

**Meaningful Use Workgroup**  
**Draft Transcript**  
**June 28, 2012**

## **Presentation**

### **Operator**

All lines are now bridged.

### **MacKenzie Robertson – Office of the National Coordinator**

Thank you. Good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourselves when speaking. I will now take roll. Paul Tang.

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

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks Paul. George Hripcsak?

### **George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks George. Michael Barr? David Bates should be joining a little bit later. Christine Bechtel?

### **Christine Bechtel – National Partnership for Women & Families – Vice President**

I'm here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks Christine. Neil Calman?

### **Neil Calman – The Institute for Family Health – President and Co-founder**

I'm here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks Neil. Tim Cromwell? Art Davidson?

### **Arthur Davidson – Denver Public Health Department – Director**

Good morning MacKenzie.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks Art, was that you?

### **Arthur Davidson – Denver Public Health Department – Director**

Yes.

### **MacKenzie Robertson – Office of the National Coordinator**

Okay. Marty Fattig? Joe Francis? Leslie Kelly Hall?

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Good morning Leslie. Yael Harris? David Lansky?

**David Lansky – Pacific Business Group on Health – President and CEO**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks David. Deven McGraw? Greg Pace?

**Greg Pace – Social Security Administration – Deputy CIO**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Greg. Latanya Sweeney? Robert Tagalicod? Charlene Underwood? And Amy Zimmerman? Amy, I know you're on the line. Are there any staff members on the line? Okay, Paul, I'll turn it back over to you.

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

Thank you, MacKenzie. Good morning everyone, and thank you for joining this call, and we have before us, before the July 10<sup>th</sup> meeting, a charge to try to get through all of the subgroups and the reason is, we'd like to present on...well actually, on August 1<sup>st</sup>, our combined draft recommendations...preliminary recommendations to discuss it for the group. This is in preparation to putting out an RFD in November. So we're good coming back in September. So, we'll present our first round preliminary recommendations for discussion as a full committee in August, and then we'll come back and present a revised version in September, as we prepare for a November 6 release of the RFD. This is to support ONC's desire to get our final recommendations to ONC and CMS by May of 2013, so working backwards; we came up with this calendar. And part of the goal is to try to avoid, at least Christmas if not Thanksgiving, in terms of things being asked of the public.

So our goal today is try to finish up with subcategory 1 and move on to category 2, and then our goal for July 3<sup>rd</sup> is to get through 3 and 4 ideally. And the purpose is, we then have one more call or do we have two calls MacKenzie, before the August meeting? I found one on July 18<sup>th</sup> and I don't know whether there's one later on?

**Caitlin Collins – Altarum Institute**

There's another on July 27<sup>th</sup>.

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

Great, thank you. So, with those two calls, what we will want to do is take a look at the entire set of objectives and try to refine them, consolidate them, get them in shape for presentation at the August 1<sup>st</sup> full Committee meeting. Okay, because of some staggered participation today, David Bates can't join until about 9:30, we thought we would move category 2 up, category 2 with Christine up first and then we'll finish up hopefully category 1 and also talk about a hearing on advanced directives for September. Any adjustments to that agenda? Okay, why don't we start with Christine then and maybe you want to talk about your subcategory and then we'll...and hopefully David will join by the time you start talking about things that you want to hand off to other categories.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

All right, that sounds good. Well good morning everybody. In your email, you've got two documents from this morning that are sent to you by the Subgroup 2 on Patient and Family Engagement and a couple of subgroup members are on the phone, so feel free you guys, to weigh in. The first is a document that outlines the potential objectives or concepts for criteria that we'd like to get feedback on for Stage 3. The second is a set of criteria and concepts that came out of the workgroup thinking, but that probably belong in other areas and so, I'll go through that, as Paul just pointed out, second; that's something that we want to ask the other groups to give feedback on and consider including in their areas.

So looking at the document that's called "Draft Conceptual Framework for MU Subgroup Consideration," version June 27<sup>th</sup>, the process that we followed was to step back for a second and really think first about the definition of patient and family centered care from a consumer perspective. And so, drawing on work that was done earlier, we looked at kind of a four-domain definition that you can see on the first page. And I won't go through it because we've got a lot of ground to cover, but we really wanted to start not with what can technology do, but rather what is patient-centered care and how do we then step back into the functions and the uses of Health IT that could support it. We also drew from some really terrific work that was done by the Standards Committee on a Power Team led by Leslie Kelly Hall, who's also on the phone, and we were able to draw from that work to distill a set of key principles that you also see on the first page of that document. And those principles really come back to this key notion of patient-centeredness.

So what we did at that point was, we went back and looked at all of the documentation since the beginning of meaningful use and tried to pick out the objectives that were discussed previously that are already part of Stage 1 and 2; but also grab those concepts that we've been talking about for a while now that could be part of Stage 3. We then essentially took those and cross-walked them back to the principles and the definition of patient-centered care, identified some gap areas and pursued some concepts and objectives that would fill those gap areas. And then the last thing that we did was, we took what was actually a very long list at first, and we created a set of principles that would help us get some parsimony in this, and Paul was a great help in that as well. And you can actually see those principles at the end of the document, on page 4. But, we used this set of sort of nine key principles to go back through each one and identify ones that needed to be changed or deleted and removed or combined, based on these principles for achieving more parsimony.

So, at this point, where the group is at is we do have a pared down list that we would like to get feedback on. I think there are a number of items here that folks are confident and comfortable with, and there are others that we really need some help in thinking through; so, you'll see a little bit of a mix on that up front. So the first item is to...is actually an adaptation of an existing objective which is to generate a list of patients according to preferred language, which was part of Stage 1 and 2, and then to be able to provide patient-specific education materials and/or reminders in languages that are spoken by more than 5% of the provider's patient population. So this was again harkening back to Stage 1 and this is one...I'm sorry, this is a concept we talked about in Stage 1 and in Stage 2. And this is a concept that you can see in the notes column, we really would like to have some feedback on how to best structure the requirement, because we don't want people to have to provide education materials in every single...all of the top 10 primary languages out there; but on the other hand, we do want to make sure that patient populations are really getting the information they need in the language that they prefer at a more localized level.

So the second is, Paul, I assume you want me to go through each of these and kind of take questions or thoughts at the end, or do you want me stop periodically or stop after each?

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

You know, I wonder if we would just do it line by line, because it might be a little bit more efficient that way. Okay, so you want to entertain some comments on your first proposal.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Sure. Any questions or thoughts on that?

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

I have a couple to start off with then. One is, why pick preferred language as...I mean, we have the ability to generate lists, and we've in Stage 2 at least, our recommendation was that by multiple parameters rather than just one, and that's really getting at functionality in the EHR, why did you pick a specific thing like preferred language? And the other is, whether 5% might be a little on the low side. So you're trying to make sure that you don't have to generate lists in all spoken languages, 5% might be a little low in your first threshold.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So let me clarify this because I think maybe I need to flip the order of how this is written. The point is to provide education material in the most common primary languages that let's say a physician practice had; it's not about generating lists. It's really using that list generation capability to say, okay, the top three primary languages that I have among my patient population are English, Spanish and Hmong. So, I need to provide education materials or reminders in those three languages to patients per what they say is their designated preferred language. Does that help?

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

Yes it does. And so really, the objective is not to generate the list...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

No.

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

...and we already have the capability, as you pointed out, we already asked for preferred language in earlier stages and we have the capability to generate lists, so that should be straightforward for them to figure out which. So I think then you're just asking the thresholds and I might propose something a little higher than 5%, but...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay. Okay and I'm also going to flip the order while we're on the call, just so it starts with provide patient-specific education materials and reminders in languages spoken by more than what, 10% would you like, or whatever.

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

Umm, first it may be 20%, just because this is your first round here...

**Neil Calman –The Institute for Family Health – President and Co-founder**

This is Neil. I think that there are standards for this in the Office of Civil Rights, if I'm not mistaken, in relationship to the way we need to provide information now. So, I think we should look at that.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

This is George. So, this is a switch in the sense that, this is a single doctor proportion, so if a doctor happens to be offering a practice in some area where there's a pocket of a language group, that doctor would have to somehow find, and 5% isn't that high, would have to find materials in potentially a language that there are no materials for. I don't know if the doctor is expected to generate the materials. I mean, they just may not be available in some of the...say you take the greater New York area, there are places where you might have over an entire borough or region, languages won't reach a certain pocket, but one doctor could just live a place, you know, one city block might be that persons catchment area, that might be a language for which no one has ever generated the educational materials and so would the doctor be expected to generate them or what would happen?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

...Neil. No, Neil.

**Neil Calman –The Institute for Family Health – President and Co-founder**

Yeah, I was just going to say, we don't want to do anything that would discourage people from taking care of folks, right. So, I mean I have no problem with raising the threshold percentage. I think the concept is basically, and maybe we could put something there, if such materials are available in the public domain, because the National Library of Medicine has lots of these materials in multiple languages, but I'm sure they don't have all languages and so, why don't we just put that qualification in and that would sort of cover people from having to develop a whole new set of materials.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Okay.

**Michael Barr – American College of Physicians**

This is Michael Barr joining the call late, sorry. I do agree though that there are some standards out there, I'm not sure if it's OCR, whether Joint Commission has some standards, but I think to the extent that we build any kind of percentages or thresholds, we should try at least to align with what's already been stated and some of those national standards organizations or federal government.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah and I think there are both; one is standards, which is more the Jacob Hinds approach and the other is actually the law, and the civil rights laws do require providers that receive public funding, including such as Medicare/Medicaid dollars, to comply with those laws. So...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

This is Leslie. Today those laws also allow for human translation at the point of care or voice line; so, there are opportunities to provide either translation material; because our focus is on electronic materials, I think we should just keep that in mind, be harmonized across all of these things.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay. All right, ready to move on?

