

**Meaningful Use Workgroup  
Subgroup #2: Engage Patients & Families in Their Care  
Transcript  
July 20, 2012**

**Presentation**

**Operator**

Ms. Robertson, all lines are bridged.

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

Thank you. Good morning, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #2, Engaging Patients and Families in Their Care. This is a public call, and there'll be time for public comment at the end and the call is also being transcribed, so please make sure you identify yourself before speaking.

I'll now take roll. Christine Bechtel.

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

Here.

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

Thanks, Christine. Charlene Underwood.

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

I'm here.

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

Thanks, Charlene. Leslie Kelly Hall.

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

Here.

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

Thanks, Leslie. Neil Calman? Paul Tang? Are there any other workgroup members on the line? Is there any staff on the line?

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

Emma Potter, ONC.

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

Thanks, Emma. Okay, Christine, I'll turn it over to you.

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

Great. Thank you very much, MacKenzie. So thanks again, ah, for joining, ah, today. We've got an hour and a half to do a pretty significant chunk of work, so we'll try to, you know, move with some efficiency and purpose here. Ah, I think we're going to do, ah, three particular things today. One is, and you have two documents, um, that we'll be working from. One is to look again at the draft, concept-, the conceptual framework for, um, Patient and Family Engagement, that's the document, the Word document we've been working on all along. There were some specific, ah, pieces of feedback that we received from the full Meaningful Use Workgroup that we need to address, so we'll go through and do that.

We also need to have a discussion about whether or not all of these potential objectives belong in the, um, in the category and, um, we have done some thinking, I think all of us, about how well each objective fits within the principles that the Meaningful Use Workgroup has provided for whether or not something survives. Um, we will err on the side of I think keeping things more than ditching them, only because I think there are a lot of areas where we're not sure, and public comment would be worthy. Um, however, that being said, we do have a fair amount in here, and so we need to be very judicious about what really remains. So we'll go through each and make sure that we're in agreement about how well, um, each individual item meets those, um, principles and those principles are enumerated in brief in the Excel spreadsheet that you guys received.

And then finally if the element stays in, we do need to give some thought to how we would measure it. We don't have to settle on a final, um, approach or number or threshold or percent, um, although if we can, I think that's great, but we do need to at least make sure it is measurable.

So those are the three things we're going to do in the next 90 minutes, anybody have questions or additions to that agenda?

Okay—

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

Christine, I think the other one, this is Charlene that you, um, raised at the broader meeting is, um, some of these areas are cross-cutting, you know, so—

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

Yes.

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

And, you know, and I know we referred, um, from our workgroup, the Care Coordination Workgroup, some of those elements to use. I don't know if we'll have time to—I think you, you had some questions to flush any of those out or if that's a separate process.

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

Okay, that's a, that's a good point, so let me add the referrals that leads to our group, because I think there were a couple that we weren't sure what they were, so I'll add that to the agenda. And then at least for the ONC staff on the line, ah, on this spreadsheet that was sent, it looks like all the that's happened is based then, the referrals that we sent to other groups are just sort of placed in those categories, but it doesn't appear that those groups have done work on them and I, I'm wondering if there's a plan for ensuring that that work gets done.

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

Um, this is Emma. I assume that there's a plan, I'm just not quite sure what the details of it are, um, because I know that some, that were some questions at the Meaningful Use Workgroup that you guys were on as well, where people weren't quite sure what some of them meant, so, ah.

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

Okay. Yeah.

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

I'll talk to Michelle. She's in a meeting right now, um, and she can get back to you on what the specific plan might be.

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

Okay, great. All right so let's go ahead and jump into the Word document, um, and start to pick through each item, and again, the first half is going to be, um, let's, I guess we should first make sure it stays in, and then if it does, address any, um, specific questions that we may have about, about it from the Meaningful Use Workgroup, and then finally, um, make sure that it is something that is measurable.

Okay, so the first one is patient specific education materials or reminders, um, are provided in, in languages that are spoken by more than 15% of the patient population, so as long as there are materials available in the public domain. So, um, my, sug-, you know, the way that we have rated this previously if any way was that it did meet, um, I, I think all of the criteria in terms of it does support a new model of care that's, you know, in other words outcomes oriented to support population health management. It does address national health priorities. It is broadly applicable, I mean, I think there's probably a medium in the case of broadly applicable, um, because there may be some, you know, particular specialties that where there will not be information available on conditions in the public domain. Uh, and then finally, I don't think it is market-driven at all, so I would put a high in that because it's not really happening today. Um, and, and, you know, Leslie, you're our standards ... and you too, Charlene, so I'm glad you guys are both on, in terms of adopted standards, I, I believe that what this would utilize is the standards already around, um, identifying patient lists, first of all, collecting language data and generating a list of patients to generate that 15%.

Then it is a question, as Neil pointed out, of making sure there are items in the public domain, um, in those particular languages. So does everybody agree that this should stay in?

Okay, does any—let me ask the other way ...

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

So in terms of the 15%, where was that, you know, because again, you have the public health facilities with huge diversity in terms of the population language, right, and then you have, you know, the small practices who are really challenged, you know, in terms of, you know, don't have that diversity, because they're in communities settings. The list—

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

For the 15% or so, if you, if it's more than 15% of your patient population speaks Spanish, then you would be, um, you would be required to provide patient specific education materials in Spanish or reminders in Spanish, um, if those materials are in the public domain.

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

Okay, and is there—

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

We have to figure out, I think the first thing is if we agree to these principles, then, then let's keep going. If we—

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

Okay, all right, I think it meets the principles, but what I was wondering is the 15% then the level, okay, all right.

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

I agree, I agree with that totally. I'm concerned about that, but I do think it has to stay in.

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

Okay, so now let's talk about how to measure it, so we, we have two dimensions of the measurement here. One is 15% of the patient population, right, and that, that is not providing materials to 15%. That is if you have 15% that speaks one particular language. Then we would need to decide okay, you should, you know, what's the measurement strategy for how to do this. So I could imagine, and it could be, you know, we want to try to keep it simple, um, so if 15% of your patient population speaks Spanish and there are materials available in Spanish in the public domain, then you would provide, um, patient specific education materials and/or reminders in Spanish what percent of the time.

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

So Christine, in terms of the scope, sorry—

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

No you're, go ahead.

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

Okay, in terms of do we have, I, this is my guess, do we have language as a data element?

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

Yes, in stage one.

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

Okay, okay, primary language, so we know that.

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

Yes.

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

Not just ethnicity, okay, all right.

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

We, we did that in one and two, this is Leslie. I think that my, my concerns I wonder is I hope we don't get into unintended consequences like somebody who doesn't want to do it, reduces their population in their census, um, that, that population. And, um, then the other concern is, ah, the definition of patient specific education materials ... two and one as a reflection in the attributions ... standard in one and two to be an attribution. They need modification. It has to say when to call a doctor and there, it's more than encyclopedic knowledge which is in the public domain.

So, um, in the public domain it's being like an encyclopedia, having an encyclopedia, not a patient instructions. So as ..., um, either we keep the public domain in, but understand that it's not going to have all those feature, or we reduce the percentage, um, and then reflect, you know, maybe there's the top five languages in the nation, um, you know that sort of we don't over, overburden ....

I don't know I'm not articulating it well. I just don't want to end up with either reduced census by a particular population of speaking groups, or to have, um, only encyclopedic references material because that's in the public domain. We've got to have when to call a doctor, how to set yourself up for this event it's much more, ah, consumer-based general information in that particular ....

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

And, you know, Christine on the vendor side, we often try, I mean the customers go out and buy these kind of capabilities, but something in the frame of the top five languages, you know, the predominant language or whatever is available or easier tools you know for them to go find, too, you know.

