreement with bullet number two, which is the new objective, which is sort of the hospital summary. Is that correct? And the major changes, but to include discharge summary when available.

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

Just a challenge, on the discharge summary, again, because we're giving it to the patient, is it pertinent to the patients, or are you – it would seem like, again, it's more necessary for the transition of care piece and care coordination. It would seem like – I'll be honest here. If you can just get everything except the discharge summary available, that's a huge step. And to add in that discharge summary is just going to add, for purposes of patient engagement, a lot of complexity to the process because of all that other stuff.

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

I agree, and it creates this timing problem, etc. How do other people feel?

Christine Bechtel – National Partnership for Women & Families – VP

Are you suggesting...?

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

I'd just delete it for the purpose....

Christine Bechtel – National Partnership for Women & Families – VP

The discharge summary?

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

...for purpose of patient engagement. You still need it for transitions of care among the care providers.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

The reason to include all this other stuff like the procedures and the immunizations and the lab, diagnostic results and so forth, in addition to the discharge instruction, was so that the patient could then download that information and then give it to somebody else.

Christine Bechtel – National Partnership for Women & Families – VP

Right. For sure.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

I think, if we're going to include all this other stuff in there, then the discharge summary, as we've heard, when available, is probably the highest value information for the patient to understand their course, but more importantly, to be able to share it with other people.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Let me ask that question again. Do we agree with what's on the screen for bullet two as a view and download for essentially a hospital summary and the new addition from the draft was a discharge summary when available?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Everybody is good?

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

I don't know if we put words in it. Again, the kinds of questions we get is do you mean all the test results? Do we capture that caveat?

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

We didn't do that yet.

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

Again, I'm not sure. Just put relevant or something. We could sort that out later, but I'm not sure you want all the vital signs.

Christine Bechtel – National Partnership for Women & Families – VP

Overarching relevance comment to probably every category, right?

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

Do you want to say...?

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

Especially for that.

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

Do you want to say – right now the bullet says, the following data elements are included. Could you say summary of the following data elements are included?

Christine Bechtel – National Partnership for Women & Families – VP

The most relevant. It's the most relevant of each. Just put a parens after included and say most recent of each or most recent or relevant. I don't know.

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I think this is going to end up being like diagnosis or something. People are going to have to figure out a way to highlight the things that are relevant. That's going to require some sort of process. And so when is that going to take place? Is it going to take place at the time you order a diagnostic test and you say, well, the MRI is going to be relevant to the discharge summary? Let me star that. Or is it going to be at some later time when you're going through a 20-page hospitalization to start starring things that are relevant? There's not really a process for this to happen. I would stick with identifying categories of things that I think are relevant. It's not going to be exact, but you're going to want all x-ray procedures. You're going to want all lab test results and whatever. But you're probably not going to want every order for an IV or whatever. At some point we're going to need to specify this. The other objective is to make this something that the machine does that we don't have to intervene, and it's not meant to add two hours of work to discharging a patient. It's meant to be able to use the intelligence of the computer to be able to do as much of this as we can.

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

Do you want to use, "Are included, as relevant"?

Neil Calman – Institute for Family Health – President & Cofounder

I think we should put in a general statement about relevance to say that we should identify the categories of things that are relevant.

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

We do say the ability to view and download, within 36 hours of discharge, relevant information.

Neil Calman – Institute for Family Health – President & Cofounder

I understand that, but I'm talking about the other part of it. That's your ability to get it. How do we determine what's relevant is what I'm addressing.

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

What I don't think we want to do--

Neil Calman – Institute for Family Health – President & Cofounder

We've got to do it categorically.

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

--is to say that all information, to require that all or most or most recent or most relevant. I don't think we want to say that.

Neil Calman – Institute for Family Health – President & Cofounder

No.

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

I think we want to leave some discretion--

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

--for how the hospital wants to implement this.

Neil Calman – Institute for Family Health – President & Cofounder

This is really going to be a vendor – I don't know.

Christine Bechtel – National Partnership for Women & Families – VP

We're talking about an RFI. Can we ask the question?

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

Right.

Neil Calman – Institute for Family Health – President & Cofounder

I think we need to call out the question of how relevant data elements will be identified, whether that should be something that's standardized, or whether it's something left up to the discretion of a provider or an institution. That's going to be the meat of this thing is that word, relevance.

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

Could we at least put the word in under the following data elements are included, as relevant, so that we trigger off that question? George?

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

it's just if you put that out, then someone could interpret that every ... is an easy out for things.

Christine Bechtel – National Partnership for Women & Families – VP

Right, or is it every single....

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

Where were you suggesting to put the word?

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

I was going to leave it like that for now.

Neil Calman – Institute for Family Health – President & Cofounder

In blue.

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

Yes. I was going to leave that. I wrote that, obviously.

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

Okay.

M

I'm afraid that's going ... and I'm a little afraid of when we start tweaking these things, it's like the monkey's paw, you know. You fix it, and then you have to fix that, and you have to fix that. You end up with a mess.

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

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

And I ... this issue that people raised when we put stuff out as ambiguity. That's the biggest problem we have. It's not lack of, it's not specificity when you say to somebody, this is exactly what you need to do. People have less problem with that than when you say, you figure out what's relevant. And then you have a whole set of activities. I think when it's important that that be locally determined, that's smart. But I we're just punting it to the hospitals because we can't figure out what's relevant, that's probably not smart.

Christine Bechtel – National Partnership for Women & Families – VP

Why don't we ask a question for the RFI that says what is the most. What is the best way to make this useful for patients in their role as caring for themselves and coordinating their care with others?

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

Before I saw a lot of head nods for this, and we added the qualifier question about relevancy. Are people still comfortable?

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

I have one data element.

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

One more data element.

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

Do you want to put vital signs up there?

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

We've got a relevant question again.

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

I know it's relevant.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Vital signs?

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

...we had it. Again, it's just....

Christine Bechtel – National Partnership for Women & Families – VP

We have it in the EP, but not in the hospital. I assumed there was some clinical reason for that.

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

Yes. It's pretty hard to....

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

You would have to do....

Christine Bechtel – National Partnership for Women & Families – VP

That's a really relevant one.

M

...discharge vital signs.

Christine Bechtel – National Partnership for Women & Families – VP

Discharge vital signs. There you go.

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

I just wrote that in, so I don't know.

Neil Calman – Institute for Family Health – President & Cofounder

That's fine.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

That's relevant.

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

Good.

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

...discharge med list after ... isn't that kind of...?

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

Actually, George, aren't those things, the medication list at discharge, isn't that another example of that? That is probably one of the biggest things you do need.

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

We need discharge. That's actually, to be honest, in here. The medication list may be the inpatient medication list because the discharge instructions, I forgot to put medication. That's actually the most important thing in here.

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

I would say yes, but....

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

It's a different list. You want to know what you're on in the hospital because you know you've got an allergy, an allergic reaction, but you can't remember what they gave you.

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

But still, the most important thing to leave the hospital with and to go to the next doctor is the med list.

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

Yes. I agree.

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

You have the med list right now.

Neil Calman – Institute for Family Health – President & Cofounder

He's got it in discharge instructions.

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

You're saying it's too buried in there?

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

It seems pretty buried.

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

Yes, but everything is the most important here. This is the list that matters. That's why we had another thing for this alone, right, your follow up appointments.

Christine Bechtel – National Partnership for Women & Families – VP

But we never defined that thing.

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

Your scheduled tests and your medications are the main things you need to know, and a summary of your condition, like you had a heart attack. This is it, and that's why it was invented for patients to know the most important things. I think this is the key thing.

Christine Bechtel – National Partnership for Women & Families – VP

What's the explanation point ... highlighted.

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

All right. I think we finished this objective.

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

Can I add one thing? I just want to remind, there was testimony at one of the recent policy committee hearings from the HHS Office of Disability and the Access Board about accessibility issues. I think that in the context of human readable format, there had been some ideas discussed. I think it's more of something that this group would either ask the Standards Committee to discuss or put out for comment. But some issues around insuring that accessible is accessible to everybody and how that might fit in with interoperability with assisted technologies and getting ideas around that.

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

Right. Isn't that an uber comment?

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

Yes.

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

Right.

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

But it comes up.

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

Right. We still have not finished this category yet, but I think we've....

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Wait. Can we just, because you want to eat and think before we decide to do with this guy?

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

Yes. Correct. We're going to go back to that one and the enrollment piece.

Christine Bechtel – National Partnership for Women & Families – VP

...what's menu because we can't go to number one without knowing if two....

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

Before we get into Christine's issues, I think we want to also beat the rush. What do people think about bringing stuff back here?

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

That's fine.

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

Is that okay? Because we do fortunately – it depends on how you look at it, but there is a cafeteria up here, and if we can just bring it down, and then continue discussion, and Christine can illuminate us over lunch.

Judy Sparrow – Office of the National Coordinator – Executive Director

What time?

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

Can't we just bring our lunch down within the next 15 minutes?

Judy Sparrow – Office of the National Coordinator – Executive Director

We should tell the audience ... 20 minutes, do you think, 15 minutes?

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

Yes. We'll start the discussion again at 12:10. We're at the appointed time. We had left off with the patient engagement, and we were going to go to your bullet one. Is that what you're saying? Is it the offered, that question?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Originally I thought bullet one dealt with discharge instructions. That's how I got confused when we added discharge instructions to bullet two. Bullet one is precisely just the offered question. Is that right?

Christine Bechtel – National Partnership for Women & Families – VP

Let me suggest a different approach or another approach. Because we don't know whether CMS will make the new objective a menu or a core item, I think we probably do need to preserve both, so ... suggest two things. One is that we actually define discharge instructions, as we just did in the exercise that we went through for bullet two. Then we go ahead and add a definition to make sure they're really robust, and then that the second change, that the change that we discussed is actually offering them to patients rather than the passive role of having to hope they know and ask for them.

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

The former one was to define discharge instructions? Is that what you said?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

The question is, does define, because we have stage one. That was the certification criteria. Did we define it?

Christine Bechtel – National Partnership for Women & Families – VP

I don't think so.

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

Stage one certification criteria for discharge instructions.

Christine Bechtel – National Partnership for Women & Families – VP

Would they have defined the data elements that need to be part of discharge instructions?

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

I honestly don't....

Christine Bechtel – National Partnership for Women & Families – VP

They did not define. The reason I believe they did not is because CMS did not, and ONC did not define. They defined the visit summary elements in a very detailed way, but the same is not in the rule, as far as my recollection for discharge. George, you're good with the rules. Is that your recollection as well?

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

...?

Christine Bechtel – National Partnership for Women & Families – VP

We're talking about discharge instructions, and my suggestion is that we apply the same definition to bullet one that we just sort of enumerated in bullet two. And Paul asked if it was defined in the rule. My recollection is no, that visit summary was for EPs, but the discharge instructions was not for hospitals, although I couldn't tell you what's in the certification rule.

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

Actually, I'd have to look at the final rule and see if there are any questions.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

I have to actually look.

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

I guess there'd be no harm, as long as we're not contradicting stage one, to go ahead and include what we just put for discharge instruction as a bullet in objective two, to move it up to objective one. One of the things we're doing then is refining. You had your – yes, that one, discharge instructions bullet.

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

What's that?

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

Yes. Copy that into bullet one. One is we're making that definition more precise. Then, two, we're now going to come back to Christine's offer. Where's Farzad? Is Farzad coming back?

M

...late.

Christine Bechtel – National Partnership for Women & Families – VP

Thank goodness, and I just want to say that this was not just me, but something that our little subgroup did agree to.

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

Okay. By analogy, let's look at the ambulatory. We don't go through a process where we offer – well—

Christine Bechtel – National Partnership for Women & Families – VP

We haven't talked about enrollment.

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

Okay. Got it. Thank you. You brought – can we switch to that one then?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Let's go to enrollment where we can incorporate education, and maybe that is a way of meeting the objective that Christine has and the group had. Enrollment means trying to make sure that we, in an active way, try to make people aware and where they would engage, take advantage of this information electronic form. Are you suggesting that we have it as an educational objective or actually an enrollment and use threshold?

Christine Bechtel – National Partnership for Women & Families – VP

I think I see benefits both ways. The stage one objective for access is, I believe, a use objective, which is why the percent is low, which is 10%. I think there is a lot of value, though, in making sure that all patients understand the capability and have the opportunity to use it, although not all patients will want to use it, need to use it, or have Internet access, etc. I think there's value in both approaches.

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

Is one implicit in the other? If you are reaching a certain target, and you've got to believe, it's certainly been our experience in the ambulatory setting, that it is in our best interest on behalf of the patients and our own to have more people use this stuff.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

That's the quote, market acting. Do you need to do more than making sure that they have some minimal? If it was at the one percent, then the entire organization and the entire patient population does not behave in a different way. Once you cross some threshold, and 30% is an example of a threshold, once you behave in a certain way for 30% of whatever, the payers, the patients, whatever, you start having to incorporate that into your workflow and sort of builds on itself. If we reach some threshold of your entire patient population, would you argue that, would you agree that that means that the organization is doing something proactively?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, so you mean reach a threshold for use?

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

Yes. Correct.

Christine Bechtel – National Partnership for Women & Families – VP

In other words, if 30% of your patients are accessing and/or downloading, we can assume that the practice has done the outreach to all patients.

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

Correct.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I think that's right.

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

One to have gotten there; two, you've got to have the systems in place, rendered in a way that's usable, etc.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

That might argue setting that threshold of use at some number by 2015 and something in between after 2013.

Christine Bechtel – National Partnership for Women & Families – VP

Maybe it's, I mean, working backwards, if it's 10%--

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

No.