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

So what's the final? Are we saying threshold...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So the final is, provide patient-specific educational materials and/or reminders in languages spoken by more than, I don't know if we landed on 10% or 20% of the population, but generating a list of patients by preferred language and this would be applicable only for languages where materials are available in the public domain.

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

Great. You want to just start with 20% and we'll look it up? I tried looking it up as we spoke, but I didn't see a percentage, and that's probably pretty hard to get.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, I mean, I worry that actually 20% of your patient population, given that we're adding the caveat around the public domain, is going to be really high. So...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

It's not, the other thing is, and in public domain, then we're saying it has to be publically domain offered and we became somehow biased against commercial offering. So let's come up with some language that accommodates what Neil's point is without having to restrict it to public...

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

But at the same time, we don't want to publish an unfunded mandate that essentially forces people to buy things.

**Michael Barr – American College of Physicians**

Paul, this is Michael. That's where I was going to head too, because there are cost implications of all of these things, especially if they're not already available, or even if they're available, there may still be a cost.

**Neil Calman –The Institute for Family Health – President and Co-founder**

Right. I don't think we should be requiring people to have to purchase stuff. I think that, my intention in saying public domain, was basically to say, if they were available free of charge, which I think right now basically would limit the materials to probably stuff available through the National Library of Medicine, although there are other databases, I think, that are being developed. So, I would...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

But, just for clarification, the National Library of Medicine pays for the materials, so it's not their property; it's not public domain materials. That's my point.

**Neil Calman –The Institute for Family Health – President and Co-founder**

They make it available free, they're available free to users.

**Michael Barr – American College of Physicians**

Yeah but, this is Michael, just being available for free and public domain doesn't mean that they're also appropriate in quality. So, we can run into some issues here. I think it's a laudable goal, but we need to be careful.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So, the whole point of this conversation though, you guys, is not necessarily to think through every weedy detail, but to get some feedback from people who know. So I think if we have these kinds of core concepts in here, we're asking for the public's input. I've got lots of notes about this stuff in here, but, if we are trying to revise...or go through every single thing on here, I mean we've spent almost 15 minutes on one line and we have a lot of stuff to go through that is actually new conceptually. So, are people okay with let's have the discussion and I'll catalog the kinds of questions we've got, but then we'll get public comment on it?

**Neil Calman –The Institute for Family Health – President and Co-founder**

That's fine.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Good, I'm taking that as a yes. Okay, number two. So the second is again an adaptation of an existing criterion, which is to record three types of data. And this is something that is also being referred to other groups, but we felt like it was so important that we wanted to also keep it on this group's radar screen, and those three data types are disability status, sexual orientation and gender identity and more granular race, ethnicity and language data. And those are concepts that we've talked about previously. Any comments on that?

**Greg Pace – Social Security Administration – Deputy CIO**

Yeah, this is Greg. One comment, one slight modification for number one, disability status; I think I mentioned this before, since there's not a common definition for disability, I would suggest making that disability/functional status.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I think Greg that those are actually two different...

**Greg Pace – Social Security Administration – Deputy CIO**

I know I see functional status showing up later on the list...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

It does, but functional status is more about my functioning in my daily life. Disability status is more, and there are actually some definitions, more around your ability to see, your ability to...your physical mobility, cognitive limitations and the point is not to sort of say how am I doing today over yesterday, which is more how I think of functional status, but so that providers can better accommodate people with physical disabilities or cognitive disabilities, or whatever, as they practice. So I think we were thinking of this in a slightly different way; and again, wanting public feedback on that as well.

**Greg Pace – Social Security Administration – Deputy CIO**

I understand. What I'm trying to make clear is, the definitions vary from both the public sector and the private sector in terms of what do you mean by disability.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Right, and that is one thing that we want to get feedback on there. We did some work around that in Stage 2, or at least, well actually, that might have been my organization in our commentary to define disability status. So there are some things from Social Security Administration and others. So, this is...you're right, and we want to get feedback on that.

**Michael Barr – American College of Physicians**

Yeah, this is Michael. In the proposed Stage 2, there were similar requests for information or inviting comment from CMS, and I can reflect from our informatics committee that they did not support inclusion of the disability status for very similar reasons in terms of no consensus on classification and each medical specialty uses a different value set and definitions. They were also concerned about the sexual orientation because of lack of consensus on a classification set, and also because of the sensitive nature of a question. I could reflect that even in the medical home criteria with NCQA when we started to try and include request or requirement to ask about sexual history as part of the requirements of a medical home, there was considerable pushback from some consumer representatives. And so I think this is along the same lines and that could be an issue. And then the chosen...for race and ethnicity, there were also concerns about the dataset or the standards or value sets which race and ethnicity and whether those standards actually exist and could be put into place.

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

But I think this is, as Christine pointed out, this is being referred to HIT Standards, correct?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, there's absolutely one, but I think two things. One is we want to trigger the Standards Committee and we want to, this is not something we're writing into a rule tomorrow, so we really want to trigger some work around getting there, and the Standards Committee can help with that and I think the public input comments, and I'm glad you reminded me of that Michael, could also help with that. And just to your point about sexual history, it's very different from sexual orientation and gender identity classification.

**Michael Barr – American College of Physicians**

It's part of that and it can lead into other questions and just reflecting that there was considerable sensitivity actually from representatives from the National Partnership when we went through some of the questions that would be part of a sexual history. So, I just want to make sure we're all consistent on them.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I agree and the IOM's actually doing some work on this. So, I think this is something where we do, you know, we flagged it in Stage 2 as the Policy Committee as well, so we want to really keep the work moving and if we're not ready by Stage 3, we're not ready, but I don't think this is the time to knock these things out.

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

Okay, it's on your other list, so we can move on.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay. So the next one is something that again, needs some work to figure out if it's possible. And this is a new concept that is about identifying patient-specific opportunities for enrollment in research or clinical trials. And the idea is to either sort of link it to clinical decision support, but it's really about creating the capacity in the EHR to look at the particular patient characteristics, their location, their disease state, their meds, whatever you need, and link that, for example, and Neil you talked about this, to the national data base of clinical trials. And so, we want to ask for public input on whether that's possible and how to automate that so it makes it very easy.

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

Is there any notion of honoring patient preference in this, I mean...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yes, there were two pieces of it; one was allow patients to say, to flag themselves as yes I would like to be part of a clinical trial, but then also to automate the EHRs ability to identify patients who want to be and link them up.

**Michael Barr – American College of Physicians**

I'd love to hear at some point obviously the privacy experts will need to weigh in on this kind of sharing of information. I'm sure there are some steps that would need to be incorporated, and I'm not really sure what the work flow implications would be at the level of a practice, when a flag comes up this patient is eligible for this particular research program, what's the responsibility of the practice. I just don't know. So, obviously a lot more discussion that needs to take place.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

And Michael, this is Leslie, I'd be happy to talk offline about how some of that automation can happen.

**Michael Barr – American College of Physicians**

Well sure, I think it needs to be, honestly Leslie, more than offline, because it needs to be part of our understanding about what this requirement might...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

I was just trying to be mindful of time, but...

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

I don't think we have the chance for that discussion right at the moment, but, I think what Christine is proposing is that the functionality be present to identify patients, not that the patient information goes off to some clinical trial.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

That's exactly right.

**Michael Barr – American College of Physicians**

Right, but once you identify a patient...I'm the doctor seeing that patient, oh this patient is eligible for a trial. That's a new workflow implication for the practice and then what happens at that point...just...I agree it doesn't have to be done here.

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

Yeah, the practice gets to decide that right now I think they're just proposing a mechanism to identify people for this purpose.

**Neil Calman –The Institute for Family Health – President and Co-founder**

And the way we discussed it, this is Neil, would be related to patient request.

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

So it sounds like the only addition here is honoring patient's preference about willing to be noted...any other amendments to this question?

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

This is George. We're working on this, as are many other groups. My main...I think it's a good idea. My main concern is priority, we have so much to do, this one's not that easy to do and this would have to be...we would have to decide if this is sufficiently important that it's a major focus of Stage 3, supporting research. Like if our main focus is quality and patient engagement and care coordination, throwing in this may be just too much extra work, even though it's a good idea. So that's my main concern with it, is just what it would take to really do this well.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah George and you hit the nail on the head. That's exactly what we want to understand from the public, because we've had other people say, it actually wouldn't be that hard, since there's a national database. But, what do I know. So, I think that's right, but I think we want to get a sense from folks on how it's going to happen.

**David Lansky – Pacific Business Group on Health – President and CEO**

Christine, David. Have you talked to Mary Jo about this? They had a...NCI had a large project to do this four or five years ago, and I think there is a lot of complexity that George alludes to, that they discovered that may support George's point that this is too big for Stage 3. I think Mary Jo should weigh in on it.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

So this is Leslie...the patient, passing the patient context in a way that can see if there's research out there I think is doable, using the same standards we do for linking to NLM for patient education material, using the HL7 contextual aware query. So, there are ways to do it. I think the point is well taken, although how much can we alter.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, so let me just throw in a couple of quick caveats that apply to all of these. What we did not do was go through and say this should be menu or this should be core; like this would be, if it's not terribly difficult, would be a very nice menu item for specialists, if it's doable, right? But we didn't go through and say menu or core, we didn't go through and establish thresholds or settings, and we also have not, anyway come through to the point where we're saying, for example, what exactly how it would work. So, there's a lot of things in here that were...the discussion in the workgroup was really about developing the capacity of the EHR to do it, not necessarily forcing the use of the function, but one of our key principles was really how do we set ourselves up for health reform, how do we create these capacities? You'll see that later in online consults and e-visits, where you can't mandate use of that in the same environment; but how do we create the capacity for being ready for that. So, I just want to throw that caveat out there, that don't think everything in here is a core item or that all of them are going to have some giant threshold around usage and things like that.