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

Yes, we, we had top five languages in the original formulation of this. And, and what Neil said was that that doesn't really—he, he was concerned that that may not be, um, very patient-centered at the local level, because you could have, you know, of, you could have 40% of your patient population be a, a smaller population and, right, that may not be a top five language, so that's how we got to the 15%. I mean, if you lower the 15%, you're going to bring more languages into play. So if anything, I, from what I'm hearing from you guys, I think if we keep that approach, you'd want to maybe up that to say well if you know if, ah, a third of your patient population has a primary language other than English, then I would say two things. One is the way this is written right now is to provide patient specific educational materials and/or reminders, so we may want to pull the reminders out if that's not available in standardized you know some common languages.

**W**

Um hmm. Right.

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

Leslie, do you agree with just focusing on patient education material?

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

I do because a reminder gets into more of, um, how, what do I do now, what do I do next, and that's definitely not in the, in the public domain, um, that Neil said, so yes, um, let's do that and I think that's a good compromise; but again, I don't want an unintended consequence like we did with quality measures in diabetes where diabetics were removed from particular, ah, panels, right? We don't want to have patients who have, ah, get removed from a panel as an unintended consequence.

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

So how do we, what should do with, with this? How, how would you define it and measure it?

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

Well, it's either got to be a nationwide approach to language or a, or per-, or maybe just get back to, ah, a higher percentage.

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

But a higher percentage, okay, a higher percentage, so, you know, it's a, you know, 50% of your patient population speaks, I mean, that's not going to do it. I know if that's going to be a lot of people, but let's say 30% speaks one of the top five, is that what you're saying, primary languages, then you need to, um, provide patient education materials to them in that primary language?

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

That sounds good, and I think we'll get a lot of public comment on this and, and, but I think that's a good start.

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

Okay, so provide patient specific education materials in languages in, let's say, the top five primary languages spoken nationally, right, so you're saying, okay. So where more than 30% of the patient population—

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

Yes.

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

—speaks, um, you know one of the top five primary languages, but then you provide patient specific education materials in all of those languages, one, what?

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

Well, because if it's not—provide could mean, um, I don't know if you have to buy an extra mo-, you know, it would seem you would want to just target it, you know, to, to those populations rather than making them, because we got a lot of feedback that we don't want to make them buy things they're not going to use, so.

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

So what's your recommendation, Charlene?

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

That, you know, it's provide patient education materials in the language appropriate, you know, for that population, so we know 30%, we know from a systems perspective, the percentage of patients that speak the language as long as we have the data element, and then should be able to measure that, you know, that percentage gets, you know, that education material in that language, so we can measure that.

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

Okay, so let me try this out. So where more than 30% of the patient population speaks one or more of the top five primary languages spoken nationally provide patient specific education materials in the language spoken where materials are available in the public domain.

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

Um, yeah, I think with this, this top qualifiers, you don't even need the public domain qualifier.

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

I would agree, because I think there's, there's products out there that we can—

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

Right.

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

Maybe it's less than the practices, but I know that, you know, that's offerings of the product out there in, at a minimum in the primary languages and some of them will have more extensive and other languages, but we're just the, we want to be the floor, so.

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

Okay, so, so the, the threshold, there needs to be a threshold, so you're providing patient education materials in one of those languages to what percent of patients?

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

What did w-, what was our past numbers that we used, because the delta we're extending is, we're increasing the breadth of the delta for this one is the more languages, right?

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

Right, and we went and in stage one we had tons of ... education was dependent on, then we went to I think it was 50% or more as requirement in, in, ah, stage two or, you know, we can only guess at this point. So if we went down that path, we could say to provide, um, you know, 10% to 30% as you—to start, and then move it again up to 50% and then add more languages the next time. So every year we add a language and increase the threshold in the existing languages.

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

So what, what would the starting threshold be, Leslie?

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

Ah, probably I think we can go as high as 30%.

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

Okay, because it's a much smaller subpopulation.

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

Right.

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

Well, it'd be 30% of that subpopulation because we know who they are.

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

Right.

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

Right?

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

Correct.

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

Or well, if you do it that way, or if you just measure across the board 30% of the patients get their, their, which we could do, too, 30% of the patients get their education material in their preferred language, preferred language.

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

....

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

Actually, actually, I like the preferred language because maybe they want it, if I'm even Spanish speaking, maybe my daughter speaks English and I want to give it to, or, or they're going to want both, right?

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

Yes, I mean I like that approach because it's more simple, but it does bring in English, right, and so I would say you'd have to have—

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

Yes, yes.

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

—you know, if you said that 50% of patients, patients materials are provided in preferred language, then the instinct is to just focus on your English speaking patients, because that's the easiest, because that's what's in stage two already.

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

Yes.

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

So do we make it a pretty high threshold, but it's a simple objective and say it's 80%?

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

Yes.

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

And if you—

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

I like that because then you'll catch those other 30%, right?

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

I hope.

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

Yes, I think so. Let's see how it looks when it's worded.

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

Yes.

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

Because then we're getting, remember how we've been working on patient preferences to get that, that whole profile starting to be populated, but this would be what's the preferred language of your education material.

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

Right.

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

...then we have those top qualifiers that ....

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

Yes.

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

Right.

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

So, so if we do that, we don't have to worry about the top five?

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

No, we do because you're still, we still have to have some qualifiers because, you see, someone might come in and say my preferred language is X, but I don't have, I don't have the materials, right?

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

Right, but, but under Char-, under the approach that we're talking about now that Charlene articulated, you simply, they would be in the 20% that's not getting education materials in a language they prefer, right? You'd have to make a threshold high enough that let's say, um, let's say 80% of your, um, patients are English speaking, and 10% are Spanish speaking and 10% are other. You have to make the threshold high enough that you wouldn't just capture all—only the English speaking patients in that, but you also would not require, you know, you also would not have to have the other, ah, language, you know, materials in other languages that are not really available.

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

So could you read the sentence back to me?

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

So I think it's, you know, some high percent. I don't know if it's 80 or 90, you know, of patient education materials are provided in the language of, ah, of the patient's preference.

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

Okay, but that, how do you, so there could thousands of languages—

**W**

Yeah, and we don't want that.

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

We don't want to have, you still to have it some way that people can actually build to it, um, so, ah, 80% of the patients in their preferred language of the top five national reset languages.

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

Yes, I'd like that qualifier in it, because then, and if you do more, right—

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

Right.

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

Then that's, you know, that's the innovation you're starting if they do more, because the customers will come and say, well, I've got this population ... and they'll drive, you know, um, you know the education force us to start to use other languages, right?

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

Right. Now the, the only other qualifier is takes, what it takes to get the education materials, and the first two, ah, meaningful uses that's been defined by the actual patient age, patient gender, um, a QRG or, ah, ICD9 or, or a CPC code. So it's geared, it's actually very, very specific to that patient, and so you have about 1,500 to 2,000 conditions right now that are pretty prevalent in the industry for treatment of, of a condition and disease or, ah, an event, right, and that, and that person's specific location here includes things like, ah, what do I do after this event, when do I, um, call a doctor? What's emergent and what's not? So there are, in general, 1,500 to 2,000 is a ...

Now, ah, they're not going to be in the market, 2,000 of those, in, in the top five right away. There might be 200, so that's another issue. Is this, is it just generic, if it's encyclopedic information, then we're fine as it is. If it's actually more geared towards patient specific education materials, then we need to reduce it to a certain number after these treatments have passed.

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

So—or do we lower, or do we lower the threshold then because if we look at the, you know, do we lower the, you know, threshold to 60% or 50%, then knowing that if we don't have to, you know the bulk of the cases are going to be in that top 200.

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

Well, I think what this would do, though, is go to, I think it has to go hand in hand with the 50% requirement, so I think in stage two it, this is going to be married with, so, provide patient specific educational materials for 50% of your patients. Of the patients who speak one of the top five primary languages nationally, 80% of those materials must be provided in the language of the patient's preference. Does, does that work or, I mean, we, somewhere we can ask for comments on it?