Christine Bechtel – National Partnership for Women & Families – VP

--maybe it goes to 25% or 30% in 2013.

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

Then '15 would be--?

Christine Bechtel – National Partnership for Women & Families – VP

2013 is what I was saying for 20%, 25% in 2013, right?

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

Right. Marty and Michael?

Marty Fattig – Nemaha County Hospital – CEO

I'm assuming you're talking about patients using the system.

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

Correct.

Marty Fattig – Nemaha County Hospital – CEO

I don't want to be held accountable for something I have no control over, which is how many times my patients access their electronic medical record. I'm going to have somebody go out there and say, hit your record 100 times today to get me up to where I need to be.

Christine Bechtel – National Partnership for Women & Families – VP

Can I ask a clarifying question?

Marty Fattig – Nemaha County Hospital – CEO

Sure.

Christine Bechtel – National Partnership for Women & Families – VP

The threshold that we're talking about is not use of how many views, but rather, even like I think the way in stage one it is set up, even if you have a user name and password, and you looked at it one time, that would count as one, so it's not frequency of use or robustness of use.

Marty Fattig – Nemaha County Hospital – CEO

I know, but there are certain populations, especially elderly populations that have no desire.

Christine Bechtel – National Partnership for Women & Families – VP

Right, which is why the threshold is low.

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

Michael?

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

I have a similar concern, but maybe a potential solution to it because, Paul, you directed us right to it. If you get to certain thresholds of actual use, that's implying that you're offering it. But if you can't get to that threshold of use, whatever that number is, perhaps the continued offering more education that you're held standard to, so you're continuing to offer it. But once you get to 30% or whatever number we come up with, you don't have to continue to show that you're continuing to offer it because you have people using it. And so that solves the situation we have of disenfranchised population where you're trying to encourage, but not holding the providers accountable for the actual use, just holding them accountable for continuing to offer education, and then turn that requirement off once they get to a certain threshold.

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

Other comments? Just to put a number out there for people to react to both here, and then later into the public domain, 30% seems to be a number where you have to be prepared in a certain way, and you have to have the workflow and the offering. Do you think, Marty, that that is too high sort of across the board?

Marty Fattig – Nemaha County Hospital – CEO

Seventy-five percent of our patients are Medicare. Yes, I think it's too high.

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

Are you changing it ... EP? Are you changing it...? Right now it's for EP....

Marty Fattig – Nemaha County Hospital – CEO

We're still in the hospital.

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

Right now we're....

Christine Bechtel – National Partnership for Women & Families – VP

We've gone back to....

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

We've gone back to...

Christine Bechtel – National Partnership for Women & Families – VP

EP.

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

Yes, for enrollment, so we've created a new objective in enrollment. Let's take them one at a time.

Christine Bechtel – National Partnership for Women & Families – VP

But for EPs, I don't think we can assume that all elderly patients won't use this because we also have to think about their caregivers, and then it is also actually the fasted population online, growing population online. But I see what you're saying. George, you've got 30% of patients access the system at least once. I like that, although I think you could have sort of a setup for everybody too that you've got 80% of patients or maybe it's an intermediate, 30% of patients, 40% of patients, rather, have a user name and a

password, and their account is set up. I guess you could think about that as an interim. I'm not sure I that's the right approach.

M

I almost think....

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

How do you define the patient...? Has that been defined elsewhere in meaningful use, as people...?

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

You use the denominator as the other denominator. Yes, you can use the same kinds of denominators for people you have touched in X period of time.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Most ... reporting period.

Neil Calman – Institute for Family Health – President & Cofounder

Specify that....

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

To respond to you, Christine, I think the most meaningful number is that they have engaged, meaning they have actually logged in.

Christine Bechtel – National Partnership for Women & Families – VP

I agree.

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

How many postcards you send out is almost irrelevant.

Christine Bechtel – National Partnership for Women & Families – VP

I agree.

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

It doesn't really matter.

Neil Calman – Institute for Family Health – President & Cofounder

I like the 30% number as well. I would support that.

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

David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I would just comment that the data suggested about 15% of people sign up, and you have to do a lot of cheering to get very far past that. If you just make things available, it's 15%. That number has been reproduced in many organizations.

M

Really?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, that's the number.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

...still a lot more.

M

...up to 60%....

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Group Health is not exactly representative of the rest of the world.

Neil Calman – Institute for Family Health – President & Cofounder

Well, that's what they're saying about everybody that's developing successful systems. There's Geisinger. There's Kaiser. There's ... anybody, but the point is, people have figured out how to get their patients engaged in this process. We're not even a year into it, and we're at 15% with almost minimal effort with a mostly underserved population and whatever, and almost with minimal effort at enrolling people.

Christine Bechtel – National Partnership for Women & Families – VP

Right. I think David's point is valid, but I think I would want to understand more about how those organizations who can only achieve 15% do the education and recruitment. I know from my own experience, they just forgot to tell me about it, and it was only when I raised with my physician, are you doing meaningful use because you would appear to suck at it right now, they said, well....

Neil Calman – Institute for Family Health – President & Cofounder

You didn't say that.

Christine Bechtel – National Partnership for Women & Families – VP

I did. There were a lot of other parts of that conversation you'd enjoy, Neil, but anyway, and she said, "No, we have a portal." Well, how come I don't know about it? The receptionist didn't tell you? No. I had to go back and ask. I like setting a higher bar to get people really thinking about how they do this effectively and not just sort of like post something in the lobby that says we got this.

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

Christine, we've heard so much about your doc, I'm wondering why you haven't changed.

Neil Calman – Institute for Family Health – President & Cofounder

...remind you, your doctor might be listening.

Christine Bechtel – National Partnership for Women & Families – VP

I know. She probably is.

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

Michael?

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

If we offer, as is written by George, for offering access, then the threshold could be 15% ... 30%, as long as we're not ... so truly making an effort to get their patients involved by not allowing ... meaningful use requirement. I think I don't have a strong feeling one way or the other. I think 30% probably is too high for some of the solo practices and small net systems.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

So I think that's going to be a strong effort. If that's what David says is the data show 15%, I would push a little lower, recognizing that we still have the option for them to provide access, encourage folks to use it.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes. My point would just be that we're talking about the whole country, and there are places where people will struggle with this.

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

What do you think about, it's currently at 10%, what do you think about going to 15% in 2013, and 20% in 2015? Remember, that's a whole new world.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I would even be okay with 20% and 30%.

Christine Bechtel – National Partnership for Women & Families – VP

Great. I like that.

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

I would sign up for that one.

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

Along with the other option of providing educational stuff if they can't get to that.

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

That's the only way you get there actually.

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

But if you're not getting there, you still get to check the box because you're offering the education to try and get there.

Christine Bechtel – National Partnership for Women & Families – VP

Right, so Michael is suggesting a bailout though. I totally get the value, but I'm a little bit worried that people might just say, well, I'm not going to really worry about the use because all I'm going to do is send a postcard to 80% of my patients.

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

But what Paul is saying, what David is saying, in systems that actually get there, they find benefits, so it's in the system's benefit to try and move patients in this direction. But if it's a disenfranchised population, maybe not Neil's, or an elderly population, if they're all Medicare, it may be really difficult, so I think we need to make sure we don't disenfranchise those practices.

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

I'm just saying where there is an outcome measure that is not burdensome, I'd hate to introduce a process measure that isn't very effective. What I heard your process measure is check offered somehow. It's so easy to measure how many people logged in and accessed.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Marty Fattig – Nemaha County Hospital – CEO

What do you do when you have vast areas of the state that don't even have Internet access, which is true in Nebraska?

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

I guess you got a zero denominator.

Marty Fattig – Nemaha County Hospital – CEO

It doesn't matter what I have if nobody can access it.

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

We certainly don't want you to send out postcards either then, right?

Marty Fattig – Nemaha County Hospital – CEO

No because it'll just frustrate them. I think the market will drive this. I mean patients drive this. They want access. If they want access, they want access, and they will demand it of their providers. If they don't, they'll change. But to set a threshold that we have no statistical information that proves that 30% of our patients even want it.

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

Just to make a comment, we've called this out a few times the responsibility of ONC to do some sort of national demand building. I think that one of the things that we can look at here would be also a way to call that out. It shouldn't be up to every individual provider to explain to every single one of their patients what a patient portal is and why it's important for people to have access to their information. We're sort of putting that responsibility for educating people about the use of computers in healthcare on the provider, when we've been saying from the beginning, one of the functions that ONC needs to have is to start to be able to do some of this at a national level so that it's not up to every provider to sort of explain to somebody, what does it mean when you can get your record on the computer. How do you do that? What can you get? I wouldn't have a problem lowering the threshold if we were sure that some of this stuff that David has said before, that there was a capability within ONC to take on some of that responsibility.

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

Christine?

Christine Bechtel – National Partnership for Women & Families – VP

ONC has been working with the Office of Civil Rights on the consumer education campaign. It'll have a heavy emphasis on privacy and sort of what is electronic health information. I think it's not clear. Josh, maybe you can add some insight. The sort of level at which the information will go out. My sense is it's pretty general. This is what health IT is. This is what an electronic medical record is. But it's not, I don't know that it's going to get to the specific level of ask your doctor for a patient portal or things like that. Josh?

Josh Seidman – ONC

I think it's part of what we're working on. We're also working on the federal health IT strategic plan, which includes one of the five objectives is around consumer empowerment and consumer engagement. And a big piece of that is trying to figure out what are the rules of ONC in helping to facilitate that. It is an ongoing process, obviously trying to figure out where we have levers to do things and where we have resources to do things.

Christine Bechtel – National Partnership for Women & Families – VP

If I could just say, part of the thing that I should be very explicit about my assumptions, as we have these discussions, is the fact that patients as the source of demand for change in healthcare has failed miserably to work in so many ways that I don't like strategies that rely on patients to get their providers to do something because really what they want is their doctors to talk to each other, and they want more time with their doctors at a very basic level. But I think there is a lot of data that says that patients want the kinds of things and interactions that this kind of electronic access can facilitate. There's a lot of data

that this is what patients want. I think the question is could we, in the RFI, suggest these thresholds, but ask for public comment for how to deal with specific conditions and denominator exclusions where you're practicing in an area that has limited broadband, for example, and things like that.

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

Christine, if we go to the 20%, 30%, and I think we still have to address Marty's concern, but if we go to 20%, 30%, I can assure you it does require active engagement on the provider side to get there.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Would that meet your test?

Christine Bechtel – National Partnership for Women & Families – VP

It's getting closer, so better than stage one, which is good.

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

Then for Marty's concern about the penetrance of Internet access, I wonder if we can do that by exclusions, in other words, the equivalence of the zero denominator.

Neil Calman – Institute for Family Health – President & Cofounder

You're going to have a bunch of exclusions, right? You're going to have people that are dealing with special needs populations. You're going to have a whole bunch of – and I don't mean people who are poor, but people that are dealing with centers for developmentally disabled folks that can't use computers, people who are dealing with visually impaired folks. We run a network of ... homeless healthcare centers. People don't even have a place to live, let alone a computer to use. You've got all these special population issues that we need to figure out because you don't want to discourage people from doing as much as they can.

Marty Fattig – Nemaha County Hospital – CEO

That's my concern. I'd hate to see a rural provider not achieve meaningful use because 29% of these patients accessed their medical records. To me, that doesn't make sense

Jim Figge – NY State DoH – Medical Director

This is Jim. I think that I want to challenge a fundamental statement that was made, which is that the marketplace can't drive this. I totally disagree with that. Nobody had to convince the marketplace to pick up and adopt cell phones, smart phones, etc. These things will drive themselves as patients find utility in them. I think it's totally unfair to put that burden on the providers. The patients will drive this when they realize value in them. Maybe they haven't realized value in some of the products up to this point in time, but when they do, they will start to demand it. I don't think that we should make an assumption so early on in the game that the marketplace is broken and that the marketplace won't drive this. I'm opposing the idea of putting any burden at all on the provider. I think this should be allowed to be marketplace driven and let patients drive it when they see value in it.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

This is David Bates. We've looked at this. We actually have a grant to study it right now, and we've looked at the adoption rate and what it's doing. In our network, which includes a lot of relatively well-to-do people, the adoption rate has not increased very fast across the network. There have been a few centers that did things that were relatively simple that worked quite well, and they've gotten to very high levels of adoption. The things that you need to do are not complicated. You just have to tell the patient that it's available. But you do have to focus on it. If you don't focus on it, at least in Boston, we've showed that the curve is just not going up at the rate that any of us would like to see. It's possible that things will take off, but I think this is a place where we could reasonably move things along faster than they would go otherwise.

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

David, what is the percentage that's staying flat? Where are you at?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We're at, I think, 17% or 18% right now.

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

That's with a lot of effort. Now to the caller's point, if we make a solo doctor out in somewhere responsible for achieving 20% and then 30%, that's a tall order for a lot of these.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think it's feasible. We've come up with a change package that we're implementing in a bunch of practices and with a relatively simple set of things that you can implement. A number of our practices have increased it a lot, but you do have to make a concerted effort to do it, and I do think there's value in it, but providers have just been a little slow to smell the coffee here.

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

Recognizing the importance, is that where we want to start putting, directing physicians in practice, with all the other things we're asking them to do, is this something that we want to make them do now in 2013?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think this is a pretty high value added thing to do. Neil's pointed out that the places that have gotten the high levels have recognized a lot of value from it, and I think as soon as you do get people engaged that it's clear that they really like it.

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

I think this is one of the transformative parts of leverage from HITECH actually.