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

Can I suggest Christine for this one, so we're going to have calls in July to prepare for August 1<sup>st</sup>, this is one of those things where I think the subgroup can do a little bit more work. I'm with...we do the same thing and a lot of this stuff comes with exclusions, which are not easy for the EHR to pick up; in fact, there's lots of complexity...what we can do is bring that discussion into your small group, before bringing it back to this group, ahead of our presentation to the Policy Committee.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Sure.

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

I think what you're getting is a lot of is nobody's objecting to the idea, people who have already worked in this area have found it to be actually more complex than is probably possible now without a lot of false positives, that's...point.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

That's the feedback we're looking for, so let's do the work to figure that out. I think that's right. Ready to move on?

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

Yup.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, so the next one is the view, download, transmit and report, which was the kind of new adaptation here to the view, download, transmit function, and we really...the subgroup really looked at this as a way to support the capability for patient-reported data. So, we thought about providing patients with the ability to self-report a range of data, depending on what would be helpful to the practice, helpful to the patient. So that could be family health history, patient-created health goals, observations of daily living, caregiver status and role, list of care team members or self-reporting of adherence to meds or diet, exercise, etcetera. So, the thought here was create the capacity for patients to self-report information, and we just had a hearing on patient-generated data, but the subgroup was pretty clear about not being proscriptive about requiring all of this or some of this, that there needs to be flexibility for what's important to the practice and to the patient, or to the hospital or whatever. So, that's the first sort of bucket in here. The second function that we talked about in this...was linking online resources to the information that is in the online access, and by the way, can folks put their phones on mute because I'm feeling like I'm yelling because there's a lot of shuffling going on. Oh, thank you. So, the subgroup felt like having let's say a portal function that had automatic links to other resources to help people interpret the information that they come across is already something that's readily available and it would be sort of ashamed not to call that out. So let me...why don't we...I'll do these in groups, so let me do one more and then we'll do half at a time.

The next one was around providing patients with the ability to send relevant updated information to the care team members. So this is like the new report function. So that's again one of those pieces where you want to kind of create the capacity to allow that to happen. So, I'll stop there.

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

So comments, maybe we'll even take them by bullets; so comments on the first bullet, which is self-reported data. Are you spelling out that they have to be these four things or are you just saying ways to report and to incorporate self-reported...patient generated data.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, it's more the latter, the ability to self-report patient generated data, but we called out some particular items that we would propose as a starting list of the kind of options that would be the most helpful to patients and to the practice or the hospital. But, it's not, like I said, it's not you've got to do all of this. There's no criteria, there's no threshold being proposed here, it's just, here's a list of what we think the most helpful kinds of data might be.

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

So you'd consider these e.g.?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I think, you know, Leslie and Neil, you guys chime in, you were on this call; I think it's probably a little bit more than e.g., but it's not all of them, but it shouldn't just be so wide open that you could report whether you intend to show up at your next appointment, right? The data should be meaningful, but here's a list of things that we would find meaningful, open to additions, and it's definitely not all of it.

**Neil Calman –The Institute for Family Health – President and Co-founder**

Right. So we were trying to separate how people could potentially use the system to record their own data, but not necessarily to be sending it to care team members. So, how could they use the system to record their blood pressure measurements and their blood sugar measurements? But then, you're about to go for a visit to your provider and you want them to have access to that, how could you then send it to the provider or to your diabetes educator or whatever. So, the ability to transmit those recordings, but not necessarily to have everything that you record transmitted to the care team.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Right, and Neil's kind of pulling two elements of it together, and he's not incorrect, but in terms of the first element, the ability to just report the data. This is really about creating the capacity of the system to accept data from patients and for that data to be digestible and usable by the electronic health record when and where it's needed.

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

This is a huge act, especially if these things are bulleted versus e.g. And the difference between bulleted and e.g.; bulleted would mean that even though you say not every...if they get turned into certifications, then it turns out every system would have to do everything and each one of these things is not only a technical challenge, including standards, but also the how do you incorporate...how do you "accept" certain data into the official medical record.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So let me ask Leslie to weigh in, because what the workgroup talked about was that almost all of these are really a basic questionnaire kind of platform...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Right. So we really talked about things in...the easiest kinds of information to get in is when it's structured and there is a questionnaire of some kind and they respond. So that list is primarily examples of where that can happen. Harder is the patient narrative, when there is not necessarily the structure around it and how do we glean information and how do we read it quickly and digest it, that's a harder concept. But when the questionnaires were used, it seems that it was very clear that the organizations that were asking questions and getting responses back they knew what to do with the data, the scope was very well defined and narrow, it was digestible back into the EMR. They could use a variety of intake sources like IVR as well as patient-facing systems. So, that top section is really around that notion of asking a question and getting some sort of a response.

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

But I think health goals, that is not a well bounded and well defined and clearly not standardized data element for example, observations of daily living, same thing; that's not...so anyway, I'm not sure it's meeting criteria that you just enumerated.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

So perhaps what we need to do is just go through and balance the list of what's questionnaire and already in a standard and what's not, as part of our work.

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

Questionnaire by itself doesn't have...doesn't mean that the questions that are asked or the answers that can be accommodated are standardized, and that's the bigger criteria I think.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

So the...I think there are two parts of the standards, right, there's the standards that actually allows it to be digestible so we're getting some kind of questionnaire format itself, and then there's the actual standardization of the content. The new things coming out of LOINC provide more opportunity for granular questions that can be standardized in the vocabulary. But I think what we could do is take that and say, here's a list, what's possible today, what's easier today. But in the patient-generated hearing, and you know Paul, when they did ask very specific information, it was meaningful to both the patient and the physician, it was very material to care. And so, we need to get that concept in here.

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

Maybe the subgroup can work on the things where there are standards, we've talked about family history, even that doesn't have...so work a little bit more on the meeting the criteria of things that can have meaning across the EHR systems that are interoperable.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Okay.

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

We can work towards something in future stages and we can signal that kind of stuff, but the things enumerated here I don't think they have standards...look at this in terms of value sets, that's maybe a good way to think about it.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy, and I have one other question which is in that top line you've got in the parentheses, "including the ability to upload and report data into primary place of choice by patient, including PHR, etcetera." Are we talking about the ability to do that into all of those, because I'm not sure all of those would be covered under meaningful use; like a PHR.? So how does the patient's...if we even get through some of these, can you just explain that sentence a little bit?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, I think what the group is thinking is, obviously we can't control the personal health record market, that's certainly correct, but really this is about the ability to...so if you do have a portal or you could have your physician do a transmit, the ability to not just download, right? So this is really building up the download construct, which again doesn't govern the PHR market, but not only the ability to download, but also the ability to upload and report, using that same construct.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

So what you're saying is it's really more about if you have stuff in your PHR, being able to have the EHR accept this kind of data from your PHR.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yes, or if you only have a portal, being able to download it...

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Input it through the portal...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

...and report it either to another portal or another physician's practice and things like that.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Okay.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So we will go back and do some work on identifying some standardized content and I think we have to have it be for discussion that we probably don't want to have here around the idea of, have you really kind of developed the capacity for data collection, for patient-reported data collection, but allow it to be flexible enough that people can use the functionality in ways that are appropriate to them and meaningful to the patient and the care team.

**Neil Calman –The Institute for Family Health – President and Co-founder**

That's well put.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So I think that's going to be a real challenge, and I don't think we can get to...if we had...we would have a lot of really nice quality measures out there in the world if we had standardized...we have standardized tools, but what I think you're really talking about Paul is agreement on one standardized tool; and I don't think that's going to be possible. So, I think we have to think about how to structure a capacity for data collection platform that allows people to customize in a way that really works for them and for their patients. And that's not going to be something that we're going to make everybody do exactly the same way and make everybody do it all the time. So, I think this is one where we have to think a little more broadly about making sure that the capacity is there.

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

Exactly right. So, I think...

**David Lansky – Pacific Business Group on Health – President and CEO**

Christine, you might want to think some more about, or get the next person to think about taxonomy that we've hinted at in this conversation. So I think the answers will be there in three or four different flavors with this, and we might be able to almost strongly...give a lot of credit to one of those flavors to harden the laws, and make it more...menu of the other flavors. But I think there are many, many issues wrapped up in the way this is done. We should definitely think of a lot of...this way and find at least one easy way to do it so everybody gets on the train.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

David, I'm sorry; I don't know if it's you or somebody else is like at the airport or in a car, but I am getting every third word.

**David Lansky – Pacific Business Group on Health – President and CEO**

Okay, I'll communicate something offline.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, that would be helpful, thank you.

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

So Christine, one way, and I think this is consistent with what David was suggesting, is there are, as he said, capabilities, the one is a questionnaire; so being able to have patients fill out a questionnaire and that get into the EHR through some acceptance process, is a capability that would be useful.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yup.

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

Another example we've talked about before is uploading data from home devices. That's another capability without being prescriptive. As we go forward in different stages, and as we try to signal, where we're looking for standards, then we get more and more interoperable things and that would be good. But, I think what you're screening for at this time is really how do we incorporate some of these things that originate outside of the office and hospital?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Right. And that's actually where the group started was really focusing on a questionnaire kind of capability and a platform for that. And then we added some context around well we would use that for family health history and you know, it could be used for this or it could be used for functional status; but not wanting to be overly prescriptive on who does what or how much. So, I think if we can reframe this and do some thinking about the capability and developing the capacity, that's where we want to go.

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

Right.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I think that's consistent with the workgroup's discussion.

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

So almost changing this to e.g. could be helpful in that regard.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Oh sure, yeah, I mean I was trying to get there with sort of any/all, but that's...