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

I think we should ask for comment. I think again, it gets back to that we define patient education materials, specific patient education materials, in one and two here's a different, it has different specificity because it's geared towards treatment, disease or plan. You know, treatments is used for tests and general education, it's not. And so do we want to have patient specific education materials and in that case, you're reducing that number to those 200 at the top condition disease or treatment. If it doesn't have to be patient specific and generic encyclopedic information, then it can be much higher.

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

Well, I think, though, the existing criteria says patient specific education materials, but it's still should be you have diabetes and this is what diabetes means, which is encyclopedic.

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

It might have both, but in general when it comes, when a patient is admitted or discharged for anything, uh, there is patient specific education and maybe that's covered in the summary of care document, so maybe we're okay.

**W**

Yeah.

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

Let's leave it as it is, what you just described, and I will look further into it. The summary of care document does include, um, patient specific, patient instructions and so, ah, we might be able to cover these bases with both the summary of care document and patient specific education materials, but I think we'll get a lot of comment and we should hope for that.

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

Okay. All right, so let me, I'll do a little bit of massaging and send this back out to you guys in the next day or so, okay?

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

Okay.

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

I think, I think I get the point, so. All right, so the next one is around, um, recording disability status and sexual orientation, gender identity, um, ample granular race/ethnicity, that actually got melded into a category above, uh, this into, um, the first, you know, big bucket of improving care, so, but there was a question for us, which was how do you define disability status.

Um, what I would suggest is that disability status is defined by the six questions from the American Community Survey and that survey was adopted as the data standard for disability status in the HHS and OMH survey standards. So I think my suggestion, if you guys are amenable, would be that that's the referral back to that group, ah, and to the Standards Committee is to focus on the six questions from the American Community Survey. Are you guys okay with that?

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

I think that's great.

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

Okay, Charlene? I'm going to take that as a yes.

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

Yes, sorry.

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

Okay, good.

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

Hello, this is Emma. Um, what group did you say you were going to refer that to?

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

Um, it's already in, um, the improved quality safety group.

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

Okay.

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

And there's a question on, just a second, I can find it for you. Um, it's 105, subgroup 105, um, so we just need to, we needed the two things there, Emma. One is we'll make the referral that—and I'll send you this, too, that it's the six questions from the ECS survey. But the other pieces I don't see there, I don't see, um, the follow-up work on their part around the more granular race/ethnicity and language data, so we want to make sure that that happens.

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

Okay.

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

Okay.

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

Thanks.

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

All right, so the next one is enrollment in, um, in clinical trials, and, um, I, I, I will say up front I'm not sure that this one should stay in, um, and for two reasons. One is something that Charlene will explain to us and the other is I don't think it quite meets the principles, um, as well as, as it could. Um, and so I think this is one that I'm not sure we are ready for here. So, Leslie in your, I mean we don't have mature adopted standards, it's definitely not market, well, I think you're right. It's medium on the market driven side. It potentially has broad applicability, um, but I think it's less directly related to the some of the other criteria, so, um, Charlene, do you want to share with us what you found out about the standards readiness?

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

Yes, yes, because I, um, we did get a testimony from, um, ... who's driving a lot of the work in terms of clinical trials, um, and used a standards and research and again, they made, um, great process with the kinds of things they're doing is when you're in a trial, you can record a patient, a diary and those kinds of things.

There needs to be, I think, push to actually get those standards implemented and then to product, so I think we've a pretty big gap there, so there are standards that are out there that have been through the standards process. The one that does not appear to be in place based on the, the vendor folks have been working in this space is the standard that actually, um, you know, is the one where it's from the patient perspective in terms of, um, you know, going out and signing up for clinical trials. There is a website I think out there, um, in terms of, um, a government website that lists trials, and there's different pharmaceuticals that are making information available to patients, so they can go out and look at trials, but that infrastructure kind of is not yet created to EHR as yet. So we've got a, a gap there in terms of the current, um, support for that, so we can certainly signal the need for that in terms of the standards community to look at that, but I don't think as Christine said, um, it's in products today. The standards aren't operational yet, but there's pieces in place that, you know, the back end infrastructure is starting to be there, so that, that it's certainly possible.

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

So does one, um, one, I was at the, ah, attending health ... research a couple of weeks ago and—this is Leslie, we discussed, um, and it's kind of two use cases. One is how do I find out if a patient I'm in care with right now in this moment is here has potential for research? And the same way that we're querying right now that NLM for education materials or we're, ah, querying other ... support systems using the four JAMA articles, ah, using ... Info Button standard, that standard is this already in place for ... could be used at the point of care to go and query the web or query a, a site, which then given this context, what is available, available, um, research opportunities.

So there's nothing on the research side that says, hey, how do I standardize so people can query me? We could say, ah, that we'd like adopt the April 7 Info Button standards as a way to have EHR seek out research sites and we would get the research community I think very supportive of that, because they don't have any way now to identify themselves as, as a site for enrollment. And it would help us, ah, use existing standards from Meaningful Use one and two, so I think we, we have a way on the EHR side, which ... business, but we haven't yet signaled that to the research community and I think this could be very, very helpful.

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

So is this something, Leslie, we want to save for stage four, or is this something that you're suggesting an alternative to it for stage three?

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

I'm suggesting that we could fit in stage three that the, ah, an EHR has the capacity to query, um, research enrollment systems using EHL 7 Info Button standards just like we're doing for JAMA, we do it for education materials and other things right now. So that in itself doesn't require the vendor to do any material changes. It only, but it does signal the research community to say hey, we have a way to seek enrollment on that.

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

Right, and they could get organized, right?

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

Exactly, with minimal changes on the EHR, but a very a definite, ah, ah, you know, line in the sand that says here's the standards that we can use to query for available enrollment.

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

So is this something that we would require use of or just require development of the capability?

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

I think we should do capacity.

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

Okay.

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

With right now and then by ... we could go right to usage, because the research group will adopt it. They are, they are hungry to have a way to say how do we get patients enrolled easily.

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

Okay, all right, I got you. So I think, you know, as we going through and trying to figure out like how to measure these things, I think we have a couple of options we should keep in mind. One is straight out move it to stage four as a signal. One is obviously remove it entirely. One would be trigger the certification process, so, and, and that's what we're talking about here.

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

Yes.

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

These are the capacities, you know, but there's not a huge requirement. The, the other two are make it a menu item or have a real low threshold, so just keep that in mind as we go through. Okay, so, all right, so I'm going to replace this with EHR has the capacity to query research enrollment systems using EHL 7 Info Button standard, no use requirement until stage four, right?

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

Um hmm.

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

Okay, all right, great. Um, or also, by the way, there's a, we can use exclusions as another tool, okay. So, all right, the next tranche here is, um, View/Download/Transmit and Report, so the first thing was provide patients with the ability to self-report information, um, and what I'm, we had a list; family health history, uh, patient created health goals, observations of daily living, caregiver status will secure team member's functional status and self-reporting of adherence to meds, diet and exercise. So what the feedback from the Meaningful Use Workgroup was is you gotta to have a standardized tool to do that, you've got to, or a value set or a data set that is specific, so I did some work to look at them, um, and here's what I came up with, and it's, I'm not quite done. I'm waiting on some, um, an answer to a question or two.

But number one would be so fam-, for family health history. It's really what's in the stage two NPRM using the standards that, um, the Office of Minority Health developed, so that's what's in the stage two NPRM. I think that's a more defined value set. Is everybody okay with that so—and this is a pick one. This is not a do all, so let's come back to how we measure this, but for the value set. That's what I'm focusing on, so family health history as per the stage two NRPM.

The second is observations of daily living. There are a number of I think of standardized tools out there and I'm waiting for a response on which one is sort of a concise standardized approach to collection, collecting ODL, so as soon as I get that, I can plug that in.

