

**Information Exchange Workgroup  
Subgroup #1: Quality and Efficiency  
Draft Transcript  
August 22, 2012**

**Presentation**

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

Thank you. Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Information Exchange Workgroup, Subgroup #1 on Quality and Efficiency. This is a public call and there will be time for public comment at the end and the call is also being transcribed, so please make sure to identify yourself when speaking. I'll now take roll. Dave Goetz.

**Dave Goetz – OptumInsight**

Here.

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

Thanks, Dave. Cris Ross. Steven Stack.

**Steven Stack – American Medical Association**

Here.

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

Thanks, Steven. And Chris Tashjian.

**Christopher Tashjian – River Falls Medical Clinics**

Here.

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

Thanks, Chris. And are there any staff on the line.

**Kory Mertz – Office of the National Coordinator**

This is Kory Mertz with ONC.

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

Thank you, Kory. Okay Dave, I'll turn it back over to you.

**Dave Goetz – OptumInsight**

Great. This is the first of three meetings that we have scheduled to frame up some of the issues we've been asked to take on for the upcoming session in September so this will be a fairly rapid-fire set of meetings where we will be taking on four different issues on, at the direction of the IE Workgroup and make an effort to decide what we think should be recommended to them to recommend to the Policy Committee.

These are an interesting kind of collection of issues. They tend to cluster around administrative or, um transactions if you will, um and I think there's probably some good opinions and, well, matter of fact, I know that there are good opinions of knowledge on this on this group to hopefully frame these things up fairly quickly. Uh, first slide, please. Next slide.

So, this is the schedule that we have to meet to starting today, and on August the 29<sup>th</sup> again at the same time next week, and then on the Tuesday, right after Labor Day, the, at 12:30, and then there's the full workgroup call, that's scheduled for the 5<sup>th</sup>, the next day, so staff will have some quick turn work to do there. And then the full IE Workgroup call on the 10<sup>th</sup> to finalize, in preparation to then meet with the Meaningful Use Workgroup so that we can merge these thought streams and work streams, um for full recommendation to the, to recommendation to the full Policy Committee. Next slide, please.

So, there, you know, again, I always have to remind myself of the context in which we operate here and what, what we're able to focus on and do because I, for one, will have a tendency to want to accomplish all kinds of things believing that I, you know, somehow have control of anything. So, remind myself that really kind of if, if you think of this um, set of options here, you can think of them as going from the yeah, we really know what to do to the, you know, we're really not sure kind of if there's a continuum there.

So, in Stage, if we were to recommend something specifically for Stage 3 in any of these areas it's because we've come to an agreement that this is exactly what needs to occur and it can be included, um in in this process, that, both in terms of what we would expect meaningful users to do or we would expect for certification to accomplish, EHR vendors to accomplish. We can propose some directions to explore in the request for comment that will be issued on Stage 3. Um, we can focus on certification only if we think some of these things only lend themselves really to something that an EHR should be able to accomplish and that uh, it's not something that you would require of providers to do uh, that's another potential recommendation.

Another one is, well, we just don't really think there's anything to do here. It's not in the control of this particular area and the last one is, well, we think there's something to do here and we have some ideas and we're going to continue to explore it, but we won't have anything specific until Stage 4, whenever that actually is, is formulated. Um, let me pause there and say, eh, are everybody on the Workgroup clear, kind of this is our task or any recommendations or thoughts about that?

**Steven Stack – American Medical Association**

Sounds fine to me.

**Christopher Tashjian – River Falls Medical Clinics**

Yeah, works for me.

**Dave Goetz – OptumInsight**

Okay, next slide, please. So, this is our, our work assignment. Four areas, medication history, prior authorization, lab orders and controlled substance ePrescribing. So with those we have one recommendation that has come over from Kory, that's from the Meaningful Use Workgroup, correct?

**Kory Mertz – Office of the National Coordinator**

Yes.

**Dave Goetz – OptumInsight**

On the medication history.

**Kory Mertz – Office of the National Coordinator**

Yes, that's correct, Dave.

**Dave Goetz – OptumInsight**

That at this point they would push this off to the placeholder to Stage 4, but they've asked us to think about it and on med reconciliation. So that you could have a more of a two-way exchange between a meaningful user and through an EHR to, that would reconcile various sources of information about pharmacies, pharmaceutical use.

