

**HIT Policy Committee  
Meaningful Use Workgroup  
Consolidation Subgroup  
Transcript  
March 11, 2013**

**Presentation**

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

Thank you. Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup, the subgroup on Consolidation. This is a public call and there is time for public comment built into the agenda. The call is also being recorded and transcribed, so please make sure you identify yourself when speaking. I'll now just take roll call. Christine Bechtel?

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

I'm here.

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

Thanks Christine. Tim Cromwell? Art Davidson? Leslie Kelly Hall? Yael Harris? George Hripcsak?

**George Hripcsak, MD, MS – Columbia University**

Here.

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

Thanks George. Marc Overhage?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Present.

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

Thanks Marc. Greg Pace? Amy Zimmerman? And if there are any other workgroup members on the line, if you could please identify yourself.

**Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer**

This is Paul Tang, but I can only be here for about twenty minutes, sorry.

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

Great. Thanks Paul. And any ONC staff members on the line?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Michelle Consolazio Nelson.

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

Thanks Michelle. Okay with that, I'll turn it back to you Christine.

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

All right, great. Good morning everybody; happy day after the time change. We had a very productive meeting last time, as you recall, for those of you who weren't on. Paul, I know you, I don't think was there. We were able to go through the entire first bucket of improving quality, safety and reducing disparities. So that was a terrific amount of progress, and we are also grateful, and I want to welcome Steve Waldren, who is going to be on the call today as another resource for us as well. So we're going to kick-off with the second bucket of engage patients and families, and then get through as much as we can, and we hope that Art will join us as well for the public health section.

As you have in your email, an updated copy that reflects our work and agreements last go around, and Michelle was kind enough to create two additional tabs. The main tab, which she has labeled simplification, is the main spreadsheet that we will use. There's a second tab, which I asked her to create, based on our discussion previously that essentially lists the care summary items. And she's really – the two columns that are important on that tab are column D, which is the care summary as it currently exists, and then we've added column E, which is Stage 3 additions. So one of the things that we're doing obviously is we are going through and trying to advance some things, beyond just sort of recording. They end up being collected often in the care summary or in the view, download, transmit requirement or other places, and so I asked her to create this just to make sure that we're not overloading the care summary. So that way can come back when we're through making our complete first pass at the spreadsheet, and just make sure that we haven't done anything that inadvertently could cause some problems.

The third tab is called our parking lot. So as you recall last time, it's difficult to stay in scope sometimes and not make changes or substance, add things that are substantively new, which is out of scope for this group. We're really looking at how do we simplify the criteria as they are knowing that we will go back as a full Meaningful Use Workgroup and look at the public comments and make changes to the criteria. But because our conversation – I think maybe somebody should be on mute – there you go. Because our conversations do tend to be wide-ranging and we don't want to stifle people's creativity, we've created this parking lot of items where it's out of scope for this subgroup, but we want to bring that back either to the Deeming Group or to the full Meaningful Use Workgroup. So, with that, any questions based on what I've just reviewed, or comments.

Okay, so let's dive on in. So we are on row 26, which is the view, download and transmit. And I am not – at least the first pass that Steve and I took through the spreadsheet; we didn't see anything that we would simplify in that criteria, in fact that criteria tends to be a landing space for other criteria. So, any way to...any suggestions for how to simplify or advance that component. Okay. So patient generated information is the next one, and that's on 27. And I think that's again one that's very new to Stage 3, so any thoughts on how to simplify or kind of combine that. I mean, I could think of a couple of ways to do that, but I'm not sure they make sense in terms of clinical workflow. If we're really looking at patient generated health data, we know when we created this criteria that we wanted some flexibility in what the information might be, so that it was very relevant to the EP or the eligible hospital. And so I could think of, for example, family health history where we could say, oh, that's patient generated health information, but that may not always be collected in that way. So, my inclination is to leave that one sit for now, until we see what happens with it in the full workgroup deliberations, but what do you guys think? Any other thoughts?

**M**

Seems like a reasonable approach.

**George Hripcsak, MD, MS – Columbia University**

Yeah, hard to – yeah, yes.

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

Yeah, okay. I agree. All right, so the next one is 204D and that is request record amendment. This, as we were going through the first pass at this, I actually thought there was a very good idea that Steve had that – it may go in the parking lot because it's – I think this actually may have been, and I need to look at it, certification only anyway, but I'm going to take a look. But anyway, the idea that, as you recall, Paul and I had gone back and forth on in an obvious manner, you know, offering this capability to consumers in an obvious manner. So if we were to suggest to ONC that they create a common amend button, that is like the blue button, but it becomes sort of ubiquitous and universal and easily identifiable. Then the burden is not on the practice anymore to show that they've done that in an obvious manner, but rather we can put it in as a certification criteria. So that might be one way that we thought about potentially simplifying this. Any thoughts on that?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

This is Marc, I'm trying to digest that a bit and think about the implications for data storage and management, you know, so putting it in the certification criteria ...