Caregiver status and role is, the value set on that is, is DECAF, and I've mentioned it before and that's, um, something that Eric Holman and the Transitions Group developed and it's, it's you know, the, the acronym stands for the type of role the person plays in their care.

The fourth is, um, the list of care team members, you know, I, I was of two minds on this. One is you could do it as for the pretext just like was the case in the stage two NPRM; or you could, um, actually extract it from here because Charlene, it's in the, it's in the care plan, right, which is likely to be a requirement.

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

Yes, yes.

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

Okay, so my suggestion then would be take it out of here, because you don't need it as part of the care plan, right?

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

Yes.

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

And then the last, um, the last one would be functional status, and, there, it's, I would suggest the VR-12, which is a 12 question set that's publicly available standardized approach. Ah, and then there are two that I'm suggesting we remove. One is the patient created health goals, because I think, Charlene, that's part of the care plan.

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

Yes, and the patient, the feedback and Leslie, you may know more on this one is feedback I'm getting from our team is we need to signal standardization around those for stage two. But we'll talk about that in our group, so all right.

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

And as long as they, I mean I believe this is a placeholder, because as long as it stays in and it's a core requirement, which I think it's, I really think it should be, Charlene. There were some other elements of the care plan—

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

Yes.

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

—that are more sophisticated prob-, and less defined and, and that's where I was saying, like some of those could be optional additions to the care plan, but there should be a core set of data that is a requirement; and the care plan itself should be also a requirement and not a menu option. And if patient created health goals is part of that, then we don't probably need it here if everybody has to do it anyway, although it, it is a type of patient entered data that, you know, they could get credit for, so maybe we should keep it here. Yes.

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

Anytime you can get a two-for, I think that helps, because it gives people optionality to collect the data.

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

Yes, right, okay.

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

So Christine, did you take out the self-reporting adherence or is that ...

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

No, sorry, that that's actually, um, almost always part of ODLs, so the self-reporting of adherence is very, um, commonly part of observations of daily living, so all I was saying was we don't have to call out specifically, as long as we are calling out observations of daily living. Are you okay with that?

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

This is Leslie. I, I, my concern is that observations of daily living is a report only that's one way, and it doesn't get reconciled with ... reconciliation process. Maybe the first phase is reporting the kind of ODL, but the second phase would be that the patient is included in the reconciliation process.

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

Well, I think that's the case for all of this and, and that's the point, right? So functional status is a standalone tool, but it has to get integrated into the record and the care plan. Otherwise why are you collecting the data?

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

Yes, I, I agree, but the, the differences today and observations are a fact that the patient presents, um, is yes, that it's a fact. Whereas in the reconciliation process, you have the pharmacists, you have other people involved in the reconciliation, so it gets back to the collaborative care plan and maybe we did cover our bases.

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

Right, I mean I think what we're trying to do right now is create the capability to get it in the record, but they've got to use the data in a way that's useful to them and to patients. And, you know, I think the medication reconciliation needs to go back to that category, so they can—that category, and maybe what we could do is make a referral to them to say as you're about thinking about medication reconciliation, we're thinking about, you know, collecting observations of daily living, which includes, um, you know, goals and, and whatnot for, you know, I'm sorry, self-reported adherence to meds, so you, you know, think about a way to link those to electronically to facilitate reconciliation. Would that—

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

That's great, that is great.

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

So Emma, so what we want to do here is you see that there's a, there was a line of, a sub-bullet under the first bullet that said, um, you know, patient reporting of, um, self-reporting of adherence to meds, diet, exercise or care plan, we want to, we want to signal to the subgroup one who is doing medication reconciliation that we are considering, we are proposing to create the ability for patients to enter observations of daily living, which would include adherence to medications and that self-reported adherence to meds should be linked to the medication reconciliation criteria.

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

Okay.

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

Okay. So that, so that leaves us with, um, five types of patient reported data. Um, one is family health history per the stage two NPRM, observations of daily living per the standardized tool that will be coming my way shortly, caregiver status and role using DECAF, functional status using the VR-12 instrument, uh, and then patient created health goals, ah, use, you know, I don't know what, um, I guess we would have to say we need, need a standard for that.

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

Yes, yes, you do.

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

Okay.

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

And this is Leslie. The only other thing we had also in the care coordination group was intolerances, um, and then do we, do we need to articulate that here or leave it for care coordination and also advance directives aren't patient generated data types. Do we need that here or do we keep it in a separate advanced records column?

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

Good question.

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

You know, Christine, you know if it comes down to it, it's almost like that advance, you might, you know, start with advanced directives in some cases here.

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

Well, are we going to get into the whole, yes, but state laws have different requirements for what's in the—

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

Yes, yes, yes.

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

I think we've got to you know, I'm not sure we want to muddy the water at this point in this, in this bucket. Let's see, we're going to do adhering on advanced directives, so let's see what comes out of adhering and we can add it here if, if we can figure out a way to do it.

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

So maybe we out here just patient directions or directives rather than advanced directives, or you're right, just leave it out because we're going to cover it later and here in the hearing we can rec-, after the hearing, we can reconcile it.

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

Yes.

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

So just Christine, you know, in the reconciliation process again, um, and this is just kind of a, a broader discussion that we're working through in the care coordination group. If you look at the reconciliation process, we believe that's again one of the as data comes in, whether it's from a patient or whether it's from a transition of care document, there's a process to reconcile that data, so the systems become more enabled to do that over time. But what I think we're going to need is to provide a roadmap, if you will, of those elements that are either reconciled and/or imported, because frankly, they expect them all to come in, it changes care process, so we get a lot of pushback from the provider community we're trying to do too much too fast, as well as from the vendor community in terms of, um, you know, we're trying to do too much too fast and you're asking too much.

So as we look at these elements, I think, across the work groups, we need to get clearer on what's that, you know, set of, what's that minimal set of data elements that we want to either—and I'm going to be broad on this, import and/or reconcile, depending on what the characteristic of the data is, so there evolves a mechanism when this data comes in, whether it's from a patient or, the DSM standards, you know, it can be better managed.

And so, again, some of these may be a little, we just need to make sure that we're aligned between care coordination I think in the patient generated data that that data element set is consistent and the same because that will help everybody. Does that make sense to you?

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

Yes.

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

So this is, this is Les, and one of the things we're working on right now for actually a ballot in January is HL7 is an overarching context for patient generated data. Um, and in general the items that we have listed here would all meet sort of the, ah, the questionnaire and a response to a questionnaire. So the data structure itself, ah, would be under a consolidated TDA, as a questionnaire type, and so I think that if we look at the structure and say let's make sure the vendors can use one structure for multiple things, we're getting at the, at the, what we want. We want to be able to have patients enter the data, all of these are things that in response to the providers, so that these are not wild ideas that don't have a place in the charts. All of these already have something, a place in the charts. We're just now saying the patient can generate it using, ah, probably a consolidated TDA questionnaire type.

So I think we're well on the way. We've got things happening in parallel on this, so, um, I, I, I'd say that, that, that we keep this in and that we make sure that we have, that we continue to promote the, the standards that are already being worked upon, um, and, so I, I feel like all of this is very, very doable. It, it seems that there are fields already in a chart. It's already meaningful for the doctor and now the standards groups are working on it. What we heard in the patient generated data here and what, where there's a nexus between what the patient wants to give and the doctor wants to hear, there's really no barriers, that, that everything ... everyone who had a good, um, plan for patient generated data really looks for that nexus. These are all things the doctor wants.

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

....

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

Leslie, I don't think Charlene is disputing that. I think she's saying something slightly different, which is, let me—but I want to make sure I understand it, Charlene. I think what you're saying is these sort of data sets are all good, but we have to make sure that it's coordinated with the data you're collecting in care coordination because some of the data is going to be very similar, although it could be pr-, collected by provider or in this case by patients, so we need to make sure there's alignment. Is that what you're saying?