Um, second one is prior authorization and I think that'll be our focal point today and then lab orders when we hope to get a little direction on that to, to give us a sense as to, as to kind of what might be the logical sequence here as we're looking at Stage 3. And then controlled substances always is largely informed by what the DEA has, has established as requirements and therefore has a lot to do with also security measures around electronic prescribing. Any other thoughts or questions on that? Hearing none, next slide, please.

So today I would propose that we explore ideas around prior authorization. At the next meeting hopefully we'll be able to bring in some of the people from the standards and interoperability framework who can give us some sense about lab orders and what needs to be done there and, hopefully, Cris Ross will be, will be available, our other team member who is recently with Surescripts, and now with Mayo and probably has forgotten more about controlled substances ePrescribing than I know, so I'm hoping that um, he will be able to help us sort through that issues.

Then in the last meeting to focus on medication history and then to finalize our recommendations for presentation the next day and discussion initially at the full workgroup. So, we have our work cut out for us here at the end of August. Um, next slide, please.

So prior authorization is something that, you know, I think we all have au, have, have kind of different opinions about and/or different lev, areas of knowledge either as direct experience or as someone who has said you guys ought to go do that and from a purchaser's point of view, which would be more of my experience. Um, and so I think here I'd really like to kick it off to have a discussion about exactly how we would define the parameters around this, what we think prior authorization means and what is really kind of more focused and doable here as we think about our task. So Steve or Chris, either of you have a kind of some thoughts you'd like to throw out at this point to help us kind of frame the issue?

**Steven Stack – American Medical Association**

Did you have a chance at all, Dave, to look at, the AMA has a, the seven-page document that kind of addresses some of this topic. Did you have a chance to look that over at all?

**Dave Goetz – OptumInsight**

I did. And I, and I think that's a public document, is it not, Steven?

**Steven Stack – American Medical Association**

It is.

**Dave Goetz – OptumInsight**

And, and so we can provide that to folks here through the system by which we make documents available. Um, so, yes I did.

**Steven Stack – American Medical Association**

So, on this particular topic I guess I would say that, we've already had people who have worked on that and this is apparently where they are and so I will commit more of it to my understanding before we talk on this again, but, but I guess that's far more robust than I would be able to insert here verbally.

**Dave Goetz – OptumInsight**

Sure, I mean it's even got a flow chart.

**Steven Stack – American Medical Association**

Yeah, it must be, it must credible then.

**Dave Goetz – OptumInsight**

If you can do it in Visio, you can, it's real, right? Um, I've got some software that works like that. Um, yeah, I think the, the, you know, the question it seems, you know, broadly is, I'm sorry, Chris Chris, I'm sorry for skipping over you. I don't want to do that.

### **Christopher Tashjian – River Falls Medical Clinics**

No, no, that's okay. I was talking and then I realized I had my mute button on. [Laughs] and I said, ah, no wonder they're not hearing me. But anyway, what I was saying from a provider standpoint, though, this is really going to be key and it really has to be something we have to address to say either from a vendor standpoint or from a standards standpoint that, that this is something that, that we, we really have to address.

And I like the, kind of the flowchart that was in the AMA article and so, yeah, it's more detailed, but somewhere in here we need to just, you know, even on a level one step above that say, yes, we think that prior auth has to be addressed and it has to be addressed in a standardized way and really be part of meaningful use.

### **Dave Goetz – OptumInsight**

So, eh, you know, I've tried to, to do some, some uh, exploration and learning over the last um, couple or three weeks to, to familiarize myself more with how some of this works in, in some places and the AMA article is, paper is very helpful in, in defining how a set of interactions can work.

Um, I don't know enough about the X12 dataset to know whether they carry enough information to be able to be helpful, helpful here. But to take a, kind of a couple of steps back if I put back on kind of my old policy had, right you know, what we're I think hoping that these transactions could do would be to improve, you know, delivery and quality, right? I mean, as, as, as, overall and I, I know they're not often seen that way, particularly by the provider community as in more of a barrier, a set of barriers and, and, and an irritant.