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

Yeah.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

... creates a bunch of questions, I think. For example, so that data gets stored, now what happens with decision support, what hap – so there's this cascade of things that quickly implies that – I want to make sure we're ready to sort and take on.

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

Yeah, so, okay. I'm looking at the RFC as we proposed it, and this is a new criteria that, and so the way we originally wrote it was, "Provide patients with the ability to request an amendment to their record online, e.g. offer corrections, additions or updates to the record through view, download, transmit, in an obvious manner." So if in fact in the RFC, it's not certification only, so I think what I'm – but I want to understand more about what you're saying, but just to kind of levels set. So, if there was, if ONC created like a branded sort of button, maybe it's the red button, I don't know or the green button, whatever, or it's a square, who knows. Then it takes the burden of proof off of the provider, and if Paul's on the line still, to be able to speak to this, part of the challenge with this one is the problem is how do you require documentation that the provider has offered the amendment ability in an obvious manner? So this would, if we put it in certification criteria only, and had a common button, then it would take care of that without putting the burden on the practice or the hospital to show that they're doing that.

**George Hripcsak, MD, MS – Columbia University**

So, I – this is George, I agree with certification Marc, I think the difference is they're not certifying that there's an automated mechanism for a patient to put, to amend the note ...

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

Right.

**George Hripcsak, MD, MS – Columbia University**

... it's just an automated mechanism to make a request to amend the note. So it's like secure messaging almost ...

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

Um hmm.

**George Hripcsak, MD, MS – Columbia University**

... that's what's being certified here. Then you would use your normal EHR mechanisms that you would use if you wanted to amend a note for a different purpose. So it's smaller scope than I think you were just thinking of.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

That helps some, I think we just have to make that really clear so that there's not an implication that that outflows through, because that just opens up a whole bag of worms. So thank you George.

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

Okay.

**Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer**

And I think I would agree with what Christine and George said, the way we did it is we just put a link when you're looking at your – let's say your summary or your immunizations, and it says, click here to update your record. That actually, workflow wise that goes to nurses who are able to edit the record. So the obvious manner is just that it's a link there when, where you could offer additional information. And it's, I think as George and Christine are suggesting, if there was a link ... but we had to put that link there, there's a link or a button that was in an obvious place, that sort of offloads the ...

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

Right. Okay, so this would, in essence, become certification only, but we would make a suggestion that ONC help to create a branded feature. So, is everybody comfortable with that? And then, I guess my question is, do we need to have a use measure that is – the capability was enabled, and can that be counted automatically or if you create ... and I just don't know the answer to this, if you create this sort of common amend button, does it just show up everywhere regardless.

**George Hripcsak, MD, MS – Columbia University**

I think if we're trying to consolidate, it would be just a pure certification and not checking that.

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

I think my question is, do we need – if you just do certification, does it mean that the button will be enabled, that consumers will be able to see it, because if so, that's great. I just want to make – that's the whole obvious manner thing though.

**George Hripcsak, MD, MS – Columbia University**

Umm, I don't know.

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

I don't either.

**George Hripcsak, MD, MS – Columbia University**

I mean, I don't think it necessarily means – it could be a function that they turn off theoretically, I guess.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Yup.

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

Okay, so if that's the case, then maybe it is certification and use, and I think that's – Steve was suggesting that the use measure is just enable it, but that's something that can be automatically reported and it's not a burden to the provider, and they don't have to worry about what in obvious manner means. Is that right?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

So you're thinking the certification criteria would include criteria for obvious manner as part of it and that the certified systems would therefore meet the criteria is that how you're thinking about it?

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

Yeah, but the obvious manner, I think, to be more specific is if ONC created much like they did the blue button idea, right, so if ONC created another icon that that's the obvious manner. And then the system was just certified to opt ... that they tur ... that icon shows up when that capability is turned on, then they don't have, then the practice or the hospital just have to turn the capability on. We don't have to go through the offer and the counting and all that junk, they just – the system just has to say, yes that was enabled. Does that clarify Marc?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

It does, and I always struggle with these things because it's the implication of that is it'll be obvious to the patient if they go to the portal or whatever that the ... offers. And we know that's low ...

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

We know what Marc?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

And we know that is a low percentage.

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

Low percent of patients who go to the portal?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Right.

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

Yeah. Right, but at least the ones, I mean I think part of the – yes, but at least the ones who go can see it. Because part of the challenge we're trying to address or prevent is that once ... you're going to have electronic data from potentially your hospital, your primary care, your specialist, all over the place, so we just need to have a way to consolidate and correct. So that's what that would do. So it sounds like for now we should leave this as certification and use, but that the use is really enabling the feature and that's it. Any disagreement with that, or other ideas?

**George Hripcsak, MD, MS – Columbia University**

No, I'm just thinking about this. So the amend button – we're not certifying the portal, so where's the button?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Right, the button's clearly on the portal...

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

Yup.

**George Hripcsak, MD, MS – Columbia University**

And then to say that they have to use it gets even more complicated.

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

Well, they have to turn it on.