Neil Calman – Institute for Family Health – President & Cofounder

The proof that this is a provider driven thing is what David just said that there are variations in the practices, but we also have providers that have almost 80% of their patients and other providers in the same practice that are at 20%, so it is clearly driven by the extent to which the providers find it valuable and to which they've converted their workflows. Once you meet that threshold, you really want everybody communicating with you that way and doing stuff because it makes your life so much easier.

Christine Bechtel – National Partnership for Women & Families – VP

Actually, to your point, Neil, earlier about overburdening providers with see the locus of sort of responsibility for this, what the survey data shows is that the number one source of trust from a patient perspective is their provider. So if the provider starts to say, look, I'm delivering my lab results electronically now, would you like that? I think it's absolutely transformative.

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

I think, frankly, this is probably one of the few, a rare example where we have an outcome that is dependent on a good process.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

And I think it really is the answer to your issue.

Jim Figge – NY State DoH – Medical Director

Then shouldn't the metric be that the provider implements the best process, but you don't hold them responsible for the adoption rate?

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

I think there are a lot of folks who've already had experience with this that say that it is possible, and that the process....

Jim Figge – NY State DoH – Medical Director

Possible in the right setting, and Boston is different than the setting in rural New Jersey or rural New York. It's not possible in every part of the country to do this. Boston is a very unique environment, and so my point is if the provider takes the effort to implement the best practice, patients will eventually adopt it when the infrastructure is there and when they see the value in it, and they may adopt it faster in more advanced urban areas like Boston, than they will in rural areas it'll take longer.

Christine Bechtel – National Partnership for Women & Families – VP

I think the primary difference that I see in rural areas is not that patients are any necessarily less inclined to see value in these things. There's lots of good data that talks about what patients want from the healthcare system. But rather, that there may be some broadband issues that are technical infrastructure limits to the access. I think, in that way, maybe ONC could help us understand if the FCC, for example, classifies certain parts of the country in a way that systematically identifies them as having limited broadband, that there may be some denominator exclusions or a lower threshold that could potentially apply to those providers serving in those areas. I believe that they do, but I can't say strongly enough. I think this is incredibly provider driven at this point in that we need providers to say to their patients, I'm doing this. I believe in it. It is a good thing, and join me, and then we will get, as David said, when people focus on it, then we will see more and more patient uptake.

My comment earlier, Jim, was not about the market. It was about patients as the source of change. The market is different and can function in a way that patients don't, literally because of the economics of healthcare and their historic aversion to walking into a doctor and saying, let me tell you how I think you need to practice medicine.

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

I think we've reached a point of general consensus about moving on with this for EPs. Should we move on to hospitals where we certainly have a lot less data, for sure?

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

Is that how you want it?

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

It's hard to read.

Christine Bechtel – National Partnership for Women & Families – VP

This maintains the or 80% are offered access.

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

I thought we gave up on that one.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think you can take it out.

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

I think we were making an argument for the actual use being a good proxy for....

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

How are we going...?

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

I think the exclusions we were talking, the latest proposal I heard was trying to limit it to exclusion based on access to Internet, and there are systematically captured data that allows us to figure that out. Now

we don't have to do that for this comment period, but also it's something that CMS would do if they felt this.... Okay, moving on to hospitals, what kind of a statement could we make there?

Christine Bechtel – National Partnership for Women & Families – VP

One idea would be to take a similar approach with potentially lower thresholds. I'm not sure if they need to be lower, frankly, or not, actually, because it is an acute episode.

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

It is really new.

Christine Bechtel – National Partnership for Women & Families – VP

It is. Maybe that's....

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

It's really new, so I think....

Christine Bechtel – National Partnership for Women & Families – VP

Maybe this is a place where we go to Michael's suggestion of the percent offered access.

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

I'm still not sure of that offer because I think what we're trying to do here is stimulate interest and development in this area, and we can do that by looking at 2015 or something and sending some kind of a....

Christine Bechtel – National Partnership for Women & Families – VP

My concern is that, well, maybe we should talk about which bullet we're talking about, but I don't. It's my personal view that I'm not sure that it is that difficult for a hospital to figure out some ways to make sure their patients know that these services are being offered, whether we're talking about the fact that you can now get a copy of your discharge instructions electronically, or the more robust access to information. Certainly with the electronic access to discharge instructions, if they have to give it to any patient who asks upon request, they have to have the ability to do it, so why not communicate that to patients now?

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

I actually confused it with the during the hospitalization piece, and you're just talking about enrollment.

Christine Bechtel – National Partnership for Women & Families – VP

Right. No.

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

I'll retract my statement.

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

I think that's kind of the playing field that has to be met. Like to date, it's not part of that process where, when you register or do your preadmission testing, they actually tell you where you can get your results. Here's how we're going to authenticate you and use sign on and all that kind of process. That's the new piece that has to be added in, so there's got to be software to do it. They've got to figure out how to authenticate their patients. There's all this worry about privacy and security. They'll be pretty rigorous, this patient access.

Christine Bechtel – National Partnership for Women & Families – VP

The bullet two because we should separate the discussion, I think.

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

Even to start getting them enrolled, and then you have the other question about, well, what if instead I'm sending my data to the HIE, and it can go there? Then that question starts too, so maybe they go to the HIE rather than to the hospital portal because there's some....

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

I think that would qualify.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that would qualify ... access.

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

But how are you going to track it?

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

Yes, and how do you....

Christine Bechtel – National Partnership for Women & Families – VP

Well, it's all going to be attestation anyway.

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

Actually, Charlene, the fact that you housed them makes them pretty accessible for you to have this discussion and communication, and you could declare, I already have one. Don't need one of those because that's clear, or they sign up for yours, one that's hosted by you.

Christine Bechtel – National Partnership for Women & Families – VP

Or don't want one.

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

Or don't want one, so there is a process where we don't have to depend on this random scheduling event. They came to you, and there are a number of intake things that happen, and one of them can be this offer or decline the flu vac or whatever it is

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

What do you think?

Marty Fattig – Nemaha County Hospital – CEO

I think offering the access is wonderful. We've had an electronic medical record in place since 2004. We do not have a patient portal, but we do offer what we can and have had the ability for a number of years to give people an electronic copy. Very few want it. But anyway, but again, my arguments as to percentages of people who access still stands, whether they're accessing their clinician's record or the hospital's record, I think, is immaterial. My arguments still stand.

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

Is the proposal on the table this enrollment opportunity on admission, and you can indicate yes, no, have it, and do we need a threshold for that?

Christine Bechtel – National Partnership for Women & Families – VP

Are we talking bullet one or bullet two? I guess it doesn't matter, does it?

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

It doesn't matter really.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I guess, could somebody, I mean, is 80%? I mean, if you need to do it systematically, is 80%?

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

It's sort of an all or nothing.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, but if you're enrolling these guys, you've got a captive audience, and you're giving them information. You're not relying on them to uptake. It's just simply I'm offering you that either you can get your discharge instructions electronically, or we have access to this list of information electronically.

Marty Fattig – Nemaha County Hospital – CEO

How is this different in the ambulatory environment where you said we couldn't do what you just described?

Christine Bechtel – National Partnership for Women & Families – VP

It's a big change over stage one.

Marty Fattig – Nemaha County Hospital – CEO

And ... 20% or 30% of use is not a new change for ambulatory?

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

Ambulatory, you may or may not – you have a reg event. That can be 20 years ago. In a hospital, you have a reg event every time you come in to the place.

Christine Bechtel – National Partnership for Women & Families – VP

And the stage one threshold is 10% use, so it's still maintaining. It's just increasing the threshold with the same metrics, whereas in hospitals it was so totally different. It was only upon request.

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

Do we even have one?

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

We don't have one in the hospital.

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

Yes, we don't have one, discharge instructions. Yes ... discharge instructions or patient education reports....

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that's what I'm saying. Right.

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

I mean, because, from a hospital ... like if you want to do it, you've got a standard portal up. There's work.

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

There's a lot of work.

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

A lot of work that has to happen.

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

A lot of work.

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

I mean, I think we clearly want to go here, but it's just that time window to get there, but it's a lot of work.

Christine Bechtel – National Partnership for Women & Families – VP

But 80% for copy of discharge instructions, which doesn't require all the work you're talking about.

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

No, no, because you just asked them....

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Because you don't have to register, you have to register and authenticate them. That's the work. You've got to get them into your system and know who they are and give them a password and all that kind of stuff. You kind of go down the path we want to go to.

Christine Bechtel – National Partnership for Women & Families – VP

Right. But so are you saying that it's easier if they only have to do that for 30% of their patients versus offering that because once you offer it to a patient, the capability has to exist to do it, right? So I'm not tracking the threshold differentiation.

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

I think I'm less worried about the threshold than the timeline. Once it's there, it's there.

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

Yes. Correct.

Christine Bechtel – National Partnership for Women & Families – VP

You're more worried about the actual functionality--

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

Right.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

—than the threshold.

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

Neil, I think you or did you have—

Neil Calman – Institute for Family Health – President & Cofounder

I mean, just to say, just to repeat what I said earlier, to me the meaningful use piece of this is the ability for the computers to generate a document that's machine readable and human readable, and that's the meaningful use piece. It's the ability for people to be able to do whatever they're going to need to do to generate this document. It's not just going to be, push a button as we've heard, because there's so many variables here. It's not just going to be push a button, it's going to be the workflows to make sure all this information is in the chart within the appropriate time periods. I mean, that to me is the meaningful use piece of this.

And then how the patient gets it or uses it. I think we're dealing with that on the eligible provider side. And I just think you could drop it on the hospital side and not lose anything.

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

Drop what?

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

David?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Drop the ... in all of it, that's what I was going to suggest.

Neil Calman – Institute for Family Health – President & Cofounder

Drop, the fact that the hospital has to be responsible for a certain percentage of people accessing it electronically.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

I would say just drop these.

Neil Calman – Institute for Family Health – President & Cofounder

Who else would attend?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

I would just drop the patient access part here. I just don't see it as being really relevant.

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

Right, I'm suggesting what Michael had suggested for EPs around offered access. I'm not suggesting the same 20% to 30% actually access. I'm saying that for hospitals, 80% of patients should be offered discharge instructions electronically. And then I'm having a hard time understanding why if the capability is there anyway, you wouldn't simply offer the access under the second objective too, to 80% of patients, so it's just an offer, it's not a use.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

That seems okay to me.

David Lansky – Pacific Business Group on Health – President & CEO

I would think if you offered them access, the log in and IDs that you've inferred access to this.

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

Right.

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

Okay, so we might be violently disagreeing.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

You could actually do this in admissions.

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

Yes, exactly.

Neil Calman – Institute for Family Health – President & Cofounder

And that's it, so there's no problem here, so let's just do it.

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

Been there, done that, okay, so—

Neil Calman – Institute for Family Health – President & Cofounder

Let's do it.

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

So let me state—okay, Michael?

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

Please explain to me why you would hold the hospitals to essentially a lower standard in terms of usage then you are going to hold the ambulatory care providers.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

But the hospitals, practically speaking are just not going to be managing personal health records for people.

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

Right, but on the ambulatory, why couldn't you offer every person who comes into your practice a user name log in to get to their record, and that would be acceptable, as opposed to laying the requirement to them to achieve a certain percentage of their patients actually act for someone.

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

No, no, because—

Neil Calman – Institute for Family Health – President & Cofounder

Because the offices have an ongoing relationship with people in the hospital.

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

Yes.

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

Right.

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

Hospitals in fact purge their data mostly after periods—

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

And actually I think we wanted the EP to potentially for many patients become actually the repository, because as the central coordinator of their care, particular for their care.

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

I'm agreeing with all that, I'm just saying—

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

But that's going to require—

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

—holding a practice responsible for the usage of that data by their patients is what I'm asking, why, as opposed to basically saying give every patient user name, a password, access to this information, not holding them accountable for whether it's 15%, 20%, 25%.

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

Because the value of the problem—

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

... ultimately some specialists, so just keep that in mind, which may be different than their primary care provider.

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

Right.

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

So just keep that in mind.

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

That is probably something to think about.

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

I want to understand, but I don't understand holding the different—

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

The value prop—

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

I understand the difference in terms of the access of patient, inpatient, in a case of care versus on longitudinal care. But as far as the burden of having to make sure folks use this on a small practice, I'm just questioning—

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

I'm not sure we're calling it, we're saying the value proposition in the ambulatory setting is much higher.

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

I agree.

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

And that the outcomes we believe will be affected and the people who have been solving these things, some have measured it, there's far better patient engagement. They do achieve better outcome scores on the healthcare. So there's a lot of patients—

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

I don't have a question about that, I'm having a question about the threshold percentages—

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

Yes.

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

—that you're holding small practices accountable for. And the standard is opposed to, basically saying the practices will offer—

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

Right.

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

—80% of their patients access to this information through or using a password. Here's how you do the change package, but then not necessarily holding them accountable on how I'm going to use it.

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

My logic is that we in this workgroup have long held this principle of a glide path. And so to go from holding them accountable today for 10% of usage backwards to 80%, you just offer access, is not forward progress on the glide path for me. And for all the reasons that we just have talked about being important, and particularly physician leadership around access to and engagement with this information. But so there's a glide path notion, and in my opinion what we're doing is building on the glide path. And the glide path for hospitals simply started at a different point.

But I would advocate that by 2015, we would actually begin to hold hospitals accountable for usage. I think that's what we need to do, it's just that they're on a different point in the glide path. So you may not agree with that logic, but that's my logic.

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

David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think hospitals should be focusing on other things other than glide path. They should be gliding up to CPOE glide path and gliding up, and I don't want them to be gliding in this direction in particular at all really.