Um, and so I think that raises the question is how do we achieve that goal, reduce some of that frictional problem and improve the quality and efficiency of delivery of care, a drive towards, you know, what, what everybody really hopefully, you know, will want. Um, so to me, I mean in my kind of, again, initial level research the interactions right now sometimes seem to work, sometimes seem pretty, pretty miserable from all reports but they're not they're not very often terribly automated right now and there's not a lot of necessarily a lot of exchange of the kind of base level of information that might make them more successful in terms of both the back and forth that occurs between payers and providers on an ongoing basis and also the success by which, how these things are resolved to everyone's satisfaction maybe some of that, maybe I'm, you know, asking for things there that can't really occur.

Um, but it seems to me that still ought to be kind of our goal overall as to what we, what we want to accomplish.

### **Steven Stack – American Medical Association**

So, again, I guess we, we're doing the policy work, not the standards part so in a way I guess we, it's not any easier, but it's less technical I guess. The most straightforward and simple prior auth scenario I can think of is just formulary, right? So, a physician prescribes a drug, you put it in an electronic medical record. The prescription is, or the order is executed. There should be a way to automate that so it's checked against the formulary; now, this is already in meaningful use, but checked against a formulary automatically and if it is on the formulary then, obviously, it's transmitted and if it's not there's, you know, fairly instantaneously a message back, non-formulary drug, at which point the physician has to either change the order to a formulary drug or, you know, appeal that or petition.

You can work through additional cases beyond that where you're talking about a specific drug, which is experimental or non-formulary where perhaps the payer of services, you know, if we can get the payer community to agree to this you could have a form where there's drop down boxes where for a certain drug if they need this criteria or that criteria you can automate it just by selecting from a dropdown menu what the indication is and then the order is authorized instantly and fulfilled.

And then there's other ones, you go all the way up to the custom thing where you're talking about a specific procedure or something like that, which may have very individualistic characteristics for the patient and their circumstances where perhaps then you can't standardize it quite as much and it can't be completely automated. But, as we talked offline, Dave, if we could eliminate the faxes altogether, right, the payers would just be overjoyed getting rid of faxes.

**Dave Goetz – OptumInsight**

And so would the providers.

**Steven Stack – American Medical Association**

Yeah, so, so, if you could automate the form and have standardized data fields, even if it's test entry, requiring human review before approval you could at least do that transaction electronically, which would keep it within the confines of an electronic medical record and environment. Um, you know, so I, I would think that this is something to echo to echo what Chris said, which is really, really would be an efficiency add for the whole system if we could get it within this environment.

**Christopher Tashjian – River Falls Medical Clinics**

When Dave and I talked yesterday, we talked about for something as simple as an MRI or something, there are set protocols in place that you could walk your way through with these dropdown text boxes and to set up those standards for medications and other things that third-party payers, you know, wanted to do. I think that's where we could be of great value is to set, help set those standards or have, you know, and have them so it's the same, you know, regardless of payer.

**Dave Goetz – OptumInsight**

So, if I think about that, I think, you know, what we're wanting to do is to make the systems capable of providing both patient context and a simple clear path that we're if, you know, under guidelines that everyone accepts, whether it's Milliman, you know, or someone like that, and again, I may be assuming everybody accepts Milliman. That may or may not be the case, but guidelines that people essentially, you know, agree to. Uh, ex, to your MRI example there's a set of five questions or dropdowns or whatever, you know, but there's a, there's a, you, you, say yes this is true, no this is not, yes this is true and by answering those questions and perhaps inputting some you know, associated clinical information either through by attaching a CCD or by, by direct, you know, input it then says yes and it goes, right?

I mean, and then you get the, you get an approval number. I mean, I'm now off into the stuff I don't understand, that's but that's, that's where the people using the X12 dataset can tell us whether or not that really is feasible or not. But is that kind of what you're talking about?

**Steven Stack – American Medical Association**

For an MRI, I mean, it would be a great example because if you go in there [clears throat] and, and whatever the criteria are that they agree on the outpatient setting, you know, you have low back pain with... symptoms and a duration of greater than three weeks, you know, whatever the criteria are, if you go boom, boom, boom and you can select answers from a menu, then that's all structure data actually, you know, and you could probably do that for a, like, you know, not, not not anywhere near a majority, but for a key number of things that are particularly high cost for which there is good data and you could standardize that.