**Steven Waldren, MD, MS – American Academy of Family Physicians**

This is Steven. One of the things that I was thinking relative to a “amend button,” and again, that necessarily doesn’t have to be a button, but the notion was if there was a common way this was done across all certified EHR technology. Then organizations that wanted to drive this functionality would have the ability to advocate for its use, just like we’ve seen the avocation for the blue button. You can tell consumers, just look for the blue button. If there was a standard representation of the amend, then that could be pushed. And again, thinking about driving the demand for this functionality by the community, as opposed to forcing the providers to push demand amongst their patient panels which is the ... reason to think about it as kind of a standard amend button functionality.

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

George, does that make sense, because I want to be clear that we’re not suggesting any kind of – I’m not suggesting any kind of a measure like 2 percent of patients actually offered amendment, I think that would be not right. So, we just want to make sure there’s an easy, obvious way, which is what we said in the RFC.

**George Hripcsak, MD, MS – Columbia University**

So the truth is that I really have no problem with saying you have to turn the thing on, it’s just that it turns it from certification only to an objective and then when they start counting objectives; it’s in the list of things they count, and it looks like more objectives.

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

Yeah.

**George Hripcsak, MD, MS – Columbia University**

So what I’m wonder is, is it worth that cost, which is kind of this odd kind of cost, I admit, but is it worth that cost for the difference between making it certification only and then saying, and you have to turn it on. And I think the answer may be that it goes into view, download and transmit or somewhere else.

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

Right.

**George Hripcsak, MD, MS – Columbia University**

So maybe it has to be conso – if it has to be consolidated with, because it’s just a certification mostly and turn it on, it shouldn’t stand on its own as an objective, so just to pick where it goes.

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

Yeah, I was just about to say that. I think that’s right, we can make this a certification only and it could be a separate piece, but if we also reflect it in view download, then that would make more sense, because we’re saying here’s the data set, so here’s the function as well.

**George Hripcsak, MD, MS – Columbia University**

I mean, in effect the view, download, transmit portal needs to have a button that says amend.

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

Right.

**George Hripcsak, MD, MS – Columbia University**

That’s really what we’re asking for here.

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

Yeah.

**George Hripcsak, MD, MS – Columbia University**

So it seems like consolidating it into the view, download, transmit eliminates an objective, and these objectives are – everyone has to read them, so they are distracting. I think if it's in there and it's multi-certification, the vendors can get it without the doctors having to worry about, or the eligible professionals having to worry about it.

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

I like that, others? And ...

**Michelle Consolazio Nelson – Office of the National Coordinator**

Christine, this is Michelle. I just want to – I think that we've put a lot of stuff in VDT now, so I think we'll probably need – the same thing that we're doing for the care summary we'll probably need to do for VDT.

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

Yup, that would be great; I was thinking the same thing.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Okay.

**George Hripcsak, MD, MS – Columbia University**

So what was the change, sorry?

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

No, no, she's not suggesting a change. You remember when I opened the call I said that because there are some things that are getting integrated into care summary and view download, we need to – and so I asked Michelle to make a list of everything that we're adding to the care summary, just so we don't do anything funky. She's going to do the same thing for view download.

**George Hripcsak, MD, MS – Columbia University**

Okay.

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

So I think where we're heading now is that the record, request record amendment goes into, it gets integrated with view download and we make a note about the common sort of button or icon or whatever it is in there, and that way it simplifies it.

**George Hripcsak, MD, MS – Columbia University**

Okay. Now, I just, that triggered me to go up to view, download and transmit. Paul, are you still on? I wanted to ask Paul about the idea of rolling the – let's not go back over the electronic note into view, download, transmit, which was something I felt uncomfortable about last time, but I guess this will come up in the Meaningful Use call on Friday.

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

Yeah, and I ...

**George Hripcsak, MD, MS – Columbia University**

Okay, never mind. Don't mean to distract.

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

No that's okay because I think we had made a note about it kind of depending on it, but then you guys had said, oh, there was – you guys said there was a recommendation from the subgroup that supported that, and so we actually did decide to include it there. But, we had a question about how to preserve the 30 percent denominator.

**George Hripcsak, MD, MS – Columbia University**

So, let's just – I didn't mean to stop us. We'll go over it when we have the bigger group on Friday.

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

Okay. All right, great. And somebody's got a fair amount of background noise, is that just me that is hearing that?

**Michelle Consolazio Nelson – Office of the National Coordinator**

I hear it too.

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

All right. Okay. All right, whoever just went on mute, it's your phone. Is that you George, I hope not.

**George Hripcsak, MD, MS – Columbia University**

Well here ...

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

Oh no, you're fine, I hear you. All right, so office visit summary is the next one, which I think one of the options that we thought of was making the summary available via patient preference. So that you could – the patient could say, well, I'd really like to have the visit summary sent to me via secure message or just put it on the portal, and that the certification criteria could support that. But I think that's, it's not necessarily that I'm thinking about it a simplification pathway; it's that we know that the visit summary needs a little bit of work anyway. I mean Steve, am I not remembering this correctly?