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

Yes, and then that's, like if you look at it, what will make the difference in terms of either importing and/or reconciling, because you can see the system starts to build a capacity to be able to do this; and whether it's again, from a patient or a provider, that's what we want, right? And you can help them if, if these two asp-, these two aspects are harmonized and we make sure that what the, what our providers say is what tell what the standards are to be able to exchange the data, and we'll then if you invite standards, it's the data, it's the value sets, too, it's the value sets, too.

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

Okay.

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

So that's, that's, I think that's great. I think we just say, ah, that our bias is to use the consolidated TDA with the patient as an author.

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

Yes.

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

Okay, ... and here's what, and then Neil would say okay, but don't, you know, um, let ... way of good, so where there's some, this is where the prioritization will help. Of those things that you want to implement and use the value sets for to start with, if you will, let's use one; patient goals. Or start with, you know, family history and the rest just send it to us, right, and we can look at it. So that's where we need to have a little bit where we can provide some guidance in that from a policy perspective or a prioritization, that will help guide the investment to actually, you know, in those areas, because you could ask for everything, then we'll get tremendous pushback. That's the—

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

... okay, so let's talk about measurement, because we're spending a whole lot of time on this and I think we're actually all saying—

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

We are saying the same thing.

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

Yes, right, so I think, so what I have put in here and, and we—there may be lots of different ways to do this, but I do think it should be a requirement. And my suggestion would be that you pick one to implement based on what's appropriate for your practice, and, you know, and then you, you either, um, and you collect that information from a fairly low percent threshold of your patients, so we're not asking everybody to do everything. We're asking them to pick one or maybe two, because patient created health goals and, um, caregiver status are pretty easy, um, but you know, maybe, maybe, so you could have a pick two, you could have a pick one. You could have a, um, you know, whatever, but that's the way I'm thinking about it. I, I do think it is more than just creating the capability precisely because of the alignment that Charlene talked about, um, but that would be my suggestion as a starting point for how to measure this. What do you guys think?

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

I, I do think there, we do want to have beyond capacity.

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

Right.

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

If we, if we look at the national priorities where we have medication, uh, issues that are readmissions or medication and pharmacology issues, I mean that's a huge one, we could, we could indicate that. But I, I like your idea because where practice as appropriate, um, and let them pick, so as exemplified by the following and, and, um, and let them pick.

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

Okay, and if you said—

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

The challenge, the challenge there is again, ah, and the pushback we'll get is, it's way too much too fast for the vendor community, you know, because it's like we have to do it all, right?

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

Well, hold on a minute, hold on. We're trying to do policy here and I don't want to get into the whole standards debate. What Leslie is saying is there's a way to do it via questionnaire and response under the consolidated TDA that, that's right, because it should be a single kind of, you know, um, you don't want to make the vendor community to have code for all five of these. You want to make them be able to code one way that can be adapted to any of these five areas. But, but I think that's what we want to get feedback from the, from the Standards Committee and from the public on is how to do this, but I think we agree that this is the right policy and then if we get feedback that says it can't be done, then that's, that's one thing.

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

Okay, yes.

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

So I think what we need to figure out is in the ideal world, assuming that you can code it in one way that's flexible and adaptable, almost like a plug and play for the other things, um, then what's the right way to measure this? Do you ask people to pick one or two based on their practice, maybe it's just one based on their practice, or it's appropriate for their practice and that they, they collect it from 10% of their patient population.

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

I think that's consistent with the other measures we started small and then grow from there.

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

Right and this is an ET, I think, only thing, right?

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

No, I don't think so. An eligible hospital gains just as much.

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

Okay.

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

Because, Christine, it could be as part of the pre-, preadmission process.

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

Okay, all right. Now, Leslie, one of the things that you said is you weren't sure that there—what I hear you saying now is that there are standards like the consolidated TDA available to support this capacity. Is that right?

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

Well, we have the work teams in place with the goal to have this completed by January valid in HL7, so we're thinking about 2014 and 2016 I don't think it will be an issue.

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

Okay, so I'm going to put for standards, I'll put medium.

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

Medium, because it—the highlighted adopted piece is going to be your ... and again, and again, as we look across everything, it's going to be—there'll be a lot of like if we do a lot of public health, there's a lot of standards, so it's—

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

I know, but I also want, I, I intend on pushing back on this, there's the fact that were—if we focus only on standards that are mature and widely adopted now, we would never advance.

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

I'm totally with you, Christine, you just can't have them, just having them all ....

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

Well, right, but I think where, where there is work that can, that has been done and is able to be built on, that's where you want to go. You don't—but, but if there's no way to do it and no one has a clue, then, yes, that's not a good thing for 2016, so that's where we would push it to stage four. Okay, all right, so I think we have agreement on this one. What I have is, um, provide patients the ability to self-report information and use that information in the EHR to provide care. Providers choose one to implement based on practice appropriateness or facility type and then collect that data from 10% of patients. Yes?

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

Yep.

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

Okay. All right, so, um, the next one, so let's start with whether it stays in, provide hyperlinks and online resources and education materials, um, through the online access function. And I had a question about this, because I feel like it should be, I mean what I heard Neil say, and I think maybe Leslie you did too, is that a lot of, um, places do that today. And if that's the case, I think it is, um, I, I, I think it's fairly market driven and I'm not sure that it should stay in, given that we've got a lot and we don't want to lose things here.

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

You know, there's ... those, and I'll, I'll just tell you where the concern lies. It's, um, one of the arguments is often given by giving patients access to the record and maybe that's just ... has a sense of it now is that they won't understand it. And so by linking to lab results, for instance, to education materials that argument goes away. Now that is often market driven because most hospitals don't want or providers don't want to give information like lab results without an explanation, so, um, but it's not a requirement. Um, I can, I can go either way on this. My concern is that we don't want access without education or it can end up blowing up access.

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

Right, and I agree with that, but I think as a public policy requirement on a national level, I think this is the one, the one piece I would lean towards, um, I think it, it's in some ways a, a lay-up; and I think for stage three, what we want to do is really push the envelope and that's going to require, um, being very judicious about things. So for this one, I, I would say let the market drive it, but as we monitor how it's playing out for patients and families, you know, like through the survey we're doing or whatever, um, then we, then it's something we might suggest come back in later in the process. But I think at this stage my inclination is to remove it, because I think we need to be more parsimonious, and this is not one for me that is massively high value in the same way that patient generated data or education materials and primary languages is.

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

Okay, fair enough.

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

Charlene, are you okay with that?

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

Yes.

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

Okay. All right. Um, so the next one is, um, the capacity to accept pre-visit prep tools into the EHR, and that was the ability to consent to treatment etc., um, and fill out administrative forms. So do we think this is one that should stay in? Again, I'm, I'm, I'm leaning the same way I was just as I was before in the sense that I think that this is more market driven. Um, what I, what, what I do, though, like is creating the capacity in the EHR for that to be collected one time at one provider and, and transmitted el-, elsewhere, so that you don't have to keep doing the same thing over and over again; but again, I, I'm not sure this really supports a new care model, really drives national priorities. It's definitely broadly applicable. I'm not sure it's, it's not market driven already and I don't know about standard, so I'm, I'm a little on the fence because I think for three out of the five, it's not scoring well for me, but what do you guys think?

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

This is Leslie, and I think that this is one opportunity where providers will receive considerable operational cost savings and, ah, and so there's that aspect of it, you know, that gathering this information up front means that there doesn't have to be so many people interpreting that information face to face. Um, also I do think that the more patients are prepared for visits, not just administratively, but clinically, the more likely that it's meaningful, their conversation face to face with the provider is. And that's not routinely done today. That is not a common practice, so, ah, being prepared for a visit is hugely important.