**Christopher Tashjian – River Falls Medical Clinics**

And while it might not be a majority it would be the high volume, so, you, you may not get the majority of procedures, but you would get the majority of orders.

### **Steven Stack – American Medical Association**

Right, absolutely, and you'd get probably the higher cost things in a lot of these instances and, and that would be the most value to people. So but then, then the default would be that if you attest by selecting these criteria, that the patient has those elements, then you don't need any other clinical scenario or data at that moment in time. You, you've me the indications and the, you know, requirements for authorizing the test. They payer should au, you know, authorize the test and then, then the second tier thing, if I'm in a payer situation would be if you have a provider who is utilizing resources at a rate that is clearly an outlier, then you address that separately. Then you'd have to do an independent audit of some sort if need be.

### **Dave Goetz – OptumInsight**

But if you've done this in automated basis and you know that, you know, that Dr. Goetz is, is in your system, you know, every day doing 30 back MRIs, you've got an issue there with Dr. Goetz, right? I mean, and you need to go, you need to go talk to him.

### **Christopher Tashjian – River Falls Medical Clinics**

Right, and that'll kind of show itself up, but you can do this with medications just as easily as procedures, you know. If you can document that you've tried, you know, two different generics, you know, same thing is you could push this through in the same way. I think there's a lot of places this discrete data could be used.

### **Dave Goetz – OptumInsight**

So, I think about, I try and think about how we reuse things that we've already kind of got going here as we think about a path forward and I think about the CCD and what potentially is contained in that that either in its full format or in a, in the truncated format would be useful to kind of help establish, again, this patient context for these decisions, whether they're automated or whether they have to divert to a, you know, a human interaction. Um, things like medication list, right? I mean, problem list based with, with ICD codes attached to it so that, you know, there's, again, it's computable if you will, that, you know, about the relationship between condition or diagnoses and, you know this particular drug is being prescribed for this particular diagnosis.

It could be there's multiple diagnoses it could be prescribed for, right, but, but it's, it's tied to COPD or whatever. I mean, it's tie, you know, and that somehow that information might be able to be contextually more useful and, and simplified, the point at which to where, you know, I think about how CRM, I mean, in a different area, how CRM software works now where, you know, you put in a little bit about yourself when you're dialing into the system for some sort of support and then it knows your history, pulls it up and says, okay, that's, you know, we now, you know, you've been here before, this is what it is and it comes in through a CCD process to make sure it's up, it's updated. Um, is that logical? Is that too much information? I mean, are providers comfortable with, you know, tossing over CCDs that way or not?

### **Christopher Tashjian – River Falls Medical Clinics**

I'm okay with that from a provider's standpoint.

### **Steven Stack – American Medical Association**

And unfor, I'm certainly a provider, but I'm an emergency provider, so I operate under the fundamental proposition that I don't prior auth anything because of my environment. But, you know, I, I don't see why clinicians, you know if the patient signs a release like they do for payment and processing that their chart, you know, is to be shared with their payer of service, it's authorized payment.

### **Christopher Tashjian – River Falls Medical Clinics**

Yeah, but it gets shared in the paper world anyway. We've got to call all that stuff in anyway, so.

**Steven Stack – American Medical Association**

Yeah, that's what I'm saying. I don't see why any of us would, that we don't have a dog in that fight. I mean, if it's going to be shared anyway, so they might as well just get it electronically.

**Dave Goetz – OptumInsight**

Well, I'm trying to think of, and, and, again, it, it, what's useful to a health plan, right, is, is, not, you know, they don't need to know absolutely everything that another clinician would know under some of these circumstances, right? They don't want it. I mean that would be too much data. Uh, but what they might want is, you know, again, some of the summary information in the CCD. They could keep some of it, they could toss some of it, you know, as long as it's, you know, computable, as long as it's discrete, right, and they could come in and they could be stored with the, you know, with the, with that claim record or with that incident record so that it would also be reviewable, right? I mean that would be, again, something that, that people would probably want because if it, you know, if it came in and, I mean, if, if it's, if a procedure's denied and provider appeals you would want the review board to have the ability to, to understand in this clinical context why the provider is appealing and made that decision, without having to box up a or scan up a bunch of stuff and send it on, right?