**Steven Waldren, MD, MS – American Academy of Family Physicians**

I, well, I think this was one with relative to preference was just if we could simplify the one a couple down, SGRP208, record communication preferences.

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

Oh yeah. Oh, that's right, thank you, good memory. That's right. So we weren't suggesting that this one get simplified necessarily. The way to – we'll get to 208 in a minute. So I think the challenge here, in my view is, you could say, let's make the visit summary available on the portal and you could do it through view, download, transmit. Or you could do it through secure messaging, but that's more of a function. But we have these sort of larger issues around the office visit summary's supposed to be temporally specific to that visit, and it's not, according to what the Standards Committee has said is that we don't have standards that would facilitate that, so I'm not sure what to do with this one. Any thoughts?

I assume we will leave it as is, I mean, I think there is some interest in moving it into the portal, although I worry about that. So, if we clarify that you can make it available per patient preference, then some would be able to do that. I think the flip side of that is that there are healthcare providers today who say, I'm delivering all my labs online, do you want to sign up for that, and then that's the way they get many more patients to sign up. So thoughts on how to simplify this piece. Okay, we're going to leave it as is unless somebody has a great idea.

All right, so the next one is patient specific education material and let's take the next three kind of as a whole in a way here, because they all kind of link to each other. Secure messaging and then recording patient preferences. So, the recording of patient preferences, this is what Steve was alluding to earlier, that you could simplify this if you built the deliver per patient preference requirement into the office visit summary and as well as patient education materials and potentially view download. So, if you did that...I'm sorry, reminders. So you've got three real patient-facing criteria, visit summary, reminders and education materials. And so we could discontinue this as a stand-alone measure if you did that for all three. Keep in mind that in Stage 2, we, the reason we pulled this out as separate was because it was only ... that that's what ... thought they were doing, but it was only integrated into, I think reminders and because of that, the certification criteria weren't created that would say, patient preferences are email, text, paper, whatever. And it didn't, it meant that what we had intended originally was that recording communication preferences would enable practice to ask for example, to ask the patient, okay, we're going to send you reminders, we're going to send you your test results, we're going to do this, how do you prefer to receive this? So I might want a phone call for my appointment reminder, but I may want my test results on the portal and I might want my patient education materials delivered on the portal as well.

Okay, so, that was the problem. So we felt like we need to at least put back in a certification requirement for the ability to record preferences for different types of media, that's number one. But, I think the way that we could do that here, and get rid of this objective, would be to say that the patient reminders, the office visit summary and the education materials are delivered per patient preference to name some of the – name out some of those things. But the practice or the hospital doesn't necessarily have to support all of them, right. So if I want something on text, but they don't support text, that's okay, but at least their EHR is capable of cataloging it. So the proposal would be integrate this one with those other three, instead of leaving it as a stand-alone.

**George Hripcsak, MD, MS – Columbia University**

Sorry Christine, so which one with which other three?

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

Integrate record patient preferences ...

**George Hripcsak, MD, MS – Columbia University**

Yeah, with ...

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

... with office visit summary, reminders and education materials. We put it in each of those, so it becomes patient specific education materials delivered per patient preference, and we would name some of those preferences.

**George Hripcsak, MD, MS – Columbia University**

Well I'm definitely fine with putting record preferences somewhere, so that's a no-brainer. I was trying to figure out could we get educational material into one other one. Like I wouldn't do secure messaging, but I might do educational materials, but I'm trying to think of where, other than the same place everything else went.

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

Well that's the thing, I think it's the portal, unfortunately or VDT, but...

**George Hripcsak, MD, MS – Columbia University**

It's not decision support is it?

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

No, this is the ...?

**George Hripcsak, MD, MS – Columbia University**

I mean, it couldn't go with decision support.

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

Oh, I see.

**George Hripcsak, MD, MS – Columbia University**

Educational material, because you're kind of selecting which material is the right one in this context.

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

Well the decision support objective is really meant for provider decision support, and Leslie did raise that to say, what about patient decision support, so I could put in the parking lot that if we do something on patient decision support, could we combine it with reminders.

**George Hripcsak, MD, MS – Columbia University**

Does it go with the office visit summary?

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

Or not reminders, sorry, education materials.

**George Hripcsak, MD, MS – Columbia University**

Does it go with the office visit summary? Kind of, you're getting your summary and you get your educational materials at the same time.

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

Good question let me, let me look at the threshold. Okay, so the threshold is 50 percent and also it's EP only, which I think both are EP only, right, yeah, visit summary and education materials. Okay, just give me a second here, let me do the math. Okay so you could, but it would still leave an EH gap, so there's also a denominator issue. So the patient specific education resources for EP is a core measure and it is provide patient ... to more than 10 percent of all unique patients with an office visit, blah, blah, blah. So the 10% threshold and then the clinical summary is a 50 percent threshold, so that's issue number one. And then issue number two is that there is a hospital measure for patient education materials, but there – you'd have to figure out – there's not an office visit summary for patient education materials. There is view download for hospitals, but no visit summary, obviously, I mean discharge summary maybe. What's the discharge summary – did that make sense to you, George?