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

Okay. The next bullet you have was online resources to help interpret. Comments about that? I might add that, there is a lot of information out on the "internet," it's pretty hard to necessarily interpret a specific finding for a given patient, so, the spirit seems good, but I'm not sure how you would implement that in a...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Neil, can...

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

You already talked about patient-specific information, right, is this similar to that?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I... let me ask Neil to address that first then I can tell you how I understood it.

**Neil Calman –The Institute for Family Health – President and Cofounder**

So basically, now our patient portal and many others around the country are using the same standards basically hyperlink information that comes through the patient portal to information that's available at the National Library of Medicine. So every last test, every drug, all of those things are available, in terms of information. So people would have access; if they're looking at a CBC result, they click on CBC and an explanation of what a complete blood count is comes up. So the idea is to be able to give people ready access and linking to information that would help them understand the information that they're getting through the portal.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So it's not Paul, I think, and Neil correct me if I'm wrong, it's not necessarily patient-specific in that your CBC count is, and the values...but it's more like kind of understanding the basic language, what is hemoglobin A1c and what does it mean and that kind of a thing. So, does that help answer your question?

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

Yes it does, so I think it may be just wording in the sense, what Neil's describing is, really is systems capability. When you publish, let's say laboratory results, the system ought to provide you the ability to hyperlink to places that you, the organization, decides. That capability is not present in all systems and that would be useful.

## M

This is basically info button.

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

But info buttons are more specific.

### **Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Info button does incorporate the languages of the patient as well as the language of the providers, so you could select in English and have materials provided in the language for the patient, in this same context.

### **Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay. Should I go to the next one?

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

Yeah, I think it's a good idea; it's basically linking to relevant resources.

### **Christine Bechtel – National Partnership for Women & Families – Vice President**

Yes, I did say provide linkages, but if you...what I've rewritten is, provide hyperlinks to online resources and education materials, through the online access function. And actually what I'll say is through the VDT function, because that will be clearer. Okay. So, the next one was provide patient's the ability to send information, relevant information, to care team members. Again, this is a capacity development issue, and also, I'm sorry, and Leslie you talked about this, too; and then also creating the sort of complimentary capability for providers to review and accept updates, which I think was something that came out of the patient generated data hearing as well, as something that was needed.

### **Neil Calman –The Institute for Family Health – President and Co-founder**

We had a question about this one, which I think is going to need to be answered, which is, what does it mean for the information to be in the system but for the provider to view it and not accept it. It's just not clear to me what becomes a legal and official part of the medical record. So if somebody's sending the information, the provider reviews it, says this is really useful. In my opinion, it's still part of the medical record, it's still there, it doesn't delete it and I'm not exactly sure what the accept function actually does. So, this again requires a little bit more discussion I think.

### **Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy, I would also say, in context to the earlier conversation, sending relevant updated information is good in some ways because it's broad and vague, but relative to the list up above, how do those two relate?

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

You might think in this case of questions that we've included in the RFD around just the legal aspects as well as the provider and workflow issues.

### **Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay.

### **Arthur Davidson – Denver Public Health Department – Director**

This is Art, would a better word than accept Neil be something like just acknowledge receipt?

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

This is Leslie and at the hearing, we got a...there was a white paper presented and it talked about that sometimes information is sent, but it's not relevant to care. So, I think it was quoted by the AMA, and I'm not sure if that's correct, that the physician has to be able to accept something into the EHR as material and relevant to care. So the patient's Facebook link, you don't want to put the timeline in the medical record, but if the patient sends you patient generated data, that you'd want to be material to care, then you'd have that discretion and that the legal responsibility was based upon what was accepted into the record. And Michael might have the wording better, so, it was just part of the testimony, and I'm probably botching it up, but that seemed to be the concept.

**Neil Calman –The Institute for Family Health – President and Co-founder**

Right, and what I was basically saying, this is Neil, was that I'm not sure what it means not to accept it if it's being entered into a portal that's sort of in a holding place for the provider to look at it. I'm not sure what it means for that not to be in the record, like if it's not in the record, where is it?

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

So right now Neil, like a direct message is sent, is coming in as a message inbound, that's not coming from a tethered portal or coming from a tethered patient-facing system, is just a message inbound. So that idea of I can accept or reject. I mean, there are many systems...health systems that have messaging coming from the patient that is not put into the medical record.

**Neil Calman –The Institute for Family Health – President and Co-founder**

Right, but you can read it but not accept it. So, I can read it, understand it and know it, but then say I just don't want that in the record and I don't think that that's a function that we want to do. I mean, if the provider sees it, digests it and knows it, then it becomes part of what information that's available to them. What I don't understand is how you can read something, digest it and know it, then not...and then just make a decision that you're not going to put it in the record. I don't know, I mean it's just...other people need to figure this out, this is not my area of expertise, it just seems a little illogical to me.

**Michael Barr – American College of Physicians**

Neil, it's Michael. A real quick example and I know we don't want to belabor it too long. Let's say a patient sends a series of blood pressure measurements over 20 days, do we want to necessarily just automatically have to accept it into the record, or should the clinician have the ability to say, hmm, I reviewed these blood pressure readings and the average systolic and diastolic is this, and put that into the record. It's still incumbent upon the physician to act and document whether the document includes the literal readings that are submitted or the note is potentially just a clinical judgment.

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

So MacKenzie, I don't know whether you know the answer to this question, but this is actually one of the...it's a key issue, and I wonder if there's the ability to get a commissioned paper from a legal point of view about this whole notion of when information...because we didn't really have this issue come up as much in the paper world, but clearly in the electronic world, it's one of the big either advantages or liabilities. Is there a way for us to get a legal white paper on this issue?

**MacKenzie Robertson – Office of the National Coordinator**

I don't know. I'll have to follow up internally here. If you have time, shoot me an email offline, we can take it offline and see what we can do.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

This is Leslie. I think there was some degree of that in the white paper that was presented, but I don't know if that will meet your needs Paul.

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

Yeah, I think it's what we need, more of a legal interpretation. I think that's something that ONC would be very interested in, and that's why I've suggested actually something where need an official kind of input. Okay, we can talk about it offline. But very real issues, but I think we certainly don't have the expertise here and I'm not sure a hearing...I think we have to have a thought from an official response.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, I've got all that in the notes column.

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

Great, thank you.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So, the next one was creating the capacity to accept pre-visit prep tools into the EHR. So if you, and this is an if, so it's not a requirement, if you give patients forms to fill out ahead of time, whether its admin forms or consent forms, or whatever; how do we make sure that the EHR has the capacity to accept those things in a digestible way?

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

Do you think this is...do you think a number of these things can be combined into essentially patient generated data?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I don't know the answer to that. I mean, there is sort of a common theme of ask patients, let them report structured data; make sure the EHR has the capacity to digest. And that could be true for pre-visit prep tools; it could be true for functional status. So, the piece I worry about Paul is it's not specific enough, so maybe how do we...maybe that's one thing we could do is sort of go back and say, to certainly create some parsimony and I think be better received, to try to put some meat on it. Because I just worry that people will go like "What? What are you doing," if it's that high level. I don't know, what do other people think?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy. If you're going to do that, I would also...I mean, I think that that's fine. I would also recommend and it may get back to your earlier point, about being able to transfer...it's a little bit different...but from EHR to EHR; so I'm going back to sort of all the old conversations around Clipboard. So, if you're filling out a bunch of admin forms, and intake forms and family history forms, typically you need the same information in many different environments. So is there a way to include the EHR capacity of however this is taken in to...or maybe that's for the health information exchange workgroup, but to be able to then share it from EHR to EHR so patients don't have to keep filling out similar related forms with the same information.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I think that's actually great because if you do have a lot of people doing meaningful use, which you do, you have specialists and you've got primary care, there certainly is that possibility. So the key themes I think for the workgroup, if I'm understanding is, figure out how to create the capacity for kind of structured questionnaires, would be one method, but I think with biomedical devices, that's like a whole different thing. But at least there's structured questionnaires, the ability for patients to use that platform to report structured data in a way that the EHR can digest and a way the EHR could transmit to others. Or I suppose that the patient could transmit to others through a portal or something like that.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Yeah, assuming they have something where they could save the same information so they don't have to re...like what I would hate to do is have to re...just like I don't want to fill out a paper form ten times, you don't want to have to reenter the same data in everyone's individual portal. That's why I'm saying, this crosses over to the information exchange area.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, I agree.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

But I think it would be really, you know, from a patient perspective, great not to have to keep filling out these forms every time you go to a doctor. And then actually that gets me into the update capability, so, sometimes things change, but...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, good. All right. I think we can work with that. I mean Leslie, you've got a lot more technical expertise than I do, did I cover the themes right here?

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

It looks pretty good.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay.

**Neil Calman –The Institute for Family Health – President and Co-founder**

This is...sign off. I'm sorry, I have another meeting. Thanks a lot.

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

Thanks Neil.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Thanks Neil.

**Michael Barr – American College of Physicians**

This is Michael. Just two minutes to the Supreme Court's going to start, so just be aware, we're all going to be a little distracted, I think.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

They're saying 10:15 to 10:30 now, so we'll see. All right, so the next is, again kind of similar to the ability, and this may be in care coordination too, but the ability of the EHR to receive data from like telemedicine or biomedical devices and, and here's the important piece, to display that information back to patients through the online access or view download capacity. And that was really in response...we talked about the capability to receive data from telemedicine and biomedical devices as a really important capacity to develop. But we also heard from patients like Hugo Campos who have told us that they don't have access to the information that is generated by some of those devices. And so one way to support that might be through having the EHR be able to receive it, and then when it does, display that back. So, I don't know if this is something that lives here or care coordination, but it's something that the group felt was important.