**Steven Stack – American Medical Association**

I would, I would think there'd be no problem with a CCD going along with it. I think it still requires the stuff that Chris and I talked about because the indication, the criteria that, that's required in order to get automated prior auth, I think you'd still put that in a structured form when you were able to from a selection menu and then the CCD can go along just to provide additional context if someone wants to review it.

But I, if it's going to be truly "automated" uh, I think that, that first step is essential, that, that for some of these conditions there are agreed upon indications and situations in which if you can answer yes and no to these certain conditions the authorization is granted automatically, that the software gives you the authorization and then any concerns after the fact would, would be due to individual provider variances, you know, that, that would give you cause to believe that they are answering dishonestly or committing fraud, you know, because the sheer volumes of things they're doing just can't possibly jive with real clinical practice, you know, things along those lines.

And then for the, the CCD would, obviously, be more helpful as, as in a tag along when the clinician is saying I want to authorize you know some specific surgical procedure or intervention that does not clearly seem to fit a common or a known pattern, um.

**Dave Goetz – OptumInsight**

Well, if you can get the problem list and you know you would not do a certain, you would not do the most common procedure with someone with one of the comorbidities, right? You would, and therefore these other things are definitely needed. You'd know that from the problem list and a short medical history, right, that you're, things that had even been tried, for example, on the pharmacy example that you tried, you know, the, the generic or you tried a, you know an alternative drug and it didn't work and so therefore you had to go to the, to the next tier.

So, I think if I think about this, I, I tend to think about it as focusing on the criteria that, an, an EHR where we would reuse as much of what an EHR already has and the ability to interact effectively with the um with, with a payer system and one of the things that I see constantly in the area is the ability to do some single sign-off, right, where you don't have to log off and log back into another system, log back into your, your EHR. If there's not some capability as just as a pure technical matter to be able to do this as part of a normal workflow, if you will, and to even have some of the, you know, the, the patient demographic information or whatever pre-populate into, into that kind of system.

Again, that may be way ideal but it, it certainly would make sense and would make this something that would speed up the entire process and get it to where if people had to have a discussion about something they could have the discussion and have the same information that they're looking at to have that discussion. That make sense?

**Steven Stack – American Medical Association**

Yeah.

**Dave Goetz – OptumInsight**

So, but there's my experience is, and maybe I'm just having bad experience because, and that's entirely possible, single sign-off is not that simple. Um, I take...

**Steven Stack – American Medical Association**

I would want a place where it's supposed to be simple for the pe, people using is, but it is, it is often not. Well, it's not simple to execute when you start, again, I don't know the technical aspects of it, but it doesn't necessarily seem simple when you're having different systems hosted on different platforms and all sorts of stuff seamlessly operating under a single sign-on.

**Dave Goetz – OptumInsight**

But, again, that's probably more of a Standards Committee question, but it, from a policy point of view, from, from, from easing the interaction to where you could pull up the list of six questions to answer while the, you know, while sitting there with a patient rather than having to, you know, go tell your office manager to write up a fax and send it and ask for them to fax back the questions so you can fill them in or for her to fill them in, does that, I mean, am I, is that not kind of the thing we're talking about here?

**Christopher Tashjian – River Falls Medical Clinics**

Yeah, that's exactly what we're talking about.

**Steven Stack – American Medical Association**

From a policy standpoint, Dave, would our little group here say, one, we believe that prior auth is important and it is something that policy levers should be used to try to advance; two we can come up with at least two or three simple to understand situations, the one being the automated approval, which already happened with formulary comparison, the second being one where it's mostly objective, or where there's objective check-box things there's not a formulary to compare against, but for a discrete number of things where payers have agreed to that's standardized and you pick the options from dropdown menus and if you can answer all the questions appropriately, automatic auth, prior auth is provided based on those answers and you, if you want, say a CCD gets tagged along – this is pharmaceutical stuff – but, at any rate, whether that's tagged along or not.

But then the third setting would be the pure custom route, which is a standardized form that's what is the procedure, what are your perceived indications, you know, and what are you asking for approval, that at least it's captured and sent in maybe a text document, but it's captured and standardized fields, you know what I mean? So, you can think like at least three use cases to, to come up with a sort of, well, at least conceptually, a clean paradigm to say this would be the way we would envision going forward.