**George Hripcsak, MD, MS – Columbia University**

No, so what's the conclusion?

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

Well we have a difference in thresholds. Office visit summary is required for 50 percent of patients, education materials 10 percent of patients, so if you integrate it into visit summary, it means that you've got to identify education materials for 50 percent of patients.

**George Hripcsak, MD, MS – Columbia University**

Well no, we have other ones where we say, here's what you do on paper, here's what you do electronically, so we have other dual thresholds. Michelle, does it help us to integrate those two at all, or is that like just a waste of time to integrate those two.

**Michelle Consolazio Nelson – Office of the National Coordinator**

I mean I think it would help what about in the care plan, which I know is right now in the proposed stage, but, any possibility we could put it there?

**George Hripcsak, MD, MS – Columbia University**

Hmmm.

**Michelle Consolazio Nelson – Office of the National Coordinator**

... thought, that would include the EH as well, so we won't have that other issue.

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

I mean, I think conceptually it's a good idea, except for the part that it's not even in Stage 3, so I would ... I'd hate to lose ...

**George Hripcsak, MD, MS – Columbia University**

Yeah, that's the only problem.

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

... something that's been in since Stage 1.

**Michelle Consolazio Nelson – Office of the National Coordinator**

So maybe we could put the concept there and see where we can integrate it when we talk about it at a workgroup level, once we go back and reconcile the feedback from the public, perhaps. I'm just, just so we don't lose the fact that maybe there is another place that it could be integrated, but for now it has to stand on its own.

**George Hripcsak, MD, MS – Columbia University**

I think at this – I see what you're saying about care plan, but for the reasons that Christine says, I think I would default to finding a way to get into visit summary, and 10% of visit summaries, or whatever it comes – 20 percent or whatever percent of visit summaries need to include patient educational material, might get you down to the original 10 percent.

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

Hi, it's Leslie joining.

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

Thanks Leslie. But George, I feel like that's just...it's two objectives that happen to be put in one row, do you know what I'm saying, I don't feel like that's one objective for them, from a workflow perspective, it'd still have to count, did they hit the 10% threshold as part of the 50% on the office visit summary. I mean I think the most elegant simplifications are those where the thresholds are close enough and they don't have to keep tracking two different things...you still have to make two different counts, I think, under the way you're thinking about it...

**George Hripcsak, MD, MS – Columbia University**

Yeah, I see what you're saying. It's just that's logically...when I'm giving the patient, okay, here's what's wrong with you, and now here's what to do about it, so that's how they come together.

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

I like that, and I think ...

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

So is ...

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

I mean, oh, you know what we could do, we could, and I'm glad Leslie's joining for this piece of it; I mean this has been in play since Stage 1.

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

As a menu ...

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

... as a menu and then it became core in Stage 2. It might be worth looking at the performance thresholds for Stage 1 as a menu ...

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

We were at 60 percent of those people that participated, with 60 percent who selected that item, and when, if they selected that item, they were up at around 80 percent threshold. So we know that once selected, it's a high penetration item. So, the – this is – the patient education materials and patient instructions can be two separate things. So for instance, I might have in my clinical summary my immediate things about this wound care, you know, this particular wound post-surgery, this is what it is, this is how you care for it, this is when to call a doctor. They're very, very short and sweet. However, that might be a wound because the patient has received bariatric surgery, and so there's much more education that goes on after that, that is both often included, but not part of the clinical summary, but supporting education materials as well.

So, how do we make sure that we gather those two concepts, or maybe we don't? Maybe we say that the patient education for the immediate issue inside the clinical summary can be at the same threshold, at 50 percent or that other threshold, and that other advanced materials like. I think in Meaningful 2 Use or Meaningful Use 2, we mentioned shared decision tools for the first time, but – so we do have a high threshold, I do not feel it would be difficult to match these two thresholds because of what we've experienced in Meaningful Use 1.

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

So let me just ask a quick clarifying question, Leslie. You're saying when it was menu in Stage 1, 60 percent of people, of EPs selected it?

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

That's what I recall, and I'll ask staff to confirm it, but that's what I recall being the testimony we received. And of those 60 percent who selected it, they were operating way beyond the 10 percent, they were way up into the 70s or 80 percent.

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

Okay. So, what might be interesting, given that, and given that its core in Stage 2, is that people will know that they can do it, so, perhaps you integrate it as a data element into – well, you could do it in a couple of places, you could do it into certainly the after visit summary, potentially in a care plan if it lands in there. But that you view it as the data set, not the threshold, so in other words you say, patient specific education resources as appropriate. And then as long as the provider can customize the after visit summary based on patients, you would essentially continue to maintain its availability as a function, but we would be making an assumption that people have, that a majority of providers, at least on the EP side, have been doing it for four years. Now we have to take the hospitals probably separately, but you can put it in the discharge summary there.