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

Yes, I, ah-, Charlene, where are you at?

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

Um, I would agree that just in terms of process, this would, it's—what my take is, I get this drive to try and consolidate a lot of these different elements into this whole capability, so my answer would be I, I would think this would be a high priority for, um, the ability to be able to capture, um, that data from the patient perspective.

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

So, so leave it in?

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

Yes.

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

Okay. All right, so if we leave it in, is it a capacity creating, it is a use requirement?

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

So read, read, Christine, read it again in terms of ....

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

So accept pre-visit prep tools into the EHR and what we wrote before was e.g. the ability to consent to treatment and fill out administrative forms, and also the capacity to send that to other EHRs is another thing that we asked about.

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

So just, um, two comments, oftentimes I totally support the need for this, and actually a lot of this, I want to kind of maybe reverse my opinion. A lot of systems have these in place already, but the biggest issue here is in many cases, they're not in the EHR. They're in the administrative systems, which we don't often, um, take to the certification process and in many cases, um, those systems, you know, don't even know how to go through the certification process, so I know that's not a reason to set policy, but it, it will be a challenge in terms of implementing it, so—

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

Well, we did say, though, that there has to be an EHR connection here. That was in our group's original kind of ... have to come from or to the EHR.

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

Yes.

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

So does this meet that, because it does make me a little nervous that if they're not—if they're mostly in the PM system, that it's not the scope of meaningful use.

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

Right.

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

I think that, I think that if we did this as a capacity, I, I, I think a good ... capacity first was something that's not been done, and then next phase is low percentage, and then the next phase is high percentage. And this is a great way to signal the industry in plenty of time, so that by 2016 or, or, you know, actually this is by 2016, they'd have the ability to do this. I, I think that that's where the market will say, whoa, that's going to be 2016. Let's do that well now, so I do think it's a capacity issue for sure.

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

Okay, so what Leslie is suggesting is it stays in, but if it's creates a capacity, there's no use requirement.

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

Yes, and I think we'll get, you know, we'll get the kind of feedback that I suggested on it and we'll have to maybe, I don't think we take it off though, for ....

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

All right, um, the next one then is create the capacity in the EHR to receive data from telemedicine and biomedical devices and display that to patients through online assets. Um, and the feedback from the group, what the Meaningful full Workgroup was, we have to be more specific, which is completely fair. So I think, you know, and I'm not sure how to do that. I'm not a telemedicine expert. I don't know what you guys think, but you know, at least what's in my mind is the ability to connect to home monitoring devices and integrate that data into an EHR; but I think we need some, you know, this might, now this is where we might have a menu item or something like that, but where there's a specific use case or use cases that really do create the capacity and some people can choose to do it. Um, but I'm not sure what the "it" is, so what do you guys think?

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

So I was, this is Charlene, as I was looking at again, um, the need to be able to create the, you know, having infrastructure to be able to, you know, access this external information in the system, that kind of fell into that category. In this case it could be the lab data, right, so it could fall into that objective, um; but you know, from hearing what we really heard was, um, to be able to import the data, then you need to have a plan and identify specific data that's needed for the particular care management process. Um, and it just felt like whereas as you put under, you know, here's this different types of patient generated data do one, you know, it feels like we need that same kind of capability to allow them to identify what the need is that they're managing, and then provision them with the capability to collect whatever that appropriate data is. And whether that's under that previous objective, you know, or a separate objective, it just seems part of the process from which they're going to engage the patient.

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

Yes, that's a good point. It could be part of the self-reported patient information that we have in the first bullet, um, and we could put one or two examples, so, um, I mean we need a specific thing to trigger the process you're describing, Charlene. So maybe it's, um, ah, you know, blood pressure and weight from home monitoring devices would be, you know, right, that's fairly common. What are the other kinds of home monitoring, home monitoring devices?

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

But if it's self-monitoring devices, that means those things like your glucose level is probably the thing that applies to the majority of things are going to be blood pressure or weight. And even if we had to choose one or the other, weight is probably, ah, the most, well in CMS case then we're probably looking at blood pressure and weight. But I do think pick one.

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

So, all right, so let me ask you this. If we, if we, uh, add those three things to the list we already had, the one that's like family health history, ODLs, you know, functional status, if we add glucose levels from monitoring devices, blood pressure from monitoring devices and weight from monitoring devices, should it still be a pick one, I, I mean, right, ... ? I think so. I mean, I think that's okay. It's just we've got a big list, and I think that's probably a good thing. So what we would do is, again, if, if providers choose one based on what's appropriate and they collect the data from 10% of patients, so now they would have eight options to choose from.

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

Right.

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

Does that work?

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

And so what, what that is, is you, know, kind of like we're creating this infrastructure to start to create that capability, and we start to identify, and then people can, you know, narrow down that list or prioritize that list as we go over time, but as long as we keep it flexible, um, I think .... I like that approach rather than having them spread out all over the place, because you'll get fewer objectives and then we can really focus on these objectives.

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

Yes, all right, I think that's good. Do we have agreement on that?

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

Sounds good.

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

Okay, great. Um so, the last one in this category is, um, offering patients the ability to reconcile information, correct errors, add addenda, and this is another one where we've got to be more specific .... In stage two we said that that, that was sort of how we actually came to secure messaging. Um, but do we want to create the capacity through online access for patients to do that error correction and addenda adding and, and if so, how, how do we do that?

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

You know, you wonder if solving that, you solve also just the whole revision and changes that might be from a care team to a care plan, how could we, how could we make sure that anything that, that if the patient has the capability to add or made addendums to information, whether it's a specific item on a chart or more broadly a care plan, maybe that's a stretch. But, ah, it does set a tone that says patients do have do have this, are contributing to their team members and have the right to make changes, and, and that's, again, addendum is a better way to put it.

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

Yes, I think well actually, though, the in terms of addenda, right, addenda could also be any of the things we just outlined as patient reported data.

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

Yes.

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

So perhaps what we want to do here is really focus on that you have the addenda capacity beginning to be developed, maybe what you really want to do is create the capacity of the EHR to accept from patients' corrections to errors in their record.

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

Right, you know and then like as in any other error that we have, you know, as it's corrected, the provider is accountable, then you document the correction. You have those capacities in systems today, you know, oh, a patient said this is not true, and then you document the correction, you know. Um, and then, then what you do with that process is that, um, I mean, again, we have to be a little sensitive that we don't want to like overwhelm the provider, because we could get pushback there, but then we've got it for medical legal purposes documented in the records.

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

Right, and I think what we would want to do here is again create the capacity of the—

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

Yes, I agree.

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

EHR to do it. It's not a use requirement, because, hey, you know, maybe you don't have errors or whatever, or it could be offer patients the ability to correct errors in their record, which would create the capacity and it's an offer, um, so it could actually get some use. Perhaps we want to do that, but there's not a, you don't have to have a percent of patients who correct. You just have to offer some percent of patients the ability to correct their record. What do we think about that?

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

I think this is once you do it for one, you do it for all.

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

Well, right, so even if we had a low threshold if we don't get tons of pushback, the capacity is there and I, it's hard to imagine why a physician wouldn't want to make that available to everybody probably through the online access feeds.

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

Yes.

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

I mean I think even if we set up for 20% of patients, they're going to do it for everybody.

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

Yes, and in, in the patient generating data hearing that one thing that I, that was a big surprise I think to hear was how much the physicians who actually took the data from the patients felt it improved their accuracy overall.

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

Right.

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

Yes, so I, I think you're right.

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

Okay. Um, okay, so what I'm going to do is, so, um, offer is it 20%? Is it 10%? I mean it could be 10%. I don't, I say again I think if ... is there, there's no reason they're not going to use it, but offer 10% or 20% of patients the ability to correct errors in the record by creating the capacity in the EHR to accept from patients corrections. There's no use requirement, just the ability to accept and flag corrections.