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

All right. I think there are a lot of issues. It's not as if we can...I mean, the case that was raised is having an AID basically put all of its data in the EHR. I mean, what you're saying to address that request is a big asking, to force all the EHR vendors to handle all the devices and display it back. I'm not sure that's...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Yeah, I think it's developing the...we've got to develop a capacity somehow to start this and where do we focus that capacity; is it to say, here's a structured way to take patients home devices, do we pick particular devices like scales and glucometers...but the capacity needs to be there.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

So this is George. I think that we can't put the whole healthcare system through the EHR though. I'm not sure that the EHR is the mechanism to display. You know, companies who give out devices and having means for patients to review it in a reasonable way.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

So, is it...making sure the EHR is capable and then also making sure that display, those are two separate thoughts in your mind?

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

I don't think...I think the volume of data is so large that you have to completely change how you do EHRs to accommodate this request, when in fact it's not...this is not really information, this is data. Until it's interpreted by someone, it's just kind of raw information. You can see it, I agree, but you...it's not a concept that would normally be stored in EHR, just the result of someone interpreting it would be installed in the EHR. So now saying well EHRs should change so they can store raw monitoring data, like no one's thinking they're going to do that in the future, so I don't know that that's a capacity we want to build in EHRs.

**M**

I think that would be another route...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

George, this is Christine. I guess maybe I just don't understand, but I thought we had long talks about the ability of the EHR to receive information from a weight scale from home on behalf of a patient who has heart failure or something like congestive heart failure. Is that not right?

**David Bates - Brigham & Women's Hospital & Partners**

No, I mean think it is right. We already do that for a lot of these things. This is David Bates.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

It depends on what device, I guess I was reading it...I was looking at telemonitoring, which is a little bit different. I guess if it's a weight scale, then you're sending a couple of facts in.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

How do you define telemonitoring George?

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Like I just meant, like a Holter Monitor, an EEG, the kinds of things that Quantified Self is going forward with, which generate say a number...a measurement every second of the patient's life; so a Holter monitoring like device and should that be sent to the EHR. That's what I was thinking of when I made my comment, not the once a day weight scale.

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

Correct.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay. But I do feel like this is something that really needs more work. I don't have the expertise to do it and Leslie, I don't know, I mean our workgroup members are Leslie, Neil, me, Charlene and Paul. So, I don't know if we've got the expertise, or, I heard David Bates, I don't know if that's something your group is working on, but I think this is an important one, but it needs more definition, that would be great, and I think I have a SCOTUS decision.

**David Bates - Brigham & Women's Hospital & Partners**

The way that I understand it is that most of the, at least these devices, output data in a pretty standard way and we want records to be able to accept that in the...using whatever the standard is. And I wouldn't ask for anything beyond that right now. I mean, I personally wouldn't ask for the record to understand it or for the provider to review it.

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

So we have to decide what “devices?” So I think we've all been...when we said this before, we've been thinking about glucometers and weights and blood pressure, etcetera. We were not thinking of, and I don't know how to define this, we were not thinking about pacemakers and AIDs and Holter Monitors, to the extent that's described here, you know, show it all and...that's not what we were thinking about, we have to come up with a definition of...how do you define...

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I would ask the question, even thinking of a glucometer, someone's taking their blood sugars three times a day. Now let's say they're marking it down in a little book, bringing it in, someone's reviewing it with them and then maybe, as was said before, someone's making an assessment and then making a note in the record. Would having every...you know three or four times a day a blood sugar for every single day in the record, is that, I'm asking because I don't have an opinion here, is that information overload unless the EHR can digest it and make some sense of it?

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

I think we have to divorce acquisition or collection from reporting, right? I could collect something every day or every hour, but the physician wants to see it cumulatively once a month.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I guess that's what I'm getting at; I think we have to balance in this definition between the volume of data and data points and what it's saying.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Right, and so the frequency of uploads should be based upon the clinician and patient agreement. The capacity of the EHR is that we have accepted something. But the patient could be gathering something offline more frequently than it's uploaded. So, it's three different issues I think. We want to make sure we capture it, as Christine said, and I think she had to go off to the decision...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I'm back, I'm back, sorry.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Oh, you're back. Okay. This is really an important concept, especially as more care gets moved to the home, that it could be monitored electronically, because that's the least expensive care we have, is home care, probably self-care. So, how do we make sure that we're accommodating the technology?

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

Now let's take this back and so, one, this is an EHR incentive program and just because it can be...data can be generated, doesn't mean it belongs in EHR and vice versa, so. Let's see if we can't define this in a way...as I said, we had some implicit impressions, but we don't have a perspective.

**Michael Barr – American College of Physicians**

Hey Paul, this is Michael. One quick point though, I think it's important to note that, even if the information is...I agree with the idea that information needs to get into the EHR, but I think we should be careful not to assume that physicians will feel it's okay to ignore it if they don't feel...once it's in there, they're going to feel an obligation to review it. So, if it's five times a day blood glucoses, think about other types of data, weights, peak flows, those kinds of things they might be doing three or four times a day. I think it's not...doctors are going to be concerned about not looking at data, so we have to be careful about what's selected to go in there, because if it's there, they're responsible for it.

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

That's why we...I'm going to talk about...talk to ONC about getting a legal opinion about that.

**Michael Barr – American College of Physicians**

All right, but that was this last point, and you're talking about that before, too.

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

Yeah.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

All right, so we've got some work to do. So, let me just do the last one in this and then, because I know we need to keep cruising here. So, the last one is pretty simple actually and we've talked about it previously, which is just offering patients the ability to reconcile information in their record through, I would imagine, any portal that's out there, so that they would have a technical capacity to do that.

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

It's non-trivial, so we have to look at that, too, but, yes, right. So you're asking for some kind of capability so that they can deliberately reconcile things that...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Right, or add an addenda or whatever the case may be. So, I think that's something that we do need to have feedback on.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Do we know, this is George...

**M**

Excuse me; individual mandate survives as a tax, just announced.

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

Oh wow.

**M**

I'm watching the SCOTUS live blog.

**W**

Wow.

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

Wow.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Wow.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Wow. Federal mandate survived.

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

We still need to finish this work so...Okay.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Reconciling information. Are we having patients correct each data element in the record or are we having them...are we having a place where they say here's my concern about this record. In other words, the patients won't realize that the same thing is documented in 50 notes. Are they going to go through and correct all 50 notes one at a time?

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

No, it has to be an addendum to the file that says here are the patient's...because no one can go back and retrospectively actually alter the record. You can go back with a separate opinion and say here's my addendum. At the patient generated data hearing, the idea of reconciliation for medications was a huge deal, too. You know, how do I reconcile what I'm actually taking.

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

I think as a result of this conversation, what you're getting Christine is the here are some additional issues, here are some of the feelings; and for each of these, I think the next step for the subgroup is to say, how would we put this in words so that some of these issues are clarified. I think we need to take that next step, because we'll get these questions...of the way. So, I think the group, the broader workgroup continues to support this idea. I think we need to flesh out now how do we answer all these questions; does it update all of them, is it just an addendum and does it require corrections of all the other places that it appears in this organizations record, and what about the places where it's been transmitted. If we can think about some of that; we won't necessarily have all the answers, but have an approach, then that would help us clear the next hurdle. Does that make sense?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I think so, yeah. Okay, so, how do you want to handle the remainder here Paul, because I know we're running short on time. I think we can probably skip the after visit summary, because the goal is...the point is we've got to figure out what Stage 2 says before we can come back and make sure that it is...

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

Okay. Yup.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

The next one is another kind of placeholder, based on what...which is about receiving drug recalls and alerts for recalls and if there are two components in Stage 2, then this is not necessary because EHRs would already have the capacity. So, there are two more in this subgroup, and I think David's group is working on, is the ability to access and update like a patient whiteboard as a collaborative care platform. So it's really sort of the central clearinghouse for which team members, which could...you know, hospitals or EPs can interact with patients and have the ability to track progress against the care plan, for the patient or caregiver to input information and get feedback for it to be interactive, collaborative and dynamic. And so, it's not a static document. And Paul, maybe you can more, because I think this came out of the hearing.

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

Yeah, so, I think the whole notion is interactive care plan. So one, can there be a shared care plan and two, I suppose, can it be updated, so can there be an accessible, shared care plan that's dynamic. And you're right, it probably can come under coordinated care, and who has that...Charlene. Is Charlene on? I think I heard her voice. Okay, so that could be something that goes to coordination of care.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I'm sorry, we're getting the Supreme Court updated, it's a little bit wild and decisions are changing by the second here, interpretations I should say. So, you want this to go to care coordination.

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

That makes sense, doesn't it? I know they've sort of adopted this shared care plan as one of the...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, I think as long as it's sort of the shared care plan is not the only thing...I think we talked about this idea that when you're in the hospital you can see who's going to interact with you that day, what's scheduled to happen and for your ability to actually input feedback on that. So, it's not just a care plan, like particularly in a hospital setting, it's more of a real-time interaction platform.

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

So Paul, this is Charlene, I am on, so I'm listening, I'm on mute most of it. Okay?

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

Okay.

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

And we've got that component in our requirements, too.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Well, why don't we hold this then until we hear from the care coordination group and we can come back.

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

Right, thank you.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, so the last one is, again, and I mentioned it earlier, is creating this capacity for online visits or consults. So this is...how do you create the ability for encounters to happen between patients and care team members? Again, thinking about future payment models; we talked about those encounters that could be synchronous or asynchronous and really the goal is that we need to make sure that the data needed to support the encounter is available from the EHR, the technical back and forth is supported by the EHR and that the information that's generated from the encounter is digestible by the EHR for both clinical and billing purposes. So, this is one...it's difficult for me to imagine a usage requirement around this, but it is, again, just this sort of we've got to create that capacity because we think that's probably what's coming in the marketplace and something that would benefit ACOs, let's say. Great, everybody agrees, let's keep moving.