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

You need to bring all that other stuff.

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

Let's start thinking about, first, only propose a little bit from what Charlene said in terms of dates, should we focus on 2015 instead of 2013 for this, for hospitals?

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

For what, for this?

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

For this, yes.

Neil Calman – Institute for Family Health – President & Cofounder

For the offer?

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

For the offer.

Christine Bechtel – National Partnership for Women & Families – VP

No, why would we do that?

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

Because I don't think it's fair.

Christine Bechtel – National Partnership for Women & Families – VP

... I mean, we've got some brand new software—

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

So it's a brand new development.

Christine Bechtel – National Partnership for Women & Families – VP

Maybe if we can menu 2013 in core, but it's just—

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

Right, I'm convinced that's what will happen. So I'd rather put this for public comment and see what hospitals are able to and capable of doing in the market. And they comment that, and then how likely it would become a menu objection.

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

But now remember, this whole thing, we've been having this tension about the development lead time, etc. We're talking about new development. And then the final rule would come out in the middle, six

months before 2013 starts. It's just not possible for them to develop a brand new functionality, that's where it's becoming infeasible.

Jim Figge – NY State DoH – Medical Director

Yes. You're talking about real significant infrastructure development here. The ability to identify proof patients isn't even established. We're having a hard enough time figuring out how to identify proof providers for things like E-Prescribing of controlled substances, that in and of itself is a massive infrastructure undertaking just to do providers.

When you get the patients, where we don't even have anything like an NPI, and we have no infrastructure, no experience with doing it, this is a huge build out. Hospitals are not going to be able to do this in a couple of years.

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

Neil?

Neil Calman – Institute for Family Health – President & Cofounder

This is really directed to you, Charlene. So let's say we come out with this as a recommendation in our comment piece, right? Are you actually telling me that vendors aren't going to start working on this the day after this is published? At least frame the structure, figure out where this data is going to come from, even if at the end the vital signs aren't part of it or the medical list is not the first, that's not been the way I understand what's going on. People aren't waiting for the last final word to come out like six months before 2013, and then going, "Oh, my gosh, look at this, we've got to create a discharge thing electronically."

People are going to start working on this the way they've worked on the other things, the day that this thing is called out as a goal. And so whether or not the specifics are there, it seems to me like, it's now 2011, January, and we're talking about something that's got two years. And in two years, we can't figure out how to create an electronic discharge.

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

And how two years for the people who become meaningful users and the very first opportunity that they have—

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

—because they don't have to be stage one right now.

Neil Calman – Institute for Family Health – President & Cofounder

Exactly.

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

Yes. Let me just speak to a couple of the barriers, but I think you're exactly right. People are listening on this call to understand what the requirements are, so they're very much in tune with what's the requirements. I think the issues that we face on this list are the things that are not standards for some of these things, and there's a dependency we have on getting the standards defined to really do the development.

We've captured this data in the systems today, but it's all over the place. But if you want it mapped to a specific standard, we don't have that information. So that's again, that's a barrier to kind of start right now. And there's capacity there, because you don't want to have to code and re-code and re-code again because that's not efficient. So that's certainly one of the barriers.

I think certainly, I think there's enough recognition in the market, patient engagement is clearly something this group has signaled, but providers in general aren't there yet. Because they're still trying to deal with what's in stage one, kind of like what David said, they're kind of building out CPOE and med reconciliation. There's hard processes they're putting in place right now. So I think that's where the glide path is a little tough.

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

So maybe 2013, and here's a totally new idea, maybe 2013 we say human readable, and that doesn't require all the standards to be out there, but it does say let's pull all these elements together and give it to a patient in a meaningful way. And in 2015, we call out that by then we expect this stuff to be structured and to have some sort of framework to it. But I think it's reasonable in 2013 to say, we know how to create a PDF by pulling the sections of our documents together that we can give to patients and give them meaningful information. I mean that's kind of a new thought, but I'm wondering what people think about that.

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

We've talked about that in our small group, and I think that there's a lot of value in that if the market can get that done as opposed to looking for structured data by 2013 and it gets patients what they need, I think that's fine.

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

Okay, so do you want to put forward a proposal for 2013?

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

Well, you just majorly take the bullet that says in a human readable form by 2013, and then you would put by 2015 at the end of the second bullet, right?

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

Yes.

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

And again, there will be some elements that we'll be able to do that with, because they're emerging standards there. And those others are going to have to be defined and standardized in this period. So it's still going to be a glide path to get to everything being standardized.

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

Right.

Neil Calman – Institute for Family Health – President & Cofounder

But at least we get the patients, since this is the patient engagement part, at least we're starting to get some information to patients that are useful to them; and therefore, useful to them in transferring to other providers that they see. And I think that would be useful to call out sooner.

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

Is that going to be here too?

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

It seems like we made a topic switch when I wasn't looking. We were on enrollment.

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

Yes, you might want to re-center us, Paul.

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

The last I thought we were discussing from a—yes.

Neil Calman – Institute for Family Health – President & Cofounder

We were saying, that was the threshold ...

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

Okay, so last on the threshold was the motion of enrollment for hospitalized patients.

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

Correct.

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

And the offer, and when would we make that, I know we asked a different question.

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

But I think I remember you said everybody was in violent agreement that an 80% offering, so we thought we were done.

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

Okay, yes.

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

For both bullets.

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

We didn't come to a threshold.

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

But wait a minute ...

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

Yes, we did, 80%.

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

Okay, fine. And the date?

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

For two or for one?

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

Both.

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

And what's the date?

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

I just remember Neil was saying, look if you're going to have the capability anyway, then you can offer it.

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

Right, give people ...

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

Yes, but it's not, and that led into Michael's question about how come we're using different logics for practices.

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

Okay, so and what's the date, 2013 or 2015?

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

Twenty thirteen is for the ...

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

Twenty thirteen on the offer, okay.

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

...

Christine Bechtel – National Partnership for Women & Families – VP

...

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

A fast moving train.

Christine Bechtel – National Partnership for Women & Families – VP

It is.

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

Especially when it takes detours.

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

Yes.

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

Is that what you're saying?

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

Yes.

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

Good.

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

Okay, Michael?

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

I have a question for Charlene about the development. If I understood what Neil was suggesting, a human readable to start and then the structured format later, is that correct?

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Is that the best way for the industry to move forward in terms of, would it be better to focus on one and not trying to develop one and then the other. In other words, just focus on the structured, is this going to be a diversion or digression from the ultimate goal?

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

If we look at the current standards and the way they're defined, they're defined in such a way that there's a human readable chunk, and then there's a structured chunk. And as the industry is moving forward, the same data elements, as we start to standardize those data elements and get smarter, we're structuring those data elements. So the systems can evolve toward more structure. I'm just saying, as you look at

this whole list, I think we need to continue to follow that path where we can start to structure problem medications, allergies, we need to be doing that in 2013.

But there's some additional elements of that list which don't have standards defined. So that's what I was reacting to. And I don't think that could happen because the standards—

Christine Bechtel – National Partnership for Women & Families – VP

But are human readable, but ...

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

They are human readable now.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

So it's a blend of the ... approach. We prefer to have us evolve that set as the standards evolve, and then we'll make the structured data available as those standards are defined. But it's the directive of the Standards Committee, they need to look at this data set, assess where it is now, and figure out how and where they can standardize those things.

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

Okay.

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

Let me just see where we are, there's no new information. So we're saying what I wrote for objective two is right, offer aid to the patient and delete it down ... see myself with some problem with, because if you offer it, do you have the ability, anyway, so it's okay, that's kind of the concept there.

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

Yes.

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

Now then we've added this 2013, is that just for hospitals or also for EPs? Am I supposed to put 2013 here also?

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

We'll be using the same structure to do that.

Christine Bechtel – National Partnership for Women & Families – VP

You're right ...

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

It's really this combination, it's not clean.

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

Okay. I'm not actually sure that we have to back off from that, but—

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

Are the standards in place, Charlene, to do what you've described, I mean in P-side or are they the same standards—

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

It's the same, the CCD document or of the CDA family, that's where actually we derived, well, the first cut at least. You added a few more so I can't say that for sure anymore. But we derived that from what was defined in the CCD as kind of our starter set, but the point that's made is some of those elements still don't have standards for them, so we can't—And there's a glide path in the certification standards document to get the standards overtime to them.

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

So I would just make another point to try and make sure that the hospital and the EP things are as perilous as possible—

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

Yes.

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

—even if you're recognizing that that's not exactly where they're starting out—

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

That's fine.

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

—from the same point. Because that there's so many things that depend upon the standards and the dates, let's try and eliminate some confusion and say everybody should follow the same pathway and do the percentages the way you said, but set them up the same way. I think that will be an opportunity here we shouldn't miss.

Jim Figge – NY State DoH – Medical Director

Let me introduce another policy question and technology question, do we have policy in place in every state and do we have the technology that's needed to identity proof and authenticate patients to access any of these systems?

Neil Calman – Institute for Family Health – President & Cofounder

Paul, we're doing it in New York.

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

Each provider has to authenticate their patients, most people do require some positive ID. I know everyone I know does that, so that is being done.

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

Yes, we do it when you—

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

It's usually done—

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

—in the facility where they quickly are looking at you.

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

Correct.

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

It's no less stringent than the DMV.

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

The majority of our enrollments are done by your actual physicians, so they absolutely have to know you, otherwise they're treating the wrong person. Okay, so—

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

Wait a minute, on the first bullet.

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

I just, I'm sorry—

Jim Figge – NY State DoH – Medical Director

Well, what about the authentication piece, because are we relying on user names and passwords, which we know are basically worthless from a security perspective?

Neil Calman – Institute for Family Health – President & Cofounder

Do you know something that I don't know about my ability to transfer all my money from one account to another using a user name and password?

Jim Figge – NY State DoH – Medical Director

All you have to do is go out and look at the NIST documents and it's clearly, stated there, there's very little security value in user name and password, and it's not acceptable for many other processes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, I think there's widespread agreement that it is acceptable to this despite its limitations. It clearly does have limitations.

Jim Figge – NY State DoH – Medical Director

Well, is there any data on that? Do we know what the incidence of breaches, getting data out to the wrong patient, HIPAA violations, all that has to be thought about.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, there is some evidence, but the incidents is really quite low. When the violations do occur, they can obviously be more substantial than with paper, because you can transmit information about large numbers of people.

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

Well that's a different, that's not this problem.

Jim Figge – NY State DoH – Medical Director

No, no—

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

I thought it was a different ...

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

For this one it's like—

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

Let me ask you—

Jim Figge – NY State DoH – Medical Director

Has anybody studied what NIST level of authentication is appropriate for giving patient data out, should it be at level three?

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

...

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

So Jim, this might be a question for the HIT Standards Committee.

Jim Figge – NY State DoH – Medical Director

Well, but it is, but it impacts the timeframe, because if we should really be operating at NIST level three, you're not going to have this available by 2013.

Neil Calman – Institute for Family Health – President & Cofounder

Well, we aren't.

Jim Figge – NY State DoH – Medical Director

That's a very big implementation problem.

Neil Calman – Institute for Family Health – President & Cofounder

We aren't.

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

And we've got many, many providers today who are doing this.

Jim Figge – NY State DoH – Medical Director

It doesn't mean it's right.

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

But Jim, I'm not sure what you're suggesting.

Jim Figge – NY State DoH – Medical Director

You should have a study to determine what the right level of authentication is and how much time and resource development does it take to get there.

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

I don't have a problem suggesting that the privacy and security tiger team for example look at that question, but I don't understand if you're suggesting that we take out all patient access to information until we resolve that or what, because I think we've already agreed as a group that we want these. It's in 2011, we want these to evolve for 2013 and 2015.

Jim Figge – NY State DoH – Medical Director

You want to do it in a way that protects patient privacy and confidentiality, and I don't know that's been adequately addressed.

Neil Calman – Institute for Family Health – President & Cofounder

This is Neil, there's a whole separate part of the HIT Policy Committee that's been working on this and it's evolving the standards while we're speaking ...

Jim Figge – NY State DoH – Medical Director

I understand that, Neil, but it implies development of infrastructure which comes together. The infrastructure to do this is very, very complicated and it requires more time. If the privacy people say you ought to be at NIST level three, you will not be able to implement this by 2013. And what I'm suggesting is you've got to get that all integrated and thought through so that you don't put out a system that's insecure.

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

So Jim, it's already somewhat of a foregone conclusion, because we do have this in stage one. I think for this workgroup's activity, that something, it's beyond the scope of this particular workgroup. And we do have a workgroup on privacy and security.

Jim Figge – NY State DoH – Medical Director

Well, it's not that it's beyond the scope of the workgroup, it's something that needs to be integrated, so that it's carefully thought through before we make recommendations.

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

Okay. I want a time check here, David Bates is going to be talking about care coordination and he has to leave at 2:00, would the group like to take a break from this, do the care coordination, and come back here or postpone this?

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

I can't stay much longer, at 2:30 I have to leave.

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

Okay.

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

How much do we have to wrap up, I think we're done with that.

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

Well, we have to actually—

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

I don't know, are we keeping the first one or are we getting rid of it now that we've—

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

No, we're keeping it.

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

Because we said, wasn't there a question of whether if point two was strong enough, we didn't need point one, right?

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

No, so—

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

I don't understand what you mean.

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

I'm sorry, ... so my suggestion was that we go ahead and keep them both, because we don't know if the second objective will be menu or core. And if it is a menu set item, then we need the first one, and if it's core, CMS will do the work of parsimony anyway. So I think we should keep both of them.