Okay, does that sound right?

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

Yes.

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

Ten or 20%? 10% or 20% as a starting point?

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

I'd say 10%.

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

Okay, I, I agree. Okay, all right so, after visit summary, we're going to hold off on because that's part of stage two. Um, we, the next one about recalls is a placeholder as well. We need to see what happens in stage two. So we had, the, the, the next one was really the whiteboard, which I think comes out of here.

**W**

Right.

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

We don't need to worry about that. And the last one, and we're doing really good on time, you guys, we really are cooking here, the last one is to create, um, support the capacity for online visits and consults.

Leslie, you had some thoughts on this, too. I mean, secure messaging we already said was one of the primary methods, um, so we can call that out specifically, but is that the only method and if it isn't, what are the other methods and how do we create the capacity or measure it?

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

So right now the secure message allows me to communicate and I can, and I can absorb that into my record. It doesn't necessarily create an episode of care that allows me to bill an event on.

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

Right.

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

So, um, so the question is do we, do we need to add capacity, ah, to create an episode of care from a secure message or from a telemetry device? Um, I, I really don't know the answer to that, because it's, it's saying that is, is care only provided when a bill can be generated?

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

Right.

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

Uh, if that's the case, then you have to generate a, an episode of care that has the ability to attach a bill to it. If care, um, if care can be provided absent that, then that can be just the secure messaging only and I, I really, I don't feel qualified to, to answer that in full.

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

And this is Charlene on that one, Christine, what we were trying to do as we were discussing good testimony on this, um, potential for the concept of, um, e-referrals and I think Paul related or identified that. And I think there are providers that I know in California that are building out on e-referral infrastructure. Um, so what we were trying to do under care coordination in stage, for stage three is again be able to request, um, a referral, an actual electronic referral, and then what we wanted to do in the care coordination side was to start to be able to track that, one of those just like an order had been sent out.

But assuming that some infrastructure was going to start to track when a referral came in, um, and when it came out and it would seem like a patient then could either, it's, you know, use that infrastructure, um, to you know make their, their requests, you know, again, and this is the part that, you know um, Leslie pointed out, what's the, you know, like I want to get that second opinion. You know, what's my, I should be able to use that infrastructure to request a second opinion or to request a referral ... so I think that if we can get more information in terms of the patient's interaction with that infrastructure, um, that would be great.

But from the vendor perspective we would be able to remind the patient, you know, that they had a request and the patient could say I'm going to go see this doctor, and we would send it to him and that kind of thing, so there's a whole engagement of the patient, um, with this, you know, e-referral, e-consult infrastructure, um, that would be great to start to build out in stage three.

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

So is that something, I, I like that. I mean it, it could be that this was one where we simply say we know we want to preserve a secure messaging requirement, but we also want to begin to think through and get public comment on creating the capacity for both electronic episodes of care, but also, you know, like e-referrals, e-consults. We just don't know and so let's just ask.

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

Yes, I think so.

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

Okay, and this is not one where we would envision ever having a use requirement because the payment model doesn't support it.

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

Exactly, exactly.

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

But it's something we want to figure out how do you just create the capacity?

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

Yes, and I think innovators in the market are working on this now, so I think we'll get more guidance in this and standards exist to do these, you know, from the provider perspective, so, um, I think the time is right, you know, if we can, like Paul said, we can start to build the infrastructure to support this in stage three. We can do more in stage four.

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

Okay, all right, that sounds good. Um, okay, that sounds good. All right, so I think that was our last, we did really good work, um, piece to get through. I think we have removed, um, two pieces, oh, wait a minute. Oh you know what, shoot, we skipped one. I, I, I had a strike through on the wrong one. So there's one more and that is, um, actually, it's actually not unlike what you just described, Charlene. It provides an agency the ability to send relevant updated information to care team members and the ability of providers to review and accept updates fast. I think, Leslie, that's sort the CCME approach.

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

Yep.

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

So this is one where we, we again, need little more specificity. Um, I think it meets the principles really well. The only thing I don't know about is standards, so this requires an ability—I mean, I would imagined they're there, because you have direct and you have secure messaging and you have, you know, other things, you have transport standards, so that, that could provide a patient the ability to send relevant info. The question is then the ability for providers to review and accept it into the record, which I thought was kind of an element of existing EHRs already because I could be wrong, like when they accept lab data.

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

Yes, this is info ... with a consolidated DDA structure does, it's not just what you output, but it's how you actually consume something.

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

Okay. So how do we add some specificity to this, to this one? Is it a, is it a, is it clear Charlene? One of the, one of the kind of principles you articulated before is that it was, you know, really clear in, in its meaning. Is it clear to you? What we need to do to sharpen it?

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

Say, say it again, Christine.

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

It provides patients the ability to send relevant updated information to care team members across settings and providers, and the ability of providers to review and accept updates. So this is the transmit part of you download transmit in a way, right?

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

Yes, this, this is TCME and it's, it says the provider protected, um, patient directed information. I want you to send this to so and so and it needs to be, with all the metadata and attribution associated with it, show that it's trusted and consumed by that EHR. So I think this is a, a really the transmit section that we're talking about—

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

Well, Charlene, do you have the CCME in your section?

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

No, no, but we have the capability. What we're trying to build in our section is the ability to be able to import data from these external sources, right, and, you know, eventually build an infrastructure, so as this data comes in we are managing it and know what to do with it, so this would transmit the data in, right, so we got it and we would tell you that we got it, right, and that, um, you know, and then we again depending on what, you know, again, you'll get variations. As that data incoming becomes more standardized if standards can do more with it, you know, get variation among the vendors, so we need a floor, so that's kind of how we're thinking of, thinking about it.

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

So this is the transmitting that I'm working on with the auto blue button project and, and so I think that this is, um, you know this is the core of transmitted CCME get it in a way that can, as a patient I can say send it to so and so and, and make it useful.

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

Right, and I, I can authenticate it, right?

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

Right.

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

So when I get it, again, I can authenticate it, so we're trying to build a provision on the EHR committee on the side, so I can authenticate it and I know it's valid. And the data, the, the problem with the definition is that, well, is it everything and what we need to do is either refer back to those other sections, you know, so that, and, and it may come out in the standard what that is, but that's where, it's all under everything, that's what gets people, you know, concerned. So it's going to be in the context of, you know, um, one of the other projects basically.

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

As a minimum, it should be the summary of care document.

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

And that would be a good place for it.

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

Right, and that, I would do a summary of care document with a very high threshold, because ... two and one.

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

But this would be what you specified earlier, Leslie, the patient generated version of that.

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

No, this is transmit, this is I want to be able to send it.

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

That's fine. I'm fine with you or it, it could be both, but, um, I'm fine with it.

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

Right, okay.

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

Okay, but I think that is, does belong in care coordination. This is different. This is providing patients the ability to send updated information to care team members, not for them to receive it or them to designate who they want their doctor to send it to. That's more of a care coordination function. This is the, the ability of patients to say, I, I just got a new prescription from my cardiologist and I want my primary care doctor to know about it, so I'm going to send the update.

Now I guess the question is do you need that if patients have, if in care coordination patients have the ability to designate, um, you know, sending an updated care summary to another physician with a cc to them.

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

This is about the patient being able to say what I want you to send to somebody else. I have new information and to have it sent in a way that's trusted by the recipient system, so that it would have to go, as a patient I say send my lab results to so and so. And so the concern the vendors have, I think, which I'm hearing is if the patients can say send anything in my records to so and so, this capacity doesn't exist.

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

Yes, okay.

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

And so what, what we want to say is at a minimum, a patient should be able to indicate send my summary of care documents to anybody I want.

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

Okay, um, so it's almost a record preferences for 10% of patients when they want their updated care summary sent to who or whatever. Or another way to say it would just be provide 10% of patients with the ability to designate who and when an updated summary of care document is sent to, um, specific care team members.