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

Right, it would be ... it is ... it's a specification for whether it is the summary of care at the EP or the eligible provider...or eligible hospital, it includes a notion of a patient instruction. The discharge summary also includes clinician instruction, but in the actual summary of care, there is a section on patient instructions. Now sometimes that's an attachment and sometimes that's embedded in the document, either one works.

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

Okay.

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

So I would feel comfortable having equal thresholds for those.

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

Equal thresholds, what do you mean?

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

The summary that was brought up earlier that we were only looking at 10 percent of patient education materials in, early on as a requirement, moving it up for the consolidation or maybe it's deeming actually that says if you're doing this at this percentage, they could be equal. The patient instructions built into it, they are getting a patient instruction every time they're getting a summary of care.

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

But – so you think patient instruction is the same as patient education materials?

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

Patient – there are two things, patient-specific education materials means that its unique to that patient, its unique to their labs, their meds and all the rest. The patient instructions are generally what's discussed for the immediate need ...

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

Right.

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

... of the patient. And then that can also incorporate advanced education, which would be shared decision-making tools, more education about the general, your general issues. And my example ...

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

So let's, let me just interrupt you and say, subgroup206 is patient specific education materials, so it's not the instructions and everything else. So what we're trying to figure out is could you integrate it into the after visit summary, the discharge instructions and say, and I think there are two approaches that we've discussed. One is, the threshold gets increased for Stage 3 to match the threshold in the office visit summary and discharge instructions, which is somewhere around 50 percent.

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

Right.

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

Or, but we have some – there were some concerns about that, or we say, people have been doing it at least on the EP side for four years, and they will use it if it's valuable, so we just make it, integrate it into the office visit summary as a data element that simply says, as appropriate. As opposed to putting a threshold on it, because they've been doing it for four years.

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

But they've been doing it in print for four years, so integrated into a summary is ... huh, no, I don't ... yeah.

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

Well, they can do the summary on VDT, too, but I mean, we haven't said that the material – we have been silent, and I think probably rightly so, as to the communication channels by which the education materials are delivered, because that should be per patient preference, and that's what we just agreed.

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

Correct.

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

So leaving that aside...

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

Okay.

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

Leaving the delivery aside, those are the two options we have on the table that I – I mean, does anybody have a third option for how you might integrate patient specific education material into some other piece of some other requirement?

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

My only concern is that the patient instruction as part of the, as defined in the summary document, is very limited and does not include a lot of expansive information. It's really about that immediate issue.

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

But the patient instructions are different from patient education materials, right?

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

Right. So if you consolidate it into ...

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

Okay, so I'm going to put ...

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

... the summary ...

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

I'm going to put that in the parking lot because we've got to figure out patient education material right now. So you're saying patient instructions, as part of office visit summary and discharge instructions, right, is limited and you'd like, it should be more expansive, right.

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

Yeah.

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

Okay, so I'm typing that into the parking lot now, because we need to figure out the patient education materials, can it be integrated somewhere else, and if so, how.

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

It's not – there would, could be a way to integrate it as a requirement in VDT, which would say that any time you view, download and transmit to a patient, their record, they have the ability to receive education attached to it, because that's not there today. All that's there is the actual record. So if an advanced use of VDT included the ability to get education, to show exactly what this lab's being sent or this med sent or this...any part of my record, then I could feel comfortable; I would feel comfortable. Otherwise, we've got a lot less education going on.

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

Okay. Other thoughts? George? Steve, anybody? I think what Leslie's saying makes sense in that it makes – it would make sense based on what Leslie's saying to integrate patient specific education material as a certification criteria within view, download, transmit. But that wouldn't obviate the need of by itself for this piece, just so we know that view download, which we disagreed to do anyway, right, because we said we would make patient specific education materials, reminders and the visit summary would be delivered per patient preference. So I think that makes sense. So we have to do that, but is there a way to delete this row by putting it with another element that exists today.

**George Hripcsak, MD, MS – Columbia University**

Wait, so we would certify education in VDT, but you want a use somewhere else, is that what you're saying?

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

Right, I mean, that's the question. So, I don't know if you heard the two options, one would definitely drive ... continue to drive use. If you just simply put it in the visit summary, which has to be delivered to ... and the discharge instructions, which have to be delivered to 50 percent of patients, then those would include that data element, at that threshold, so it would guarantee a 50 percent use. And Leslie's given us some information that tells us that that may be, in fact, possible or at least worthy of getting public comment on, because of the data that she shared from CMS. The second thing would be to acknowledge people have been using it for some number of years, at least two, maybe four if they chose it as menu in Stage 1. So if we simply integrate it and say it's as appropriate, it's not a required data element in the visit summary, but it can be there.

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

Well, the visit summary as a minimum includes the patient instruction, as a minimum, which is part of patient education, and that we don't want to go away, because that tells them how to do immediate ...

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

Right, right.