**Michael Barr – American College of Physicians**

I'm sorry, we're all just...I'm just watching this freaking news. It looks like...

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I know, it's all over the map Michael...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

I can't even tell what's happening, it looks like there are so many different opinions about this guys.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, it's very confusing. Just don't even bother yet, wait an hour and you'll get the right story, I think.

**Michael Barr – American College of Physicians**

They're saying it's all upheld.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I know, but then they were saying...I think CNN was saying it's struck down. So, it's all over the place. Okay, so create the capacity for online visits and consults, is there anybody who has comments on this?

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

Yeah, Christine, and I think I was on the call when we discussed this one. I mean, I think it starts to make sense to me. Again, there were some issues around things like e-visits and e-consults, but again, I think the concept of starting to articulate the provider to patient communication, because standards are starting to flow around that makes a lot of sense to me. And you can start to think through, in a straightforward way, how your systems can support, if you will, those use cases. So again, I think we talked in our call that again, one of our concerns around it was the context in which you do an e-visit in terms of a.k.a. it's not paid for today, that kind of thing. So, I don't know how we want to handle those kinds of things, but, functionally it made a lot of sense.

**M**

So, it's just an extension of secure messaging in a sense?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

It could be; that could be one component. I mean, we wanted to be, and Paul, you were on that call, too. We wanted to be technology agnostic, so there were...we talked about things like video-interactions, secure messaging, and so that' why we had that line about it could be synchronous or asynchronous.

**M**

Okay, yeah.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

And I think that's the element of the work that we need to do to understand, okay, because secure messaging could be one. But, what other options are there, where we need to create the capacity.

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

So once again, I think there's support for this notion of being able to conduct care transactions online. We probably have to come back with some specifics to be able to answer some of these questions. So, it does not require X, like videoconferencing. I think we just have to try to be a little bit more precise in the wording. It may be a particular secure patient messaging. I mean, that's probably one of the most common ways it's done now, in terms of patient's giving input or asking questions and providers responding. And that is an online consult.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

And that was part of the testimony from one of the key groups, that in doc to doc, that talked to us about that, and maybe that's the capacity that we start with.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

And that's already in...it's in the proposed for Stage 2, so if that's the starting point for stage 3, then there's...then we should just call this secure messaging. What I'm wondering is, what are the other...this is another thing that's been kind of kicked around for a while, what are the other capabilities, aside from secure messaging, that could be used and that should be deployed on a more widespread basis. I don't know that we want to install video cameras everywhere, right, so there's a limit. But I just don't know if there are capabilities beyond secure messaging that we should look at or if what we're talking about for Stage 3 is secure messaging, then we should just call this that.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

I think you're right Christine, messaging is one way to do this, but what we were trying to get at is, is there a video encounter...or not a video, an e-encounter that could be done in other ways?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

So maybe staff could help us sort of develop this to understand the details of what the options are, and again, if it turns out to just be secure messaging, we'll move this and call it that. But, if there are capacities that should be developed, then we could at least understand those, to make sure that we're ready for more of the accountable care model.

**Arthur Davidson – Denver Public Health Department – Director**

This is Art. If this is a synchronous event, why do we need to use something different than the current encounter, we just need to label the current method that's being used when someone's in the office, this is an office visit, to now this is an e-encounter visit, are we talking about new media? Is video really that important or should we just be using for a synchronous encounter, we're just saying this is an e-encounter. For asynchronous, that might be the secure messaging. How far do we have to go with new media?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

I think that's the question, Art. I don't think we know the answer and it's one thing that we wanted to get the workgroups thoughts on first and so we could go back and do some homework.

**Arthur Davidson – Denver Public Health Department – Director**

It seems like we should take a simple step.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, oh definitely, and I think secure messaging is definitely that. Okay, so keep it simple, got it.

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

Yeah, I think that's the feedback here.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yup. Okay. All right, I've got it. So, that's all of that and I don't think we have time to go through the referrals, or do you want me to do that quickly.

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

Interestingly, that would give people heads up on what they are receiving, so, what do you think David, is that okay?

**David Bates - Brigham & Women's Hospital & Partners**

Yeah.

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

Okay, so if we can go as quickly as possible, all you need to do is have the recipient understand the hand-off.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, so we don't necessarily need to talk or argue about them, I just need to explain them, right?

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

Right.

## **Christine Bechtel – National Partnership for Women & Families – Vice President**

Okay, just making that clear. We had a number of things for the quality group, and the first is around advanced directives. This may be for the hearing, too, I would imagine; but we were looking at two components, one would be the ability to document the advanced directive on line in a way that's retrievable and can be incorporated. And then the second was to be able to doc...have the capability to document and integrate the physician order for life sustaining treatment POLST, into the EHR and on the right-hand side of the second column, there's an explanation of what POLST is. We also talked about needing a revision management strategy to make sure the care team knows that it's up to date and things like this. And I think Leslie suggested the S&I team could work on the technical capability for that; so, I think there's enough in there to get the workgroup started, and actually it would be great if ONC could use those in looking at the questions for the hearing, as we formulate that.

The second is, we already talked about, which is the recording of disability, sexual orientation, gender identity and granular race, ethnicity and language data, and the work that needs to be done there. The third is patient decision aids for preference sensitive care. So the reason this is coming, we were suggesting that this comes into the quality group, is because we agreed that it really is something that is more of a clinical decision support intervention category, where we should think about alerting providers to the highest value, preference sensitive condition, using maybe the FIMDM list to draw a small number from that list and add a measure of capturing and accommodating patient preferences in clinical decision making. And so the provider could really decide which clinical decision, shared decision making or decision aids could apply to, and build a CDS rule around it. So, stop me if you have questions.

The next one is, I think around medication reconciliation, the ability to accept a data feed from PBM. And then finally, we talked a lot and we had this originally in kind of the view, download, transmit, report function, but the ability is really a functionality for patients to be able to compare themselves with others, whether that's their risk status or how they're doing in terms of receiving evidenced based care. So, we felt like that was something that the quality group might be able to look at.

The next is actually for the quality measures workgroup, which is the patient reported measures focusing on functional status and patient experience. And again, it's just idea that we need a questionnaire kind of platform to collect standardized data that can be integrated back into the EHR.

So for the care coordination subgroup, we talked about a couple of things. One is, the ability either for the patient or the provider to record their caregiver status and specify the role that their caregiver plays in their care. So, Eric Coleman, with the care transitions group, has done some really nice work around something called DECAF, which is a structured data approach for the patient or the family caregiver to say, I play a role in providing direct care to the patient or I provide them just emotional support or I am the person who leads care coordination, or I do advocacy, or I handle the financial stuff; and that's the DECAF acronym. The next one kind of became known in the Lexicon as CC me or my designees. So, if a care summary is being sent, provider to provider, the ability for the patient or the family caregiver to say, anytime you transmit that, I want you to send a copy to this location.

We talked about comprehensive care plan in the whiteboard context of versioning, interoperability, ability to upload, so I don't think we need to talk about that; but we did throw, David, some specific kind of elements that we were thinking about into this sentence, which is around versioning, updatable and also with the lead provider designated, if that made sense. So that was something we wanted to suggest that you all think about. List of care team members, their roles and we were thinking about it originally in the context of it being a piece of patient-reported data. So, that's food for thought. And then finally, in this category, we discussed at length information sharing preferences. So, how do we standardize the collection of information about which care team members should always be sent certain types of information. So, you could really set your preferences and say, "when my cardiologist updates my record, I want a copy to always go to my primary care provider, if it has these things in it, or whatever." Any questions on any of that?

Okay, last two were actually privacy and security related. One was the ability of patient-facing systems to be supported by mobile devices, to allow me to log into my portal or whatever on my phone, for example. And we felt like there were some privacy and security issues there and we needed some help thinking through if that's doable in this context. And then the second is something that Neil raised and the group really agreed with which is, wanting the Tiger Team to weigh in on whether or not you could have providers do registrations for the electronic access online, without having to be in person, at least before the first visit. So that that would allow them to create the account, fill out the forms, blah, blah, blah; but that they don't get access to the full PHI until they went in person for their first visit, or whatever, and were authenticated on site there. Another workgroup member raised the question or whether we needed some kind of national framework for authentication. Okay Paul, that's it.

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

Thank you so much Christine. With regards to the last one, I believe, I don't know who on ONC is online, but I believe ONC is taking that authentication issue up separately; in fact, there is a July 11...so ONC is considering taking up this whole authentication issue separately.

**David Bates - Brigham & Women's Hospital & Partners**

And can I just go back to the care team thing?

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yes.

**David Bates - Brigham & Women's Hospital & Partners**

So, I think it shouldn't have to be patient reported, I would think it could be patient reported or otherwise.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Definitely.

**David Bates - Brigham & Women's Hospital & Partners**

And I'm worried about doing the thing where the patient sets all the preferences about who sees what.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

It's not who sees, it is really more, when information is generated about me, in one provider space; I want a copy to automatically go to someone else. So, it's more about making sure there's coordination among the team. Does that help? Or is that different from what you heard?

**David Bates - Brigham & Women's Hospital & Partners**

Well, I'm just trying to think about how we would manage it and I, maybe some other people could weigh in about that. I just don't know how to orchestrate that.

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

What if I propose the following, in terms of this list; so, Christine has proposed these topics...that the subgroups weigh in on these topics and has sort of divvied them up in the different subgroups. Would it be reasonable to just ask all the subgroups to go over these questions and come up with an opinion of them?