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

Okay.

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

The content of number one, I thought was the offer and we took care of that with enrollment.

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

Yes, we're just saying the same thing that's there.

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

One is offer and enrollment.

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

One is—right.

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

I know, but we wrapped the concept of offer into enrollment and then used the outcomes of 20% and 30%--

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

For EP, this is hospital.

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

Okay.

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

Hospital is an offer only.

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

This says only offer.

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

Right, okay.

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

Okay, so I just leave this sort of.

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

But one caveat here in terms of, I know this is an important one, but if you're going to offer it to 80%, you assume that the capability is there to download, and the timeframes are still really challenging in that 2013 timeframe. So if you're going to say it, that means then we have to have that software in place to be able to do that download in 2013, right?

Christine Bechtel – National Partnership for Women & Families – VP

But the VA is here, so VA and Medicare, and they did the basic download capability in what three or four months?

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

Of an ASPE file.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

The bar is higher here. And I'm not sure we meant it to be higher, because we were talking about the Standards Committee use of PDF for ... specifically thinking about the ASPE file.

Okay, so my concern is two-fold, one, they've got to be able to do the authentication and register these patients so they can provide the download capability and stand up a portal or whatever. And then the second piece is they'd have the ability to be able to do that, and that's a lot in the timeframe. If by the time they get the software and they get the capability, it's just that that one's a really tight one. Now if it's menu, that give us some leeway.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

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

It gives us some runway.

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

Charlene, is that the same on the EP side too?

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

The EP has some, they have to provide the access to 10%, so they're already on the runway.

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

Okay.

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

The hospitals aren't on the runway yet.

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

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So the last thing that I had flagged was an upload capability, and I'm thinking, and it's obviously for EPs. So it may be that we need to think about that for 2015, I'm not sure, but I'm thinking about how, so if I go and download my hospital data, I'd like to be able to upload it into my primary care physicians, my portal with my primary care doctor, so that he or she could also see that. There needs to be a connection between two, otherwise what are thinking, why are we asking the hospitals to do, you know what I mean?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Wouldn't it also be satisfied with the care coordination?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And that may be, so maybe we should, if we're done here, go to that, because I think there is that transmission piece that we need to—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

And it could occur through other mechanisms too—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

—which might sort of take place at various speeds and various markets if there's a regional exchange, then—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

—they'd be able to get that information.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, great. Now, we do have to come back to some of the other ones under patient engagement, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I thought, have we not done those previously, because I know we held a ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You're right, you're right, you're right, okay, got it, I apologize.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Because we do have secure messaging in here, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so now we're to care coordination.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Okay, so for the first line, I think we should leave things, which is perform tests of HIE, stage three we have down 80% of requested disclosures are exchanged electronically, and we don't have anything in stage two. This is really in the hands of the interoperability group, but I think it's relevant here. I just think we should leave that the same and note it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So there's one question that's come up through states, is this does not actually nudge people over towards taking advantage of exchanges, and one question is should we? Because all this can be point to point, even our stage three. So should we make any comment about going to exchanges, because then they become discoverable, there's a pull, etc. That's an inflection point, what do you think about that?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think it's a good question, I don't know what the right answer is.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The other question I would add, which is one I posed before, is when we were talking about the test notion, it was at a time when ONC was developing NHIN Direct, and that there would maybe at least be sort of a basic secure kind of messaging capability across clinicians. I don't know where that's at, I keep asking, I don't know if we can get maybe a specific report to the workgroup so that we know. Because in my opinion, this criteria needs to evolve desperately.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I mean, at a minimum, it ought to be a successful test if it's going to be a test. But I'd like to see it go much beyond that if possible, but I think that relies some on NHIN Direct. So maybe it's possible that we could get a recommendation, so I'm thinking from the Information Exchange Workgroup that is based realistically on where the market is at, but that would be a criteria that would actually incent and drive progress rather than just sort of be something for something's sake.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So what if we take our methodology of working towards stage three and then work backwards rather than incrementing stage one tests and what do you do after that? And also maybe we use the where available kind of qualifier, because we've just got to be able to go discover and exchange and pull, not just sit around and push. So it seems like we have missed that—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

—function completely in our roadmap.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

If we had the where available, I think we could come up with some—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

—figure, where we have to standard something.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

And send a signal that people should start doing it, because they certainly should.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. So I think we need to do that, we do the where available. It's a combination of the IE workgroup and standards to figure out what's where available, but we can't leave this alone—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

—that's like one of the three categories that seems to—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And it is the title of stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's the title, yes. It's really the title of stage two. So let's, what would be stage two, so 2015, the meaningful use incentive program is dried up in its current form, where would we like to be where it's feasible and possible to be there? It seems like we would want to have it, well, it's a little hard to describe, but what you would like, from a functional point of view, I'd like to discover and retrieve all of the information about you where I have your consent to do so. And I need that kind of infrastructure in place, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I think we really, really need to have understanding where NHIN Direct is at too, because that expands the where available notion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I know, but that's for us to figure out later, but what's functionally, we're the Meaningful Use Workgroup, functionally what do we want to have, be it what can we accomplish as a provider acting on behalf of your patients by stage three? Neil?

Neil Calman – Institute for Family Health – President & Cofounder

I don't have the answer to that question, but I'll tell you where we're at in the situation, maybe that will help us figure something out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Neil Calman – Institute for Family Health – President & Cofounder

We're in three separate exchanges within our network, they all are exchanging different information and have different standards for how that information is being swapped. And so the reality is that's going to evolve and those things are going to start to come together overtime, everybody is going to figure out what that is. But for right now, I want to be able to be a meaningful user in stage two. So I think what we need to, and I guess I'm responding a little to what you're saying, in places where there are regional exchanges, some of the hospitals in our region are participating. It so happens that the one that we use isn't for the majority of our patients.

But yes, we're participating because we want to start this exchange process and learn how it works, and we're participating even though the small numbers of our patients are in there. So you kind of want providers I guess at the next stage to start participating in whatever is available, whether it's direct or whether it's regional exchanges or whatever. And to be able to do that, they're going to need the vendors to be able to know what's going on in all these frames, and there's no consistent way in which people interact with these exchanges, and that's been sort of the dilemma. I think the answer to your question is very complex in terms of what we're calling out for people to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David and then Charlene.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I agree. I mean we've done some surveys on this data play around the country is very much what Neil describes, most of what's moving around is labs, almost nothing else is moving around. So maybe we make it even sort of more process oriented and say something like, base it around provider participation in the available exchanges. You shouldn't have to participate in all the available exchanges, because somebody might be unreasonable, but you participate in at least half of the available exchanges—

Neil Calman – Institute for Family Health – President & Cofounder

Following any one, I mean, it's what ...

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We're working in available exchange, at least one available exchange.

Neil Calman – Institute for Family Health – President & Cofounder

We need to specify it specifically that we're, maybe to specify it specifically, that would be a good idea, maybe to specify that the lab piece is not what we're looking at here, because we looked at that, that's kind of the easy low hanging fruit. I mean, not that it's easy, but it's the piece that everybody's going to do first. What we're really talking about is provider-to-provider, some form of provider-to-provider exchange here.

Christine Bechtel – National Partnership for Women & Families – VP

What about Charlene's meaningful use data set concept, I think I just jumped in queue, I'm sorry.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

My only comment was, I was going to just align, it's really more than, in some places HIEs are in town and other places, there's direct exchange between provider and provider. So it's really kind of come back

where they participate in where an exchange is available. And I think that's kind of the next step up, because I don't think we know whether it's going to be direct or HIEs or some combination thereof. So I'm kind of more on that page, because at least people know they have to do that and they're getting the standards are in place and the readiness is in place in stage one, and we need to be doing some of that in stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Neil Calman – Institute for Family Health – President & Cofounder

It will help to promote the exchanges too if we put something in there that says, if there's a regionally available exchange that people successfully test their ability to use that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But it's more than an HIE, it could be direct-to-direct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So I think all I've heard so far is just promoting the test to direct without meaning the NHIN Direct, direct exchange of information by stage two. And we still haven't heard for stage three and Christine.

Christine Bechtel – National Partnership for Women & Families – VP

Well, I'm still in stage two, but thinking about, I like the idea of asking people to at least start exploring participation and exchange. But I'm also thinking, if there was sort of like a meaningful use core data set, if we were to look back at for example, we just had these discussions about downloadable, viewable information where we're trying to drive portability. If we thought of that at the beginning of a core data set, could we ask providers to have arrangement or the ability or even describe their ability to exchange with 5% of the doctors in their region, and that could happen through an exchange through NHIN Direct or through I know that I have secure e-mail to go one to the other.

And the reason I'm thinking, bear with me for a second, the reason I'm thinking about that is I'm also thinking about a concept we had discussed before, which was if you start to get a patient showing up, let's say you're a specialist, and the primary care doctor contacts you first and said, "Look, I have all this information on this patient who's coming to see you, I want to send it to you electronically, can you accept it?" Then at least that second doctor is getting touched by, this is like that meaningful use thing where you have to exchange data, what is it? But at least it's sort of driving awareness and beginning to get them to think about how they might except that and accelerate exchange more broadly. So I want to throw that out there as a point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We do have the CCD, which is coming up, and that I think will be the obvious thing to land on at least in the near term, because anything broader than that would be pretty tough for people.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so what about a stage three milepost?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

We need to re-wordsmith stage two I think.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Because I think, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So whereas stage one is perform a test, to pass or fail, stage two is exchange—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

I think it's providers participating in at least one exchange or in—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Alright, so that's different.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

What's that?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

You made a process.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So you're talking about participating in exchange, can the exchange just be a one-to-one, point-to-point?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

It could be one-to-one—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

—or an HIE.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

But I think we should explicitly mention an HIE.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

That way we begin to get it on the radar screen.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But if you participate in, if you have the ability to send data electronically to one other doctor, that is the same as a test for me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, because the test is where you can't even fail.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. A test where you can just try it with a vendor test system. You need to really transmit and use this function.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

For the test.

Christine Bechtel – National Partnership for Women & Families – VP

But that's what the test was, it was a test of your ability to send data to another provider.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Period, no.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You just passed the function.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

No, I don't think so. I could be wrong, but I don't think so. I think it was send data to another provider.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But this actually—

Neil Calman – Institute for Family Health – President & Cofounder

Why don't we make this operationalized.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is actually, you're starting to use it now. And even if you just do it between a practice and the hospital, there's a lot of experience that's gained.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

That's better to practice in a hospital, but I'm saying one primary care doctor to one specialist, and they meet this criteria one time, there's no difference between that and the test in my opinion.

Neil Calman – Institute for Family Health – President & Cofounder

I would make that operationally, why don't we just change it to operationalize. Operationalize exchange in available with either one HIE or directed exchange with one other provider. Operationalize it is different—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

—it means you're doing it and you're using it in an ongoing way.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

In an ongoing way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

A permanent capability, maybe something like that, a permanent capability? Because the test was a one pain thing.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm trying to find the words like you are, operationalize, it's really there and I think this could be used for all time.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Established.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Established and ongoing.

Neil Calman – Institute for Family Health – President & Cofounder

Established and ongoing ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Ongoing exchange.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Ongoing, yes, established and ongoing are good, yes. Okay, but still we need to get something in stage three to give a much stronger signal about the participation, the ability. And again, we also have, in addition to just say, "Hey, I want something," and it's like turn your fax machine on and push, you need to be able to discover and pull, and that isn't here yet.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Neil Calman – Institute for Family Health – President & Cofounder

Right, I just wanted to, can we put in bilateral?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

bidirectional ...

Neil Calman – Institute for Family Health – President & Cofounder

Bidirectional—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Because I just—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I agree.

Neil Calman – Institute for Family Health – President & Cofounder

—one of the exchanges that I just heard about is allowing people to pull information down even if they choose not to participate in contributing information. I think we need to put a clause that this needs to be bidirectional.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And where do you want that in, in stage two or three?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, he just put it in, that was two.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That is bidirectional.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So that automatically invokes the pull. How does stage three look different from stage two, and do we want to add the notion of these HIE? I'm a little scared of saying organization because it doesn't have to be an organization, but it has to be an exchange, not just point-to-point.

Neil Calman – Institute for Family Health – President & Cofounder

I think the problem, I'm sorry, go ahead.

Michael Barr – American College of Physicians – Vice President, PA&I

Haven't we put the HIE in the stage two already, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, the way it's worded, you can do a point-to-point exchange without having this information be discoverable no matter where, without the predetermination that a patient, that the information is going from point A to point B. So when the patient travels or whatever and goes to point C, they can still discover point A is A and B, that's what's not in stage two right now.

Michael Barr – American College of Physicians – Vice President, PA&I

So you're saying like a record locator service or something, I'm not sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It depends on a record locator, right.

Michael Barr – American College of Physicians – Vice President, PA&I

Yes, okay.

Christine Bechtel – National Partnership for Women & Families – VP

Not so much in stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Not in stage two.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Stage two, like if you're connected, it's that governance layer application in stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Because that's the tough piece.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the tough piece.

Michael Barr – American College of Physicians – Vice President, PA&I

So we don't really know—

Neil Calman – Institute for Family Health – President & Cofounder

And it's going to evolve in stage three, right? I mean, think about what's happened in the last 12 months between direct and HIE.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right, and we each have to signal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But I guess what we're saying is if we don't signal that you need to go find this information, there is no place on here that says, this is the kind of functionality that the vendors have to supply. This is the kind of governance that we have to supply in whether it's an NHIN or the local version of that, that's what ...