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

... care. For ongoing patient education, if you were to eliminate this line, you could also, we could also consider that in the clinical decision support where they're doing shared decision making with patients, so it could appear there. It could appear in reminders, where patients, in advanced use cases of patients getting a reminder with education and pre-visit information, so you're preparing for that surgical visit, here's what you need to know, and so forth. So, there are opportunities for education, patient-specific education materials to be used in a variety of places. And maybe it's a deeming versus a consolidation question. So if I'm doing an advanced ...

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

It's definitely – yeah, I mean it's definitely easier for the deeming people, so you're saying leave it as separate for now.

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

Yup, and then we can ...

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

... leave it as ...

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

... yeah, because for instance there are twenty-six of the CQMs that include the words consult a patient or educate. And so, we could look at that deeming and this together, along with the patient instructions and patient specific education materials. I'd be happy to take that offline, but because I think it's worthy of some consideration, but I just can't do it off the top of my head at the moment.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

I think – this is Marc – I think it's really important though that we not confuse delivering some text on a piece of paper or on a website to a patient and educating them. They're clearly not the same thing.

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

Well we've user-tested both, and each patient has a different learning style, and some will have better results.

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

Wait a second, wait a second. What the meaningful use criteria is, is use the HL7 info button to go out and look at the EHR and then identify patient education materials. That's what we know.

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

Yup.

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

So just to clarify that Marc, I think that is different than just sort of hey, go get a flu shot or whatever.

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

Right.

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

Flu is bad. Does that help Marc?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Well, I'm just saying that our goal in the clinical quality measures is not just to hand somebody a piece of paper or point them at something that they can read.

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

Oh, I agree. The – I was trying to get at, in some of the quality measures, we do have educate and consult, is there opportunity for deeming. That's my only question.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Got it.

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

For instance, one of them is an A1C, does the patient understand the frequency with which they need to take A1C's, and can demonstrate that, great, that's a good opportunity. So, that's my question and I just don't know the answer.

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

Okay, so unless anybody has a different proposal, we're going to leave this one as it is, even though it does have some real opportunity here to put this in other places, we're going to have to leave it here because I don't hear agreement. Any other proposals or anybody want to advocate for a particular ...

**George Hripcsak, MD, MS – Columbia University**

Well I would just mark that we, for the Meaningful Use Workgroup, that we discussed these two options and are for now leaving it alone, rather than leaving it blank.

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

Right, no, I know. All right. Okay, so, moving on. We, okay so we've gotten through secure messaging and record patient preferences. The next one is already certification only, that's query research enrollment.

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

Right.

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

So I don't, I don't think that you can do anything, because ... more to advance that since it's already certification only. And that gets us into subgroup 3. Okay.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Christine, before we move on to subgroup 3, I just want to make a note. So for the view, download, transmit one, in the RFC, kind of at the end we integrated another item, which could almost be an objective on its own, and I just want to make sure that we don't lose that, and that was the menu item related to blue button, where we ...

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

Yeah.

**Michelle Consolazio Nelson – Office of the National Coordinator**

... it said “provide 50 percent of patients the ability to designate to whom and when a summary of care document is sent to patient designated recipient.” And I just want to make sure, because right now it’s included in VDT, but I’m not really sure if it is its own thing, and I just don’t want that to get lost in the conversation.

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

The way I understand the specification on the VDT, that whether you’re initiating that push to someone else, all the specifications would be the same. So if we did put the ... inside VDT and the blue button the ability to link to education materials, we should have it covered in all three use cases, so VDT and push.

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

So Michelle, I’m going to add, in terms of the difference between Stage 2 and 3 column, back in row 26 which is view, download, transmit, I’m going to add a note that not only does the data set have some newness to it, but I’m going to put comma also add auto blue button as well. Because I think that it – I think it is a functionality of VDT that if it was standing on its own, our instinct would be like, oh no, put that in VDT. So I think yeah you’re right to flag it, but I would leave it in the view download and make sure that stays there. Does that make sense?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yup, thank you.

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

Okay, thank you for flagging it. Okay, and in fact we’re going to...yeah, okay. All right, so we’re going to go to the third bucket, which is really the care coordination area. So the first one is medication reconciliation. One option, and Steve, maybe you can help me recall on this one, what we...the extend reconciliation to immunization, problems and allergies and that’s streamlining again, how?

**Steven Waldren, MD, MS – American Academy of Family Physicians**

Yeah, so this is similar to the record patient preferences. There are other requirements in the document around immunizations, for example, to be able to do that reconciliation. It’s not really called reconciliation, but there’s a requirement to do some decision support and query out and find immunizations in a registry. So, I think the intent, at least from a clinical perspective, is to make sure that the medication list, the problem list, the immunization list and allergy list is complete and up-to-date. So that was the only thing here. I was thinking about if you expanded this reconciliation to include those other clinical domains, you could look at some of the other requirements that are in the list around, there’s interdisciplinary problem list later on, I’d have to...we have to find that in the list, that may be a future only and not a Stage 3. And then like I said, there’s the immunizations and then just from a clinical perspective, I’ve put allergies in that list, but I don’t know if there’s a specific requirement to do that reconciliation for allergies, other places in the proposed requirements for Stage 3.