Now, over time some of the things that are in the third bucket, which is a pure custom approach that's only semi-automated, meaning you transmitted electronically instead of using a fax machine or phone calls, it may be that over time more things move from bucket three into bucket two, where it's much more structured, um.

**Dave Goetz – OptumInsight**

That's my experience. I mean, I know it has to be yours, too, is that over time, you know, new, new processes and procedures come up, people get more creative, you know, and that you have to be able to have, that's why I'm trying to figure out, okay, what, you know, how do we, how do we maybe help people build that path and automate that path to march down, right? Because I mean you would want to, to be able to do that.

**Christopher Tashjian – River Falls Medical Clinics**

That would be the goal.

**Steven Stack – American Medical Association**

Should we, when I say we, who's on the call with us, Kory or someone else from...

**Dave Goetz – OptumInsight**

Kory's taking notes furiously, I hope.

**Kory Mertz – Office of the National Coordinator**

I am.

**Steven Stack – American Medical Association**

So, so the royal we, you know, of course, which is always ONC staff and the Chair of the Committee, right? But should, should we mock up a, like a three, like I sort, and I'm just throwing this out, like a three pathway sort of thing because we're just talking at the policy level to say we think this is good and desirable. We think it would be worth the Standards Committee considering, can, you know, are there standards that can carry this, that can execute this and, and then, then that would be I guess the HIT Policy Committee and Standard Committee at the highest level making the final determination at some point if this was ready for prime time to advance.

But, for our little group it sounds like the three of us have consensus; that it's desirable there are use cases that we can, don't have to stretch our minds to imagine and it should be doable, it certainly, I mean there's formulary checking right now. That can already occur. So, if that can occur these other things can occur. It's just a variation on a theme.

**Christopher Tashjian – River Falls Medical Clinics**

I agree.

**Kory Mertz – Office of the National Coordinator**

Yeah, I think the one thing – and this is Kory – that's going through my head is you know, thinking about what is within the reach of meaningful use and what is outside of those levers and how we design whatever, you know, whatever you guys are thinking about putting forward as far as meaningful use, making sure it can work within meaningful use and if there's other things that need to happen you know, that's certainly an important piece, but I think wanting to make sure you try to structure it in a way that it's going to work with the levers that we have through meaningful use, if that makes sense.

**Steven Stack – American Medical Association**

I would think for meaningful use for Stage 3, the way you use that program is you say for, you know, for pharmaceuticals or conditions for which electronic prior authorization is available the physician will make use of it, right? I mean, that, so, meaning you don't fax, I mean you just, you don't call.

**Kory Mertz – Office of the National Coordinator**

Yeah, and then you'd give exemptions where health plans haven't done that or those sorts of things.

**Dave Goetz – OptumInsight**

Yeah, it would be where available, the ubiquitous where available.

**Kory Mertz – Office of the National Coordinator**

Yeah, I just want to make sure we're keeping that in mind because I can just see that being...

**Dave Goetz – OptumInsight**

But then we also have the certification route, don't we, I mean, that you would then have, you would then have sta, you would rely on the Standards Committee, but it should be a policy that EHR vendors would have systems that would produce these standardized interactions that would facilitate our authorization streams.

**Kory Mertz – Office of the National Coordinator**

Yeah, so just one other point, you know, I think all this is going to feed into the RFC, but I think that one thing that the Policy Committee and Micky's done this on a few things for this workgroup, in particular, has been trying to do is have some of these kind of check-ins with the Standards Committee at a more ad hoc level rather than, you know, waiting til everything's done and then throwing it over the wall to the Standards Committee to look at.

So, you know, this is, after we get a little more you know, structure to this, this could be something you guys ask Micky to throw over the wall to the Standards Committee just for, ah, some input on it potentially. Just a thought.

**Dave Goetz – OptumInsight**

No, I think that's right. I think that's, I think that is the next, where it would go.

**Christopher Tashjian – River Falls Medical Clinics**

Yeah, and I think you know, it's, it's a difficult situation, isn't to and, again, I don't know how it all works on the standards side, but it seems like things tend to work the best when there's a policy imperative, Standards react to the policy imperative to make sure that the technology can do it. Having a technology imperative with no policy push at the same time, maybe that happens all the time. It quite, pos, it quite probably does happen all the time, but most of the things we've discussed I think, in like the Information Exchange Workgroup at least, though, are things where we'd say this need to be a push and then the Standards tel, people tell us either it can or it can't be done and, or if so, how.