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Could we make it similar to stage two, but supply some threshold and say something about requested disclosures? Change it to something like 50% of requested disclosures, 80% make me very nervous. I just can't imagine, I hope we can be able to handle that. Neil's going to ask me for my radiographs or something that I don't have.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Marty? We've got four years to go.

Marty Fattig – Nemaha County Hospital – CEO

Could we go first of all here, go out and define the future state?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's what I'm trying, I've been—

Marty Fattig – Nemaha County Hospital – CEO

And then back to ...

Neil Calman – Institute for Family Health – President & Cofounder

And that's the problem, I don't think we can define the future state, that's why I don't know how we would do this.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

This is a big one, we could—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It's depository, don't depend on HIE or direct, what is it that you want to have happen in that future state.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So maybe that's how we ended up with disclosures, and then now David's trying to pinpoint the threshold.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Alright, so what proposal for a threshold would you like, 50%?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I said 50%. And that—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And that you say you're in stage three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Stage three, I guess.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Do you think that's wildly unrealistic? I mean, it seems wildly unrealistic to me having to look at all the existing RHIOs and listening to what they're doing.

Christine Bechtel – National Partnership for Women & Families – VP

Well, but remember it's not the way you guys are saying this, not just RHIOs, it's also point-to-point electronically.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, I don't have a lot of confidence in point-to-point frankly.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I agree, but that's the way this reads. So if this includes point-to-point, that 50% maybe not that scary. But if it's just through an HIE.

Christine Bechtel – National Partnership for Women & Families – VP

So does a requested disclosure include at point of discharge and generate my discharge summary or whatever equivalent and send it to the primary care doctor, that's a requested disclosure because it's an established condition?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In fact, should we go ahead and take advantage of our previous work and just pin it on those two "documents?"

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Well, I think it's more than that, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Because the most important ones are the unanticipated ones. It's essential to do the ones that you did anticipate, but when somebody shows up in my place and I was not expecting them to come, then I need to be able to get information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm sorry, no, what I meant was the data set.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Because otherwise 50% of what denominator, and then you had your fear but, if we go 50% of the request for this set of information.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, well, the key things are labs, x-rays, medication lists, then notes, and referrals would be number five, but those are the things that are the key data types that are being exchanged now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So I'll get Michael and then George.

Michael Barr – American College of Physicians – Vice President, PA&I

Well, I gave you the key data types, I still am having trouble figuring out how you would ever get to a denominator to get to the first 50%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Michael Barr – American College of Physicians – Vice President, PA&I

It just boggles the mind. If I request I want these three things, is that three disclosure requests, one disclosure request? It's just not calculable, at least as far as I can tell. I like the idea though of focusing in on the things that are already established as sort of the things that should be exchanged if we want to kind of want it motivated.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

The way night clicks work is you put your data from your database into an edge server, which is on your campus, but is really controlled by the HIE, like you never see anything else, it's just your data is in the database. And I'm sure you can ask for some log files from them, I guess, that's what they'd have to set up, but normally that's not the way it works. You've made your data available and then they worry about the rest of it. I never know who accesses my data. There's some emergency room that get consent from the patient, they query the data, and I never see any of that in any of my systems, not in my EHR. It's external. All my EHR knows is I sent all the data to this edge server that I don't control.

Christine Bechtel – National Partnership for Women & Families – VP

So George—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So I don't know how we would measure this.

Christine Bechtel – National Partnership for Women & Families – VP

...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Go ahead.

Art Davidson – Public Health Informatics at Denver Public Health – Director

George, I just was wondering isn't there an audit file on that edge server?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

There is, so I guess, yes, night clicks would definitely have an audit file. I don't know how they audit the requests. They would certainly audit the supply of information, but I don't know how they would audit. In other words, if an ED, they give me all the information on this patient, that's a request. If they don't get any information from me, it just doesn't show up on the list, it never shows up, like it's a failed request, but you don't know it. You'd have to do the match between the request that occurred at another hospital's ED, and the fact that night clicks didn't match that request to a patient who's in my database. How do I know they missed their guy in order to be able to get that denominator.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You'd have an accounting for disclosure requirements, so I think you're going to have to solve this problem.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

What's that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You're going to have to know who you disclosed all this data to.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That's different, that's the numerator, they have that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

They have that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

The denominator, how do I get the denominator?

Neil Calman – Institute for Family Health – President & Cofounder

It's how many times ...

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

How many times they didn't find the patient in my database?

Neil Calman – Institute for Family Health – President & Cofounder

I'm sure that that's reportable too, but—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I don't know, you'd need someone manually match those.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

How do we—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I just don't know, it's always a hundred percent.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It's about making the data available is what I'm picking up from George.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, can we rely on the former clinical summaries as our denominator for right now?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So you make some version of the clinical summary available to an information exchange.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

When people request the clinical summary, it's available ex-percent of the time electronically. It's transmitted ex-percent of the time electronically.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But I think that relies on a lot of people to get really meaningful, we're talking future state, robust information flowing, that relies on a lot of people requesting that information. I'm not sure that's going to happen. So what if instead we create the supply?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the disclosure part, okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Well, we say you have made your data available, some core set or whatever it is, to all of the exchanges in your area. And either you're sort of right and it's more of a process component I guess.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I don't know.

Neil Calman – Institute for Family Health – President & Cofounder

That could have a huge cost associated with it that providers are not going to be able to bear. I mean, there's membership fees for these things in the \$10,000 range that you can end up, you wouldn't want to be, plus if you're really thinking about it, at some point everything converging, it won't matter where you pay in the system, because it will sort of go out the different ways. You'd only want to have to learn to play in one place.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I wonder if we should ...

Neil Calman – Institute for Family Health – President & Cofounder

Maybe this will be helpful, because I don't know how to get it to be helpful, but here's what's happening in New York. So New York State defined in one of their recent grant proposals that the providers that want to get access to these funds have to define the set of specialist and people, define the network that they use. So we had to define who are the people that represent more than 50% of our referrals and whatever, and that could be 8 people or it could be 20 people. But somehow look at the people who are the circle of providers around a given provider, and that could be a specialist or a primary care provider.

And then say if the people within that primary group, and I'm trying to remember what they called it in New York State, but within that primary group of providers are capable to exchange electronically that you do so with 50% of those people. And because what it helps to do is it helps to define that scope of practice so that you can say, these are the top ten people on our list of who we work with, and we have to exchange information with them electronically if possible. But it doesn't force you to go into a community and connect with a hospital where none of your patients go.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, and—

Christine Bechtel – National Partnership for Women & Families – VP

What I liked about that is that it, as I think about the purpose of information exchange, like sort of beyond the obvious, in this environment we have to be thinking about how to set providers up for success under ACOs, medical home, independents at home, these different models of care. And the ACO thinking at least today is exactly that, that the ACOs would really kind of define their networks from ... I like that and I think that it's not actually unreasonable to ask it in stage two. They define their sort of top referring patterns and assess their information exchange capabilities, and then that still applies, establish a bidirectional connection with at least one of them or with a health information exchange.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so those are.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I like that notion, we could add to stage two, define your circle of care and then do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And establish with one here, right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Right, do we have time to ask for a little more input from the ... Workgroup around this too?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sure.

Christine Bechtel – National Partnership for Women & Families – VP

I'd like that.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But I like the concept that where you're going, which is kind of if you've established that circle, and then you start to build, and you're just increasing your threshold. The software is there, bidirectional, and you can start to build it out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. David Lansky, are you still on?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

As opposed to, so I'd go to stage three with kind of just expanding stage two when the future stage is all built out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. And then so Christine also said or participated in health information exchange that gets you a "credit."

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, good. So stage two was one other, and stage three, do we have a number or it's just a placeholder?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Stage three I think is complicated ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

More than two.

Christine Bechtel – National Partnership for Women & Families – VP

More than one.

Neil Calman – Institute for Family Health – President & Cofounder

Once it's defined, then I think we would be in a position to set a threshold, but I don't think we can do that now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

In other words, once you define that network and we can see what the adoption rates are and stuff around the country, then I think you could realistically—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

—possibly call out a threshold. So maybe we could say that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So it will be a TBD and consult with IE—

Neil Calman – Institute for Family Health – President & Cofounder

Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Consult with IE Group.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

George, I think while we were talking about is slightly different than what you're writing.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So the suggestion was ask the Data Exchange Workgroup for their recommendations about how to evolve this performed ... criteria in general I think. But that under state two, what we're saying is the requirement would be exactly that, define your referral pattern, the people who make up your referring partners.

Christine Bechtel – National Partnership for Women & Families – VP

And that would be the same, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Trading partners, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Trading partners, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We call it the trading partners.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And that that would be in stage two. And then you either exchange with one of them, at least one of them or an HIE.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Michael?

Michael Barr – American College of Physicians – Vice President, PA&I

This is Michael. So the idea of defining who they refer to as a generalist, we know for Medicare data that the average internist or average primary care doctor refers to over 200 different specialists for Medicare only. So that becomes a logistics issue, so depending on how you define this. And then from the sub-specialty perspective, many of them receive referrals across state lines, regionally, I mean, the general idea is okay, but recognize the implications and logistics associated—

Neil Calman – Institute for Family Health – President & Cofounder

So we're saying the top standard.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But the most common.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's not an exhaustive list, you basically, you get to pick one. So you can make it one if you want to.

Michael Barr – American College of Physicians – Vice President, PA&I

I heard you to define the list, so we need to, all I'm saying is narrow the focus for explicitly ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Highest volume.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We could use a copy of the language from New York, it has already been done.

Michael Barr – American College of Physicians – Vice President, PA&I

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. Sort of the highest volume actually.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, David, we need to move along so that you can—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

So should we talk about ... reconciliations?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

So for that, there's a 50% threshold in stage one. I think we should pick some higher stage in stage two for relevant transitions. I would pick something like 90%. I mean, I—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

For stage two?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So right now, our—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

We actually already required to do it here, I'm talking about—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, what we did was move it from menu to core, that was our recommendation from last time. Right now it's a menu set.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So what we did was move it to a requirement—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

—mandatory—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

For stage two?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Yes. Well, okay. Which care transitions are we talking about? I couldn't remember that.

Christine Bechtel – National Partnership for Women & Families – VP

Today it's the hospital on admission.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

Yes, so on admission under research.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, and then it was settings or providers as determined by the provider.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So it became that's their translation of what we called "relevant encounter."

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Okay, I think we should probably have a higher threshold for stage three then anyway.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We just need to keep raising the bar.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. So your proposal then would be, that would—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I would propose 90% for stage three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So you're happy with the switch of 50%, going to mandatory in stage two then?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. And then raise it to 90%?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

David, it is, at least on the hospital, it's only on admissions right now.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

It should really be both at admission and discharge, maybe we should say that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

If you want to say—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

The Joint Commission requires that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And you remember for sure that it was only—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

We don't get these kinds of calls.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

In the care of an EP or admitted to the eligible hospital, inpatient or emergency department, that's the measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And on admission in terms of the measure right now.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

The three times that are important are at admission, at discharge, and then immediately post discharge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So what is it for EP?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

EP, it says 50% of transition of care in which the patient is transitioning into the care of an EP, so into the care—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

—or admitted, so it's just at—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

So post discharge would count.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It's not included, well, no, it's not ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So what's medical reconciliation for the provider?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The EP?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

EP, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It's when they first come into the practice is what it sounds like, I'm not sure how it's measured, I don't have that answer, but it's transitioned into the care of an EP is what it says in the measure.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

So it's actually really important after every hospitalization has pretty good evidence about that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But I thought there was a notion of we change the settings or you change the provider.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And the determination of when it was "relevant" was up to the discretion of the EP, because we couldn't come up with a better definition either, but it allows for that kind of thing.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Right, we didn't want the dermatologist to have to be doing these.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So there may be exclusions in the detail, but right now it's just at the point of it's not on discharge—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So do you want to be more explicit then?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Let's be more explicit, the key times are really at admissions—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Admission, discharge, and—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

And immediately post discharge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

First post discharge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Marty?

Marty Fattig – Nemaha County Hospital – CEO

What we have found is that admission and discharge of the hospital is a lot of the times when we pull together the various sub-specialties that basically seeing who, the primary care physician has no idea of who prescribes their medications. So this is where we kind of pull the whole thing together ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I mean, I think this is a good start on admission.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I mean, there's enough around that space right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We should say admissions, discharge, and the first post discharge.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And just to kind of amplifying that one of the test in direct is to look at on discharge generating one of the CCD documents, so the practice has that data available to do that post discharge reconciliation process for that link for that.

Neil Calman – Institute for Family Health – President & Cofounder

I think for eligible providers, this is probably a step backwards, that would be my call. I think people do this more often now than what we're requiring them to do here. I think people—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

With the system?

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

With the system?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I mean, that's the only way to do it, that's the only place the patients medications are recorded ...

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

You're thinking about primary care providers, aren't you?

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Do you think specialists are doing this all the time?

Neil Calman – Institute for Family Health – President & Cofounder

I think with changes, no, but what I would want to say is that with changes, with significant changes in chronic medications, that's when you have to do med reconciliations to review everything that the persons taking is when you're changing somebody's chronic medications, you want to review medications that people are actually—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We had language in there before which I think had covered that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, we had that, see, there's two things, one is we also inserted into the maintained active med list, because we inserted the concept of being up to date. This is with category one.