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

Right, so this is, there, there are two concepts in here that also came out of the White House during one of the transmits, which is what you just described is sort of auto blue button, send it any time there's an update, send this information to these people.

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

Right.

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

So that's the second use case, the first use case is send this on demand when I ask you, send this summary of care document to, ah, so and so, so there's two, two use cases for transmit that I think are widely, um, agreed upon. And what Charlene's point is if you know this is something already like the summary of care document, this is a no brainer. It's done and so we could push for a very high threshold right up front for auto blue button or CCME because the summary of care document has already been defined. We're already producing it. Now we're just adding these two functions.

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

Okay.

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

Right.

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

All right, so provide 50% or what, 80%?

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

I agree.

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

Okay, so provide 50% of patients the ability to designate who and when an updated summary of care document is sent to specific care team members, and you have to create the capacity in the EHR for providers to review and accept updates, or is that already part of transmitting the care team document to today?

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

That's already part of that, so it's, it's being able to on demand CCME for auto sent.

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

Okay, all right, got it. So I think that's pretty straightforward, 50% of patients the ability to designate who and when an updated summary of care document is sent, right?

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

Yes, but two concepts, one is either on demand and one is auto ...

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

All right, but, but that's part of who and when, right?

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

Okay, okay.

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

I think. I mean, but, but if it's not clear.

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

I think we already have those two definite use cases that we can go forward with.

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

Yes, I mean I think we're, I, I think this is all auto, right?

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

No, because I might have, I might say today I'd like you to send, here's my care team that I want you automatically to generate to my cardiologist and my endocrinologist every time I get a lab update, but tomorrow I go in with a broken arm and ... I want you to just send that to my primary care doctor.

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

Okay.

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

Or as, as a roadmap to doing, you know doing, okay, I'm going to get a second opinion, I just want to send my care records only to the doctor that I'm going to go get the second opinion, so it's a roadmap not all the infrastructures in place yet, but at least I can send them that, because the big challenge now is to get that data in your record available, you know.

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

Also it gives you the ability because we're saying that this is a patient who's participating in this. The patient can send it to any of their designees. As long as—

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

Okay, so okay, so what I needed to hear is get the wording now. So it's 50% of patients the ability to designate who and when an updated summary of care document is sent to other care team members in both an ongoing manner and on a one-time basis and/or, is that right?

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

Yes.

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

Okay, alright, I'll send this out to you guys anyway and, and you can, you know, red line it as, as appropriate, but I, I think I've got it now, and I think that's a lot more specific and it's, and it's a no brainer, so I get it, Leslie, thank you.

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

Okay.

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

All right, now we're really done, um, so the last thing on our agenda, and if you guys don't have time, because I know, or if MacKenzie cuts us off, um, we can take it up offline is to understand the referrals that we received from, um, Charlene's group and she's on the phone. So let me go and find those if I can.

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

Hello, this is MacKenzie, there's no call scheduled after you, so it's okay if you run like ten minutes over.

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

Okay, great.

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

Except I've got another—actually, I've got another call, so. This is Charlene.

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

Okay, well, Charlene, explain to me, so ability to self-refer, did we take care of that today?

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

Yes, yes, we did, we touched on that one, so this is again that, and I think we did what Leslie said were at a minimum in stage three, they can transmit, you know, the care record summary and a provider can accept it. That starts the path to get there.

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

Oh, oh, okay, so do, okay, so do I need to have a separate placeholder for e-referrals and stuff if we're doing that?

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

No, I think you need it because I think that's a center state.

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

Okay, all right.

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

And in the future state we're going to want to track it, you know, the current state maybe we just want to communicate it, so that one is just plain old communication and then step two it's starting to track this stuff.

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

Okay, great. All right, so what I will do then is I will clean this up a little bit and resend it to you guys. I'm going to ask Emma, so I've been working just in the, um, the document that, we as a Word document because that Excel spreadsheet is awful.

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

Yes, I know.

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

It's a mess, yes. We work, we worked on Power Point, so we do the same thing.

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

Yes, exactly, so I'll send that, but first I need to do some cleaning up of it. I'll send it out to the both of you. I will then send whatever the three of us agree on back to Emma, so that she can incorporate it into the big matrix.

The only thing I ask, Emma, is that what I'm doing with the far right hand column is making sure that it's note, so that for the RFC. I don't want to lose the questions that we need to ask for the RFC and we did lose them the last time around, so I really want to make sure we keep those somewhere.

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

Okay.

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

Um, but we'll go from there.

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

All right, um, I have a quick question. Um, I know that Paul and, um, Michelle a little bit have been sort of pushing, um, you guys for the idea of prioritizing the objectives, and I know that you, you did eliminate a couple today, which is, you know, um, that's, that's great. Um, but if you do have sort of an idea of, um, what objectives you really, um, prioritize more than others, I think that would be really helpful for both the end use group as well as Michelle, um. When she had originally sent out that document that talked about like high, medium and low, and green and yellow and red, she was, um, sort of under the impression that if there were objectives that were all green, those would be objectives that was almost automatically go through kind of thing.

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

Yesterday in the, this is Leslie, yesterday in the Standards Committee we talked a lot about the, that last column, which is the standards already adopted and the team was very clear to say just because something is high or medium or low does not necessarily mean it's grounds for not going forward.

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

Right.

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

It's a way to articulate the status.

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

Yes, so I would say, Emma, you know, I mean based on what we did today, there will be very few things that won't be almost all green if not all green, because I think we did eliminate some, um, elements, but we also did something, which was before they opted to do the ranking exercise, which was we went through and said that a number of these are just creating the capacity cap, so it shouldn't be a big issue. So I'm going to push back a little bit and say we are not at the point where we are writing the rule. We are at the point where we need help from the Standards Committee and from the public to tell us how to do this in a way that works. So I wanted to, and Paul agreed the other day, err on the side of leaving this stuff in and getting public comment and then going through a probably different exercise with a slightly revised set of criteria, um, to really figure out what stays in.

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

Right, and, and I apologize if I wasn't clear. I wasn't trying to say that if it wasn't green that it shouldn't be, shouldn't get ....

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

I know, I know you weren't saying that. You were just saying it's more of like a no brainer, but I'll just make everything green. Do you know what I mean?

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

Right, yes, so, um, but I think that sort of articulating what you guys really want to push though, it would be important in the sense of we value this objective due to, you know, it's, it's really good for the patient or, you know, something like that. Um—

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

Well, unfortunately for you, I think that's all of them, because we ... down to a greatly pared down list. The only thing I think is, you know, the sort of question mark for me is what, what happens with the after visit summary, which we don't know, and what happens with drug recalls and alerts, because, um, we can, we're going to be able to take that out if, once we see the final rule, we hope. And then about two thirds of this is just creating a capacity, so, or maybe half of it. So I think for now we're, we're, we've completed the prioritization exercise by removing criteria and by, or by saying this is just to create the capacity because it's not quite ready for prime time.

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

Okay. Um, I'll make sure to communicate that to Michelle, um, so that she's sort of on the same page with you guys, um, as far as knowing what your philosophy was behind it, um, so that she can communicate that to the other, um, workgroup members. So, that will be great.

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

Great, thank you. All right—

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

This is Charlene. I'm going to have to step off, but thank you and I'll, I'll review the work.

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

All right, thanks, Charlene, and we need to do public comment, right, MacKenzie?

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

Yes, operator, can you please open the lines for public comment?

## **Public Comment**

**Operator**

If you'd like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press \*1; or if you are listening via your telephone, you may press \*1 at this time to be entered into the queue. We have no comments at this time.

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

All right, thank you, Leslie and thank you, Charlene in absentia and I will, um, do the follow-up as promised and talk to you soon.

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

Thanks, everybody.

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

Thank you.

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

Bye.