**David Bates - Brigham & Women's Hospital & Partners**

Sure.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, and then just send me a note or any other subgroup member, if there are things like that that you don't understand. I mean, just very briefly in that case, as to how we were thinking about it was, much like you collect the communication preferences and you say, if I'm sending you an appointment reminder, do you want that delivered by phone, by email, whatever. It's really the collecting...at least starting with just collecting preferences around, if you come and see me, is there any other provider that you want me to share certain kinds of information with, or maybe it just starts all of it with, the care summary for example.

**David Bates - Brigham & Women's Hospital & Partners**

Right. It gets complicated fairly fast because I think it's a factorial sort of set up and some people have a lot of providers.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Yeah, true. Simple is better, but I was just thinking if there is a simple way to do it, that was what the workgroup was looking for. So...

**David Bates - Brigham & Women's Hospital & Partners**

Yeah.

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

So they all have good intent and it's a question of one, is it part of meaningful use, two, is it now in Stage 3 or could it be something we put a placeholder for future stages. But at any rate, so I think these groups, if the workgroup leads that are on the call agree, could just be taken up in their subgroups and render an opinion.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

And can the ONC staff make sure they all get a copy of that table?

**David Bates - Brigham & Women's Hospital & Partners**

So, that makes sense.

**MacKenzie Robertson – Office of the National Coordinator**

Sure, we'll make sure Michelle gets that out.

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

Thank you. All right, thank you Christine.

**Christine Bechtel – National Partnership for Women & Families – Vice President**

Thank you and thank you to the workgroup members who worked really hard on that, and showed up for phone calls and everything. So thanks you guys.

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

Okay, David, we're ready to come back to category 1. And I believe the last one we were about to work on was the clinical decision support.

**David Bates - Brigham & Women's Hospital & Partners**

Okay. I'm trying to locate that. Does anybody know what page that is on our...

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

It is on page 11.

**David Bates - Brigham & Women's Hospital & Partners**

Page 11, okay, I was on page 9, okay, good. Okay, so on clinical decision support, let's see, the things that we asked for, or that we considered asking for, was requiring some sort of additional function, like the focus for example on high cost imaging or the use of generic drugs. We did recommend using the original recommendation for the five CDS attributes and these attributes are incorporated into the NPRM except that we recommended simplifying the citation of the reference source and we recommended not having a special call out for linked references. And then we said that the...we suggested specifying that the fifteen most important ones be included, but we would need comment on those, and we suggested...so there is clearly a focus on chronic conditions, which doesn't apply to some specialties. We noted that because ACOs are coming, that'll push people in the right direction and we could avoid being too prescriptive. We were interested in including renal dosing CDS and those were really the main things, although this is an important area and we wondered should we get some more information from the marketplace. So let me just stop there and maybe we could talk about this a little bit.

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

Okay, comments? So you are setting a threshold of 15, up from 5?

**David Bates - Brigham & Women's Hospital & Partners**

Yes. That's what we suggested.

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

And I guess include...and one of the mandatory would be the renal dosing?

**David Bates - Brigham & Women's Hospital & Partners**

Yes, and that delivers a lot of value, and it's pretty widely relevant.

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

And that was one of the standards surrounding renal dosing is one of the questions we sent over to HIT Standards Committee.

**David Bates - Brigham & Women's Hospital & Partners**

Correct.

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

Your survey of the vendors is to ask them what questions.

**David Bates - Brigham & Women's Hospital & Partners**

Really to ask...so, one question would be, are there age-related dosing suggestions that are widely available, are there other things that vendors feel would deliver high value that could be included in this list that might not otherwise make it into the top 15.

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

Okay, because one of the ways of doing that is to include that in our RFD. Other folks' comments?

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

So David, this is George. This is 15 what's, renal dosing is one of 15 or...

**David Bates - Brigham & Women's Hospital & Partners**

So this is 15...so the prior was...basically called for...

**M**

Five.

**David Bates - Brigham & Women's Hospital & Partners**

Right, five...

**M**

Was it five or three? I forget, because it was five...

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

Five.

**David Bates - Brigham & Women's Hospital & Partners**

It was five in Stage 2.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Ok, so what's the target number that we're trying to get to?

**David Bates - Brigham & Women's Hospital & Partners**

Well, it depends on how you count. I mean, we have around a thousand, to give you some sense.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Yeah, I guess I'm just worried about the sub-specialty providers.

**David Bates - Brigham & Women's Hospital & Partners**

No, of course. And that's why...but almost everybody should have some and, you know, we could allow for certain people to exempt out should they elect to do so this is important because a lot of the value does come from this.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

Um hmm.

**David Bates - Brigham & Women's Hospital & Partners**

But I agree; it's a tricky one. We're trying hard to be flexible and not too prescriptive on the one hand. On the other hand, we want to ask for enough that people are going to get some value.

**George Hripcsak – Columbia University – Professor and Chair, Department of Biomedical Informatics**

So these would be chosen from an ONC set?

**David Bates - Brigham & Women's Hospital & Partners**

Yes.

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

So if we review what we've done in the previous stages, Stage 1 we said just do something, in a sense, we said try one. Stage 2 we said, and we called it a rule, I believe; Stage 2 said, look, instead of specifying what the "intervention" is, here are some attributes about it, it's basically being context sensitive and shown in a timely way to the right person. And Stage 3...and there was a number of five. Stage 3, are we looking either only or primarily on increasing the number or do we start talking about aligning CDS with national priorities.

**David Bates - Brigham & Women's Hospital & Partners**

We were trying to do a little bit of both here, you know, both to ask for more and to get some alignment with national priorities. Presumably the ones that ONC identifies are going to be aligned with the national priorities. I mean, they'll mostly be for chronic conditions.

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

Okay, so it's an...it's somebody's published list of priorities.

**David Bates - Brigham & Women's Hospital & Partners**

Yeah, well, I think that ONC is doing some work in this area.

**M**

Okay, well we're not finished, I think...

**Arthur Davidson – Denver Public Health Department – Director**

This is Art. Who's working on that list at ONC?

**David Bates - Brigham & Women's Hospital & Partners**

Is there somebody from ONC who's on line who could comment, I mean, Josh, are you on?

**Emma Potter – Office of the National Coordinator**

This is Emma. Josh and Michelle are at an...conference, so they're not on this call. I'm with the ONC, but I don't know the answer to that question.

**Arthur Davidson – Denver Public Health Department – Director**

I just...because we've had some discussion about CDS for immunizations as well in Public Health, so, I don't know whether that's a way to get...if we need to introduce...the discussion.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

And this is Leslie, I think a question to the ONC is if we're aligning with national priorities then, are we...we would have to distinguish between acute and ambulatory or even self-care decision making when we roll these things out to patients in shared decision making.

**Arthur Davidson – Denver Public Health Department – Director**

I think that's an important point. I think that David and George suggesting that this is mostly a chronic disease list is probably appropriate, but there may be some preventive things as well that could be added.

**David Bates - Brigham & Women's Hospital & Partners**

There are definitely a bunch of preventive ones that are of high value.

**Arthur Davidson – Denver Public Health Department – Director**

Yeah.

**David Bates - Brigham & Women's Hospital & Partners**

There are about six or eight that are kind of easy and big wins, and patients benefit from seeing those.

**Arthur Davidson – Denver Public Health Department – Director**

Yeah.

**Emma Potter – Office of the National Coordinator**

Okay. This is Emma; I'll pass that information along.

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

Okay, ready to move on then David?

**David Bates - Brigham & Women's Hospital & Partners**

Yup. Okay, so the next one focuses on laboratory tests and here our one suggestion was to increase the threshold to 80% from 55%.

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

Any comments there?

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

I think it's great.

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

Okay, we can go.

**David Bates – Brigham & Women's Hospital & Partners Senior Vice President for Quality and**

**Safety**

Move on. Okay the next one was to generate lists of patients by specific conditions and here we noted that lists tend to be retrospective, we'd rather see this as something like a dashboard. We weren't sure if we were overlapping with other groups, in particular the quality group and we wanted to focus on high priority conditions. So, that was really the short summary.

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

All right, any other comments there? Okay, we probably have to define dashboard a little bit more when we publish it for the Committee.

**Michael Barr – American College of Physicians**

What's that Paul?

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

We probably want to define dashboard so people know what we're talking about.

**Michael Barr – American College of Physicians**

And so my question for this is, I mean it sounds good, it's just do we need to make it sound more like an objective. I mean we have to see what... I mean, the first one is conditional, it's not included in Stage 2, put it back, but, I think this just goes for a lot of what we discussed today, eventually has to look more like an objective and less like an idea.

**David Bates - Brigham & Women's Hospital & Partners**

Right. I mean, there are lots of examples of dashboards, the question is, how you describe it in a way that makes it easy to ask for.

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

It's sort of a, instead of generating a report where you submit it to whoever does your reporting and it's a retrospective look back, the notion of dashboard was essentially real-time, it's like real-time reporting and it's made available to clinicians at the point of care, it could be the morning when they log in, or it has something to do with this patient when they're seeing somebody.

**M**

Okay.

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

Next one?

**David Bates - Brigham & Women's Hospital & Partners**

So the next one focuses on sending preventive or follow-up reminders to patients. And the Stage 2 measure called for more than 10% of patients being sent a reminder per preference. We weren't sure exactly what to do with this. There was some sentiment towards retiring it, but we didn't really want to do that. For Million Hearts, for example, the notion was that we could target a set of things that would be sent for everyone versus doing something in a priority...in a much more targeted way. So, this is one where I think we didn't have a really clear, sort of specific recommendation.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

This is Leslie and tools are emerging so that when a patient is either discharged from a hospital or finishes a visit, not only do they get patient-specific education materials, but then perspective things like on week 2 you should be doing this, on week 3 you should be doing that; or for chronic care self-management, things that can be staged over a period of time that remind the patient to have their A1c test or to follow this diet. So, I think it's about capacity, making sure there's a capacity to send clinically relevant or health relevant reminders and the same question comes back, do we do this as the national priority items or do we just do the capacity I think.