Neil Calman – Institute for Family Health – President & Cofounder

I thought we did it in the other direction, we said that the med reconciliation was going to take care of the updating of the med list.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, actually the note say that we're going to define what up to date means, and Neil Calman was saying—

Neil Calman – Institute for Family Health – President & Cofounder

No, no, no, but I just thought in the workgroup call, what we said in the workgroup call was that we didn't want to call out every time somebody was supposed to update the problem list, but what we would say is that the process of med reconciliation is the updating of the problem list and that we should ... on the medication list and that we were going to punt back frequency discussions to basically say, let's just make that an outcome of the med reconciliation process we're calling out. What you have, came out of nowhere.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I think Neil is right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, Neil is right, do you have the language in front of you about the relevant encounters, because that's where I'm ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Which measurement?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's really the med reconciliation, and if you search for relevant encounters, I think that's the key word, the phrase that we used.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

All I have is the objective, okay, objectives, EP, eligible hospital, who receive a patient from another setting of care or a provider of care or believes—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

—an encounter is relevant, should perform medication reconciliation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

If the measurement doesn't correspond to that, but the language of the objective is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, that's the objective. Okay, so it's in the objective.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, you've got the objective right, you don't have the measure there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And that's under care coordination?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

So I think that remains the objective.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Doesn't it?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The objective is blah, blah, blah, received a patient from another setting of care or provider of care or believes an encounter is relevant should perform med reconciliation, so that captures Neil's piece. It's just that the measure doesn't correspond, couldn't define what is relevant.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

That's an important part of that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We don't have to do everything that the measures define, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Alright so—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

At least the providers ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I know. Are you ready for the next item then?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes. Okay, well, this is, here it's called the summary care record, which is fine. So what I would suggest here is that a summary care plan be available for like electronic exchange for some percent of patients with high priority conditions.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Stage two?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So what we had said before was it's already at 50% in stage one as a menu, and we had suggested—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Summary care plan is?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

I think it's a new one, isn't it?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

No, I think summary care plan is new.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. So are you changing it?

Christine Bechtel – National Partnership for Women & Families – VP

No, there is something in stage one that's set at 50%.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So this is the summary of care records—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So the EP is eligible hospitals ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You're talking about the care plan, David—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
—or the record?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine
I'm sorry, I'm talking about the care plan.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine
So I'm getting confused between the summary care record and the longitudinal care plan.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the summary care record—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine
So is that the CCD?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Or a piece of paper today, so—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And it really corresponds with this. This is where it overlaps with the patient engagement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Yes, can't it be the same thing that what we called clinical summary?

Christine Bechtel – National Partnership for Women & Families – VP
I think Neil, when we were talking, like so for example from the encounter summary from a hospital setting, I think there are more things that are probably displayed in different ways for a provider than for a patient.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
So I don't know that it can be the same.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I think we've got probably provider things into the patient in the last conversation.

Christine Bechtel – National Partnership for Women & Families – VP

...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, we may have.

Christine Bechtel – National Partnership for Women & Families – VP

They did, so a lot of the realities—

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I think we should see this as saying, I mean, otherwise we're calling out like nine different documents.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Neil Calman – Institute for Family Health – President & Cofounder

While it should be the same.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Okay, and now I'm on the right page here, 2015, there's a strong movement to go beyond what's in the CCD to get some additional data, which is going to be specified in the CDA, but all of that is not fully specified at this point. So what I'd like to do is to say that there will be additional elements without being specific about what they will be at this point, does that seem reasonable, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, and the feedback on this one and talking with the vendors is there's so much variation, this area, the plan is not defined. There's a lot of variation around the plan. So clearly work on that and understanding that will help. The good news is, actually, some of this is being tested in the Beacon community.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

If we could get some testimony from that in terms of these shared care plans and what works.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

It's also being tested in Massachusetts. There's been a group that's established something called the Massachusetts Care Transitions Form in which they established after going through a consensus process and looking at the standard that the Hospitalist Society put together. And there are a couple of other similar things, and so it's not been fully tested prospectively, but it's reasonably robust.

Christine Bechtel – National Partnership for Women & Families – VP

So I'm a little bit confused between, are we adding a new criteria that would be longitudinal care plan or whatever we call it, because there's a care plan and there's the summary of the care record.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We need a care plan too, and that we have to add, and that we'll do in the next one. So here, we're talking—

Christine Bechtel – National Partnership for Women & Families – VP

You're talking about the summary record?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I thought you were talking about the plan.

Christine Bechtel – National Partnership for Women & Families – VP

I thought so too.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, it's kind of like as you look at what we put under the patient engagement piece to start to build the plan into that. So the question on the table would be, could you do the same thing with the summary record, start to build it out, so the plan is encompassed in that context.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Well, if you took the definition that we did under the patient family engagement piece, which would include a care plan, that could constitute the summary care record, unless it's already assigned in the rule.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think that there's a whole separate thing on the provider side that's focused on defining which specific elements people needed.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

It turns out to be things like details around the code status, what the plan is around Warfarin. They're a bunch of specific items that are needed.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Just beyond what the patient ...

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, yes. And the patient might want to know about those two, but—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, yes, okay. But we do need to, at least for the care record, do we need to define the elements or at least refine the elements that's already assigned?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Well, in 2013, what I would do is just use this, is just lean on the CCD, that's what I was thinking.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay. And then the question is, what do we ask them to do with it, because right now, what is the requirement right now? What are they supposed to do 50% of the time?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Fifty percent of the care record, and I forgot how this one—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Provide the summary of care records, more than 50% of the transitions of care.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And how is it defined?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And this is an EP transition.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, how is it defined though? What's the summary of care record?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It could be a PDF today.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, but I mean, what's the content?

Christine Bechtel – National Partnership for Women & Families – VP

Charlene, do you know?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I don't have that.

Neil Calman – Institute for Family Health – President & Cofounder

We need to like you've said before, we need to have titles for these documents. Each time we define one, we should nail down a title for them, so that we can—

Christine Bechtel – National Partnership for Women & Families – VP

Josh, do you know if the summary care record is defined in the rules?

Josh Seidman – ONC

I believe it is, but I don't know the particulars.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I think it maps, I just can't foresee that.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

We could do some extra homework on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

My impression after trying to read everything that I could was that it was the CCD, but I might be missing—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so it's separate from the patient care summary, okay?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And then you are adding a longitudinal care plan.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Correct, so that's another line, and that's, let's see where is that, is that below the—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

—so that's right there, okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The summary.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You already have it care.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

So care team members and the longitudinal care plans—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Two down.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

—should be separate things, somehow, one of them migrated down to the right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think the longitudinal care plan should be available for like chronic exchange in 2013. For some percent, I suggested 10% of patients with high priority clinical conditions. And that in 2015 that that should be increased to some other figure like 50%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So what we had previously said perhaps you see, because there was no definition—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

—is to say, and one of the things we heard from the hearing was, "Gosh, if I even know who was on this person's care team that would be a major contribution, " so we said that.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think we should do two separate things, the next thing I was going to ask for is the list of the care team members—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

—including for some percentage. And I think we should do two separate things that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

—one is the longitudinal care plan, and a second would be the care team members.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. And who’s going to define this longitudinal care plan?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

In most instances it will be the primary care provider, but in some other instances, it would be the nephrologists or somebody else.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So how would we turn that into a requirement of each meaningful user?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

That, this is we’re talking about patients that have high priority clinical conditions, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

So these are people who have some sort of substantial illness, and they should be being managed by somebody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

And for an eligible provider, they don’t have to have been the one who did it if somebody else did it—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Like a care management.

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

If nobody else did it, then the provider has to talk to the other providers, and somebody has to take responsibility. That’s the way I’m thinking about it. I can’t think of a better mechanism to figure it out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So can we get into that space by 2013 though?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

That 10% is not a very high threshold. I think it would be reasonably straightforward to do so.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I guess I’m—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

That was a really strong recommendation from the hearing that we had.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's just timing.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The first percent is going to be the hardest. I mean, what does that look like, who's plan is it, and who has to transmit it? I mean, one way is to say, everybody should be knowledgeable about it. So whoever generated it, what is it, and how does everybody get access to it so that they can keep passing it on and operate on? That seems like a big cultural and workflow thing.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So that first percent is the biggest.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And so then the question is just timing.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I think this is a huge impact in the vendor community, because we don't have the standards, this hasn't been done in practice, IT doesn't have to follow practice.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

But if we're going to improve care, people with chronic conditions ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

We don't disagree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We don't disagree—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

We totally agree.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes, we're talking about a very small tenth of the world.

Marty Fattig – Nemaha County Hospital – CEO

Yes, my concern is this ...

Christine Bechtel – National Partnership for Women & Families – VP

Is there a smaller bite you could take or something? It's just going to—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, how?

Christine Bechtel – National Partnership for Women & Families – VP

It's just 2013 is just so unobtainable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

How do we do the first percent, either what's the, yes—

Christine Bechtel – National Partnership for Women & Families – VP

But you have to have it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Does the care team—

Neil Calman – Institute for Family Health – President & Cofounder

Let me just do the question, does the care team include, are there people on the care team who would not be documenting any electronic records?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I think that there could be, but I think—

Neil Calman – Institute for Family Health – President & Cofounder

The majority of them would be, right?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Mostly they would.

Neil Calman – Institute for Family Health – President & Cofounder

So then why don't we require the system to just extract the list of the people who have documented in the record with their role.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

He has other separate lines.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

That I think we should do.

Neil Calman – Institute for Family Health – President & Cofounder

But I said 10%.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

But that's necessary, but not sufficient. Here, we're talking about the plans—

Neil Calman – Institute for Family Health – President & Cofounder

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

—not the team.

Neil Calman – Institute for Family Health – President & Cofounder

But the information about the care plan is not necessarily something that's generated by the EP, means if you follow the train, you have a bunch of people who are documenting in the records, you know who they are, but the EP isn't necessarily the one responsible for developing the care plan.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Well, right now, most of our patients don't even have the care plans.

Neil Calman – Institute for Family Health – President & Cofounder

I understand that, but as we move forward to them—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

And ...

Neil Calman – Institute for Family Health – President & Cofounder

—we’re hiring people to develop those, because we think as developing fair plans for chronic disease, and we’re bringing in educators and other people who are doing that. If we’re talking about on the EP side of it, and meaningful use is an EP sort of criteria, some of this may be out of the hands of the eligible provider is what I’m saying. The development of these care plans in an organization may not be something that’s within or even in an office where people are using other providers. It may not be within the hands of that eligible provider.

So I’m just trying to figure out, because that’s who’s responsible for meeting meaningful use are the EPs. We had this issue in a couple of other things, I can’t recall what they were, where we’re involving people outside of folks who are the ones we were supposed to be qualifying. And I think it’s a very important piece.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So just kind of on this, this is like the reality side, today, within a venue, care planning exists or doesn’t exist or is very specific to that particular venue. So we’re trying to reach the bar of making a consistent approach across settings, that’s a really big jump process-wise. So that was why I think from the vendor community, there’s got to be some standards to where we’re going to, and we can start to get on the glide path of getting there. So as you start to define goals and outcomes and interventions, are you going to use those words? Those are nursing words or it’s those simple things.

And then of course, they should relate to those other standards that we set. So that framework has to be set, or do we just agree we’re going to like get to a consensus on problems or something? So that’s the discussion that needs to happen to start to drill down, and then the vendor community can start to work toward that glide path to get to the care plan. But today, what I’ve got in the hospital, and it varies by hospital, and then it varies by practice. They don’t even do them in the practices. Care managers do them, so we’ve got them there. There’s a lot of experience in that space, but it’s not connected or coordinated at all.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So I guess what I’m hearing is that culturally we don’t yet have agreement with the let’s say EPs on what it is and how to transmit it even if we had it. And then the vendors don’t have that kind of functionality to help us even if we did have it. And with everybody buying into the idea, maybe people are just asking to shift it by one stage. And the question, do you think there’s anything shorter term that we could do or would you agree with this shift to the stage?

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine

And if we’re going to do something shorter term, we would I think it would just be to have vendors to have the capability to store a care plan.

Neil Calman – Institute for Family Health – President & Cofounder

Capability, yes. What about the certification?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That’s the certification—

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

That's not bad. I mean, like—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, how do we—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

—on the hospital side, we kind of have to do that, on the EP side, I think you've got a bigger gap there, and they'll push pretty hard that we need a standard or that—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

And then we put a care plan in 2015 perhaps.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The shared care plan?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I'm sorry, the longitudinal care plan in 2015.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, right, right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Not the shared care plan, that's already in 2013.

Christine Bechtel – National Partnership for Women & Families – VP

But you mean in 2015 would be the exchange of it, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So right, maybe that's where we're getting close, so you're saying—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

All I'm saying put it off to 2015.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The longitudinal—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The exchange of the ...

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Not the exchange, just the development of it. I mean, you also need to exchange it for it to be valuable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, maybe the—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Maybe it can start to be consistent and see ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the in between is what you may have suggested, which is record a care plan—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

—in 2013.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And then exchange, i.e., longitudinal in 2015.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So that, by recording, that's how you get the certification criteria that makes them store it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And that's how you loopback to the patient family engagement criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Does that make sense, David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

So that would be fine.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And then longitudinal?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

...

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So we're just getting rid of 10% and saying we're just going to record a care plan for the—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

For what percent?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I would say 10%—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That would need the capability, alright.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Marty, and then Michael.

Marty Fattig – Nemaha County Hospital – CEO

A comment overall statement that I wanted to make note of here as that a lot of these criteria that we are outlining here are based on the assumption that a large number of eligible providers and hospitals become meaningful users in stage one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Effectuated, yes.

Marty Fattig – Nemaha County Hospital – CEO

And that is not a given.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That was another piece about 2013, that would be hard.

Marty Fattig – Nemaha County Hospital – CEO

That is definitely not a given.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I just have one more thing that I would like to suggest, which is on the list of the care team members, I think we should call out, including who's the primary care provider.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, good.