So yeah, in this case I mean it almost sounds like our work today is nearly done as far as if, are you all okay if we come up with that three bucket sort of paradigm?

**Dave Goetz – OptumInsight**

Yeah, I think that's a great start.

**Steven Stack – American Medical Association**

I do, too.

**Dave Goetz – OptumInsight**

And then, yeah, I mean, I think that's, we've now tasked Kory to do that. We'll work on it, Kory.

**Kory Mertz – Office of the National Coordinator**

No, yeah. I'll, I can put something together and send it out to you guys to get your feedback.

**Dave Goetz – OptumInsight**

And, you know, we'll ship it around and make sure it fits, so, but that will help us, it will give us something to review on our third meeting and then be able to perhaps even have a little bit of informal feedback to make sure that the, that Micky and other Committee members don't think we're headed in a, in a difficult direction and to review with them.

Okay.

**Steven Stack – American Medical Association**

Dave, one little thing off this topic. I'll be with you all on the 29<sup>th</sup>. I know on the 5<sup>th</sup>, unfortunately, it's just an atrocious conflicted week for me, so I won't be able to make that call on the 5<sup>th</sup>, but I'll review whatever happens by e-mail and comment to you all.

**Dave Goetz – OptumInsight**

That'll be great.

**Steven Stack – American Medical Association**

Or the 4<sup>th</sup> rather, I'm sorry, the 4<sup>th</sup>.

**Christopher Tashjian – River Falls Medical Clinics**

Yeah, I don't know how you picked those dates, but for me they're, miraculously I'm not in clinic in any of them. So, I'll be there. I couldn't believe it.

**Dave Goetz – OptumInsight**

Well, that's great. Um, so what else do we need to do today, Kory?

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

Are we ready for public comment or do you still have more discussions?

**Kory Mertz – Office of the National Coordinator**

Uh, there's just one more slide.

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

Okay. Oh...

**Kory Mertz – Office of the National Coordinator**

But.

**Dave Goetz – OptumInsight**

It's just, yeah. That's what we'll, that's what we just said.

**Kory Mertz – Office of the National Coordinator**

Yeah, so. Yeah, and like I said, I'll, I'll work on reaching out to the S&I folks to get somebody to come talk about the lab order stuff that they're doing out there.

**Christopher Tashjian – River Falls Medical Clinics**

Well, even what you said, Kory, makes more sense to me now, you know, I have a better understanding.

**Kory Mertz – Office of the National Coordinator**

Okay.

**Dave Goetz – OptumInsight**

Right, all right, yeah, I think we're ready for public comment.

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

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

## **Public Comment**

**Rebecca Armendariz – Altarum Institute**

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press star one, or if you're listening through your telephone, you may press star one at this time to be entered into the queue. You have no comment at this time.

**Dave Goetz – OptumInsight**

...good job.

**Steven Stack – American Medical Association**

When we first started doing these things three years ago, there were public members who called in. I'm not sure how much it happens now.

**Christopher Tashjian – River Falls Medical Clinics**

Yeah, I was going to ask, has everyone, anyone been on the call where the public actually called in?

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

We have a lot of public people listening in, but they don't necessarily provide comment. Um, but there are other workgroups that do get public comments.

**Dave Goetz – OptumInsight**

Um, hm, so you're saying we need to be more exciting.

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

No, it's, it's sporadic.

**Rebecca Armendariz – Altarum Institute**

Excuse me, everybody, we do have a public comment. We have three, apparently.

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

Oh, well, there you go.

**Dave Goetz – OptumInsight**

See, that's what we just had to do.

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

Look what you did, okay. Can we have the first public comment, please?

**Rebecca Armendariz – Altarum Institute**

That was the Operator's fault, I'm sorry. Excuse me, I'm sorry, we don't have any comments at this time.

**Dave Goetz – OptumInsight**

Just trying to make us feel like we're wanted, okay, all right.

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

All right, so there's no public comment. I think we're all set. Any other closing remarks?

**Dave Goetz – OptumInsight**

No, great. Thank you, everybody. I think we've given some good thought here and I think we've established a good direction. Thanks for everybody spending your time on this.

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

All right, thanks, everyone. Bye.