**David Bates - Brigham & Women's Hospital & Partners**

Exactly. And this is being covered by another group too. And, do we need some sort of threshold versus do we just require it as a capacity.

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

In a sense I guess we already have it as a capability of EHR, and I suppose one of the ways to think of this is, so we've inserted this capability and made it available to folks, we know that we're just part of the equation, the other part is the pull from the policy changes. So, if you're an ACO, you're going to want to take advantage of...I mean, ACO or others, you'd want to take advantage of this capability to do outreach...

**David Bates - Brigham & Women's Hospital & Partners**

On the one hand. On the other hand, for example, in Stage 1, just asking the docs to provide the summaries to patients, I think has been one of the most powerful objectives, because it's one thing to have the capability, it's another thing to actually do it. And this is a pretty potent one, and I think asking for people to do it at some level would not be a bad...might be valuable.

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

So we already have it, right?

**David Bates - Brigham & Women's Hospital & Partners**

Yeah, we could increase the threshold.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

I agree.

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

So do you want to increase it to something?

**David Bates - Brigham & Women's Hospital & Partners**

Something like 20%.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

This is Leslie. Paul, is the website down? I can't get the Altarum site back up again. Are you guys having the same problem?

**David Bates - Brigham & Women's Hospital & Partners**

It's up for me.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

Okay.

**Caitlin Collins – Altarum Institute**

It may have been your internet connection. You may need to log out and try logging in again.

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

All right, thank you.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy and I would agree with upping the threshold.

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

Okay, and I would too.

**David Bates - Brigham & Women's Hospital & Partners**

Okay, should we move on?

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

Yeah.

**David Bates – Brigham & Women's Hospital & Partners Senior Vice President for Quality and Safety**

Okay so the next one is around automatically tracking medications from order to administration using assisted technologies in conjunction with an eMAR. And here, what we wanted to do was increase the threshold in Stage 3, and instead of just looking at whether or not things were recorded electronically, track the mismatches. And we also thought about asking people for the capacity to be able to report on various errors and what the actions taken were around those.

**Michael Barr – American College of Physicians**

When you say track mismatches, do you mean the provider has an ability to see how many mismatches or do you mean that's what gets reported to CMS?

**David Bates - Brigham & Women's Hospital & Partners**

So that the provider can track that. Which, and I don't know whether every system already does that, I'm not sure that all systems do make that easy to track.

**Marty Fattig – Nemaha County Hospital (NCHNET)**

Yeah, this is Marty, our system does allow us to do that and then we have the nurse who noticed the mismatch comment on what happened and why the mismatch occurred. Sometimes it's as simple as a bad NDC number, but sometimes it's wrong patient, so...

**David Bates - Brigham & Women's Hospital & Partners**

Yeah, ours lets us do stuff like that too, and it's pretty valuable to have the information.

**Marty Fattig – Nemaha County Hospital (NCHNET)**

It's great. It's very valuable.

**M**

Is mismatch only defined by drug or is it also about timing?

**Marty Fattig – Nemaha County Hospital (NCHNET)**

Both. Although the timing ones tend to be less important and more numerous.

**M**

I agree with that, yes.

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

Okay, if that's your intent, you might want to spell it out as we present it.

**David Bates - Brigham & Women's Hospital & Partners**

Okay.

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

Okay, next.

**David Bates - Brigham & Women's Hospital & Partners**

So the next one is around incorporating imaging results and information into EHRs and so, our thought about this was that this was moved to core and we thought what we should do about this really depends on what ends up in Stage 2. If it didn't end up in Stage 2, if it got taken out of Stage 2, then we would probably still want to ask for it. But if it does end up in Stage 2, we might not need to do anything.

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

Okay.

**David Bates - Brigham & Women's Hospital & Partners**

Does that sound reasonable?

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

Yeah, we recommended that they lower the threshold from 40 to 10. If they kept it at 40, then we might have to think whether that's sustainable as a core for everybody.

**David Bates - Brigham & Women's Hospital & Partners**

Exactly.

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

Okay.

**David Bates - Brigham & Women's Hospital & Partners**

Okay, next one is on family history. And here what we suggested was focusing on high priority conditions with different priorities for different groups. An example of a high priority condition is glaucoma; we suggested that...there was some debate about how often this needed to be updated, there is some sentiment in favor of doing it once and other sentiment in favor of doing it, for example, every five years. We noted that it should probably focus on a few specific high priority conditions like colon cancer, breast cancer and it has to be linked with the right...the CDS has to be there, which can then use this information. And we had a note that there might be some standards that were being developed in this area but I don't think we have more data about whether they're available yet or not.

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

Michelle is that...or Emma...anyway, we can make a note whether that's one of the things we sent to Standards Committee; I believe it was, but I'm not positive.

**David Bates - Brigham & Women's Hospital & Partners**

Yeah.

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

So I guess the open questions are how often do you update is one of them.

**David Bates - Brigham & Women's Hospital & Partners**

Right.

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

You're asking for prioritized, and I guess we have to specify that...

**David Bates - Brigham & Women's Hospital & Partners**

Right. And I think the things that we wanted were colon, breast, glaucoma and then we'd be interested in other people lobbying for other things.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

So this is Amy. I would...I mean I don't know how far you want to go, but I would say some of the sort of chronic conditions, diabetes, high blood pressure, cardiac. Because that cuts across...every family history I've ever had to fill out always includes those. And I think they're pretty core to some chronic disease management and preventive care.

**David Bates - Brigham & Women's Hospital & Partners**

Right, I mean diabetes and MI ends up being important; with hypertension you can just measure whether the person has it or not. So...

**Leslie Kelly Hall – Healthwise – Senior Vice President for Policy**

What about surgical history?

**David Bates - Brigham & Women's Hospital & Partners**

Well here we're really getting at family history. So, surgical history I think is in a different place.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

And what about cardiac family history?

**David Bates - Brigham & Women's Hospital & Partners**

Well, history of MI is an important one.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Yes, okay.

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

Okay, so what do people think about the update? I might say if we get out...the simpler the better.

**David Bates - Brigham & Women's Hospital & Partners**

So, I think maybe one time...I mean, it becomes complicated, especially for example for a young person, you just don't know how often you're seeing them.

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

Right. Okay.

**David Bates - Brigham & Women's Hospital & Partners**

Yeah. Okay.

**Emma Potter – Office of the National Coordinator**

This is Emma. I just have a question. Are you asking about how often you would ask the patient about family history or how often you would update the family history in their EHR?

**David Bates - Brigham & Women's Hospital & Partners**

Well, the former, but the two are linked right, because if you'd ask them, then you would update it.

**Emma Potter – Office of the National Coordinator**

Right. Well, I didn't know if you all would be asking them every five years or if you would just be interested in only updating that every five years.

**David Bates - Brigham & Women's Hospital & Partners**

Right. There aren't good guidelines for that. I mean, right now, about 20 or 25% of patients have good information in their family history. So, just getting any information for everybody would be a big step in the right direction. There's no guideline about how often it should be updated, at least that I know of.

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

Right.

**David Bates - Brigham & Women's Hospital & Partners**

There's a lot of work going on in this area and there could be things that I don't know about.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy. I may be naïve, but it's hard...I mean it depends on probably the age of the individual and how much their immediate family relatives that are still living have changing conditions.

**David Bates - Brigham & Women's Hospital & Partners**

Sure.

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

Right.

**Marty Fattig – Nemaha County Hospital (NCHNET)**

This is Marty. I'll add something to that, I don't know how you're going to enforce a standard like this, so I think getting entered is great, but other than that, I don't know how you would enforce it.

**David Bates - Brigham & Women's Hospital & Partners**

Right, you know, the other thing I think it's useful to ask for is that it be linked to the decision support because if you don't link it to the decision support, the value goes way down and it does have a big impact on decision support, especially for breast and colorectal screening. Those two are sufficiently common that it changes your recommendations in a lot of patients.

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

Okay. Okay maybe we can do...well, you know what...

**David Bates - Brigham & Women's Hospital & Partners**

Should we stop?

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

Yeah, we probably should stop. So I think what we're going to do is on July 3<sup>rd</sup>, we'll finish up category 1 and we will try to get through 3 and 4. And the goal is...the reason we're trying to push for this is because we'll need July to...we already have some things that we need to tidy up, as a result of this call. We just need to get it all in order before our August 1<sup>st</sup> presentation to the full Policy Committee. Any other final comments before we go to public comment?

**Emma Potter – Office of the National Coordinator**

This is Emma. Is there anything that you would like to relay to Josh or Michelle?

**M**

Just remember where left off.

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

Yeah, really.

**David Bates - Brigham & Women's Hospital & Partners**

We have two left, where we left off.

**M**

We have two left, we have to remember that.

**Emma Potter – Office of the National Coordinator**

Okay.

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

Okay, well thank you so much to all the people participating on these subgroups and to David and Christine for leading categories 1 and 2. And for Art and Charlene for 3 and 4. So this has been a lot of work, I think we're getting good output and we'll have to step back and relook at the whole thing in July, before we present, to come up with our preliminary recommendations to the Committee for discussion. Okay, operator, you want to open it up for public comment please.

**MacKenzie Robertson – Office of the National Coordinator**

Operator, could you please open the lines for public comment?

## **Public Comment**

**Caitlin Collins – Altarum Institute**

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

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

Thank you everybody. Thank you all for participating in the call and for keeping your attention here while we had the SCOTUS decision going on, and talk to you in just a few days actually. So thanks a lot.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks everybody.