Neil Calman – Institute for Family Health – President & Cofounder

I would say a list of the members and their roles?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

...

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

It's especially important to know who the primary care provider is, if there is one. If there's not one, fine.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The recordings were only 10% and really low ...

Christine Bechtel – National Partnership for Women & Families – VP

Right, this is not exchange?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Neil Calman – Institute for Family Health – President & Cofounder

But team members should, that should be started, and I think that should be a hundred percent. No really, which reports, which reports—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

It should be an electronic exchange.

Neil Calman – Institute for Family Health – President & Cofounder

No, we're not talking about the exchanges.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Then we've got to change it.

Christine Bechtel – National Partnership for Women & Families – VP

We're talking about—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

We're talking about—

Neil Calman – Institute for Family Health – President & Cofounder

We're not just recording it, you have that in there. Anybody that's documented, and we could specify only that the team members should document in a clinical record ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

No, no, no, George, right below you. In the box ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So this is on the man who says he doesn't do care plans if I recall.

Neil Calman – Institute for Family Health – President & Cofounder

No, team members.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Or recording ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, Michael.

Marty Fattig – Nemaha County Hospital – CEO

You might want to check the downloads.

Michael Barr – American College of Physicians – Vice President, PA&I

This is Michael, I have a question about the care members, is this an EP or a hospital that we're talking about or both?

Marty Fattig – Nemaha County Hospital – CEO

It should say longitudinal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right now, it's EP.

Michael Barr – American College of Physicians – Vice President, PA&I

Okay, so—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In a hospital a lot of it—

Michael Barr – American College of Physicians – Vice President, PA&I

So within the EP, Neil keeps saying recorded in electronic health record, are we including the sub-specialist and others who are also part of the extended team that needs to be listed, because they're not recording in my electronic health record, they're recording in theirs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's not shared yet.

Michael Barr – American College of Physicians – Vice President, PA&I

It's not shared yet. So what's the requirement for listing of a care team when it involves a pharmacist, cardiologist, gastroenterologists, and the general internists, and the primary ...

Neil Calman – Institute for Family Health – President & Cofounder

That's where I said people who are recording within the electronic health record.

Michael Barr – American College of Physicians – Vice President, PA&I

So that would just be my practice then.

Neil Calman – Institute for Family Health – President & Cofounder

Right, exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

For now, for 2015.

Michael Barr – American College of Physicians – Vice President, PA&I

But that's not really very helpful honestly to anybody at this point in terms of just the people who are in practice.

Neil Calman – Institute for Family Health – President & Cofounder

Well, maybe not in the solo practice, but in a group practice, it's helpful to know.

Michael Barr – American College of Physicians – Vice President, PA&I

That's fine.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, I mean, we've heard testimony, Michael, maybe I didn't understand what you had said, but we heard a lot of testimony that basically said, even when I show up for a PCP, they don't necessarily know about all the other clinicians involved in my care outside that practice.

Michael Barr – American College of Physicians – Vice President, PA&I

Well, that's my point.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Michael Barr – American College of Physicians – Vice President, PA&I

What Neil's saying within a multispecialty practice, that's important. I would buy that no problem, but that's not going to get you to where you just described, because it's only if you just define this is recording in my electronic health record. Because the pharmacists are not recording my electronic health record, and either does the cardiologist or GI.

Neil Calman – Institute for Family Health – President & Cofounder

But we're still ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Oh, I'm sorry, I misunderstood what Neil was saying. I think it is, the record is generated by the solo practice, but the list is not just the people who are typing on that system. The list is everybody involved in the patient's care.

Michael Barr – American College of Physicians – Vice President, PA&I

And then it's going to be manual entry on the basis—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Michael Barr – American College of Physicians – Vice President, PA&I

—of the primary care provider.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Michael Barr – American College of Physicians – Vice President, PA&I

So that's a very, very different requirement that we have to talk about.

Neil Calman – Institute for Family Health – President & Cofounder

That's a whole new—

Michael Barr – American College of Physicians – Vice President, PA&I

That's a very, very different and logistically. I mean, I'm all for the idea, but I'm just saying that's not something that's easily done, that should be done. The other thing is, I just want to point out on the, oh, you just lost me, we moved it, George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Sorry.

Michael Barr – American College of Physicians – Vice President, PA&I

But the longitudinal care plan for the high priority health conditions, I think that's very important, and is consistent with what the medical home recognition criteria moving towards in terms of focusing on patients, at least initially, and those at high priority conditions. So I think that's a very good ...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Michael, what should the threshold be for that though, because 10% to me seems really low?

Michael Barr – American College of Physicians – Vice President, PA&I

Well, recording it, I think I would agree with you 10% would be low. Patients to be defined at high priority conditions, they all should have a care plan, assuming the EHR allows you to capture it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So for people with high priority conditions, should this be 60% of your patient panel that has a high priority should have a care plan?

Michael Barr – American College of Physicians – Vice President, PA&I

It's a hard number, I don't know, 50%, if they're a high priority condition—

Neil Calman – Institute for Family Health – President & Cofounder

I think it should be 50%.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay, so 50%.

Michael Barr – American College of Physicians – Vice President, PA&I

So 50% is unreasonable to get the comments on.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Michael Barr – American College of Physicians – Vice President, PA&I

And then we have to manage the stage three in terms of exchange for 50%, I don't know. I mean, if the capability is there and you have it, it should be relatively straightforward.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And just an alignment point, as we looked at that exchange up above in line 53, we define the network, and as the care team becomes a network, so they might end up being, it might be nice to say.

Michael Barr – American College of Physicians – Vice President, PA&I

It would be just as nice if we could reuse ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Neil Calman – Institute for Family Health – President & Cofounder

By the way that could be populated with the referrals that you sent with the names of the people and the specialty of the referrals you sent out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Neil Calman – Institute for Family Health – President & Cofounder

I mean, there's lots of really good use of this thing. Yes, you know, really it's good.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, it's really good for the patient engagement you have to ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, because we have a lot of Christmas lights on this.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I won't hear that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

And half of them are burned out already and we haven't even like listed things.

Christine Bechtel – National Partnership for Women & Families – VP

This is going to be painful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

And that's care coordination.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's what?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

That's care coordination.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's care coordination.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, that's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, thank you.

Christine Bechtel – National Partnership for Women & Families – VP

Now, shouldn't those things go in column one, oh, they're stage two, sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

I'm sorry, I was wrong.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks, David. Okay, we have a little less than 20 minutes. Art, do you want to get started on population public health?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Sure, if that would be what you would like to do?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, versus what? We can postpone it to next call? Okay, I think there's a—

Art Davidson – Public Health Informatics at Denver Public Health – Director

This week, we've got to catch a train.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so there's folks who need to—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Alright, so why don't we, we have an hour and a half call on the 10th, we would get through public and population health, and then Deven may want to add something to privacy and security.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I would suggest that Art and Deven do a version of the spreadsheet, put the date and the time—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That would be great. That's okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Rather than, because an hour and a half is very short.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It is, thanks, George.

Art Davidson – Public Health Informatics at Denver Public Health – Director

What time is that call?

Christine Bechtel – National Partnership for Women & Families – VP

I don't know ...

Judy Sparrow – Office of the National Coordinator – Executive Director

I'll send a reminder, thanks.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Do we need to talk at all.

Judy Sparrow – Office of the National Coordinator – Executive Director

On the 10th.

Christine Bechtel – National Partnership for Women & Families – VP

It's Friday.

Judy Sparrow – Office of the National Coordinator – Executive Director

Another Friday.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

One o'clock.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And Judy and I have a ...

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

One o'clock Eastern.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And I won't be on ...

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, 1:00 to 2:30.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, 1:00 to 2:30 Eastern time.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So Judy and I—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Alright, anything else?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And then one of the meetings, Christine's not there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Christine's not here. Okay, well, Art, it makes it a lot easier for you. Now don't take advantage of it, Art.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Art, this is Charlene.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Hello, Charlene.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The vendor association had done some gap analysis on immunization, so I'll just send you that content so you can look at it.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Thank you. I'll prepare a document for disclosure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And Art, this is not, what I'm going to say, is not for you specifically, it would be a really great idea if any documents that get sent around have in very clear bold letters, draft for discussion only. Because if it gets circulated, we don't want it to be misinterpreted as having even been vetted by the committee. So if you would please do that.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director

And all future documents.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And all future documents, yes, please, thanks. Anything else? Public comment?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, operator, can you please check if there's anybody in the room, which wishes to make a comment, come up to one of the microphones or anybody on the phone, I believe you push star one if you're on the telephone. And operator, can you give the dial in number if they're on a computer, please?

Moderator

Yes, if you are listening via your computer speaker, you may dial 1-877-705-2976, and press star one to be placed into the comment queue. And we do have comment on the phone.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. If you could please identify your name and your organization.

Moderator

Thank you, our first comment comes from Michelle Blake with TPG Healthcare Solutions, please proceed with your comment.

Michelle Blake – TPG Healthcare Solutions

Hello, yes, I'm calling to get a little bit of clarification, and I'm not sure if you can do it in this forum or not. I am hearing today again, the discussion of the various menu items versus the core items. There has been a lot of recent media out about the interpretation of the frequently asked question number 17 on the ONC Web site that seems to have the connotation that if a certified EHR program is capable of doing all of the requirements, all 24 for hospitals, all 25 for an EP, that the implementation needs to include all of that functionality.

And as someone who, I'm a physician assistant, and I spend all my time going from hospital to hospital and physician offices and doing these implementations. We're currently doing all of these things. And I need to know, we need to know, what do we do? Do we instruct our clients to go and implement all of the items, including menu, including core or should they just focus on the core and save those menu items for later?

Judy Sparrow – Office of the National Coordinator – Executive Director

Ms. Blake, yes, the committee can't really take that kind of a question. We're really here for comments, but if you would like to get in touch with me, I can refer you to somebody at CMS, who might be able to answer that question. And my contact information is on the ONC Web site, this is Judy Sparrow.

Michelle Blake – TPG Healthcare Solutions

Judy Sparrow, okay.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, thank you, Ms. Blake.

Michelle Blake – TPG Healthcare Solutions

I appreciate that Judy, thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Are there any other comments?

Maury – American Medical Association

Hello, this is Maury with the American Medical Association, and I sent Judy a comment for the last meaningful use call. I tried to make a comment on the phone, but I wasn't able to get through for technical reasons. And again, I pose a question to the committee, are you guys aware that for January 1st that, and this really does not have to do with stage one, but it is something I hope you're aware of.

Judy Sparrow – Office of the National Coordinator – Executive Director

I did pass that on, and that's actually something that's being handled internally. So I will be back in touch with you, Maury.

Maury – American Medical Association

Okay, so just as a public note, so that I can make the comment then, because they may not know what I'm saying. Okay, so it has to do with January 1st, the cMASS is going to be requiring that physicians start reporting on the E-Prescribing data using, and they'll be basing the 2012 penalty on 2011. So it's something we're worried about, because with all the messaging that's going on. And we're really in a scramble mode right now, because all the doctors were told, "Oh, you can't do both programs, you can't do meaningful use and you can't do E-Prescribing." It came as a big shock and it's something that the physician community, well, at least the associations are very upset about. So I hope that we can engage with you a little bit further, and we will be sending a letter to the secretary. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Maury. Any other comment? Alright.

Moderator

We do have another comment on the phone.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay.

Moderator

Our next comment is from Morris Rang with Blessing Health System, please proceed with your comment.

Morris Rang – Blessing Health System

Good afternoon, everyone. Just a few comments, first of all on your CCD and then you lift data elements below it, you really should try and match those up where readable and electronic are about the same thing. Because right now, the data elements that you're lifting are not entirely in the CCD, but they could be in the CDA document.

In regards to patients accessing their encounters, their discharge information, it's really hard to dictate a threshold on something that the EP or the EH can't control. So maybe you should just consider that if an account, maybe out on a portal, has been created, you could use that as the measure.

As far as our final rule, in regards to discharge instructions, it was stated that hospitals are the ones best suited to define discharge instructions. And in regards to your bidirectional that you were putting on stage two and from your latest discussion here, once you introduce the word bidirectional, you're going to imply from an HIE perspective, use of an NPI and an RLS or you're going to mandate that they use direct. Thank you very much.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Mr. Rang. I appreciate that comment. Any other comment?

Moderator

We do not have any other comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Dr. Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good, thank you very much to the workgroup members, thank you to the staff, who always is prepared to get us together and keep us honest, and thanks to the public for listening in, thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you.

Public Comment Received During the Meeting

1. From the rule re: Summary care contents: EHR must be enabled to provide a summary of current status of vitals, medications, lab results, along with a current diagnosis and treatment plan, including problem list. The information is comparable to a hand-off/shift change on a nursing unit, however the EHR must be enabled to provide the summary information at any time to a receiving external facility. As stated above, the summary of care record can be either electronic or paper based.

5. It was my understanding that all items, even menu items, need to be implemented if the certified EHR has the functionality, in order to establish meaningful use, based on ONC FAQ #17. This is done through an audit trail with most EHRs. Every major one has them. You set up reports within the EHR that you can map against.

6. Yes, I completely agree - we're working on this right now! I am trying to help several hospitals all over the nation trying to implement this into their workflows, and we are making changes on the fly as we get direction from ONC.

8. Please note that the CCD does not have "sections" for all the data elements listed for hospitals.

13. Ask the guys if we can put the table up somewhere live where changes can be maintained. I'll volunteer to set that up in a secure password protected area if they want.