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

Yeah, well, there was subgroup107, which was the allergy list that then gets covered through care summary, view download and potentially this, but I’m not sure the difference, because I’m not a doc, between an allergy list and reconciliation.

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

So the question, this came up in one of the testimony on allergies for things like food and other issues. So the allergy at the hospital – consider more clinical-facing and the patient allergies that wanted to be included were things like my food or my specific intolerances and how do we reconcile them, that was discussion.

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

Yeah, so that's different though, that's in the parking lot already from our last discussion, because that's a new thing and we're not adding new things. Or, well, it was – that's already an issue that we need to take up as a full workgroup. So I think, anyway ...

**Steven Waldren, MD, MS – American Academy of Family Physicians**

Christine, this is Steve again. Maybe one thing would be just to continue through the document and as we find those other couple of areas, which I think they're referenced back to this particular one, then we could have that discussion to see if we wanted to change. Because I don't think there's anything that's recommending to change from specifically medication reconciliation.

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

Right, it's more of a receiving area for others, so I was thinking the same thing. If folks are comfortable, I'll highlight this row and we'll come back to it at the end. Okay, hearing no objections, this is going to be my new mantra. So the next one is 303, this is the care summary. Okay, so this is again a receiving place for some of our other simplifications and we, Michelle has made a list that we have already added entering the referral using CPOE, indication of advanced directive status for patient's 65 plus and high priority family health history. So Steve, do you want to – is there anything that we need to think through here, in terms of how the care summary might need to change if we're adding things, or should this be something we again kind of come back to at the end.

**Steven Waldren, MD, MS – American Academy of Family Physicians**

Well the only thing I would say, and again, sorry because I wasn't able to participate in the full meeting last time, but one of the things, concerns I had, it sounded like you had something similar when you talked about the potential for overloading the care summary. There's currently not really a set of criteria, at least that I could find for certification for a couple of points here, so labeled 1 and 2 in column H. The ability to include and exclude specific types of data, so there's the certification criteria to be able to have the problem list, those other data elements in there, but there's not an ability for the user to be able to say, for this particular transition, I'm not going to send a problem list, for an example. And then the other was this notion of being able to include attachments into that. As you look at some of the other requirements out there around electronic notes, though there's a requirement later on to record electronic notes. Well if you require them to be able to be exchanged, then they have to be captured, so then you could eliminate that, same thing with advanced directives. So those are the only two things that I think were interesting in regards to my thoughts.

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

Yeah, those are actually very good points. So that's, and that is the more that we add to the care summary, which makes a lot of sense in many ways. But we also heard a lot of testimony from people that we don't want notes or the summary or any other thing to just be a data dump, we need to be able to customize it so people can say what's important, what do I need to include here. So, Steve's suggestion is to be able to customize it so you can include or exclude particular types of data, even though you're collecting all that data, there are going to be specific circumstances where you don't want to include all of it. And that would also include attachments. So I think that makes sense as something to flag for coming out of our work, a potential recommendation and new certification requirement. Would peo – does everybody else agree with that? Okay. Again, hearing no objection, we're going to fly right along.

So, 305 is a referral receipt. So this is, George, something where I think you need to weigh in in particular, because you were on this subgroup and I wasn't, but the referral receipt is something that is new for Stage 3. But it makes a lot of sense also to kind of make it part of the care summary and not have it as a separate measure. Is there a reason though that you guys chose not to take that approach?

**George Hripcsak, MD, MS – Columbia University**

I don't remember why it's separate. Yes, I agree it should be incorporated.

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

Okay. All right. Anybody else want to offer another idea there? Okay, and so, oh, interdisciplinary problem list, Steve you just mentioned this. This is a future stage, but is this something that could be included as part of reconciliation, if med rec was larger?

**George Hripcsak, MD, MS – Columbia University**

Yeah, this was just an idea I think for a more advanced, more fancy problem list. And I guess there wasn't a lot of concern about creating objectives because it was for future stages, but, yeah, I would say it could be mentioned under that objective as future.

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

Okay, under the – so if, I think the idea is, if medication reconciliation became reconciliation more broadly ...

**George Hripcsak, MD, MS – Columbia University**

Right, exactly.

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

Okay.

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

And then the ... we had this earlier in the parking lot, but in future stages, the patient-generated information that says here's the drug I'm on, or here's ... any ... beyond anything that we're trying to reconcile, that we also include the patient-generated stuff in the future.

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

Okay.

**George Hripcsak, MD, MS – Columbia University**

The reason it's separate – now I see, because it was from the first group.

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

Oh.

**George Hripcsak, MD, MS – Columbia University**

And then we pulled it down here, so it never got merged.

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

Okay.

**George Hripcsak, MD, MS – Columbia University**

So PBM could probably do the same thing or 125.

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

Okay, yeah. I'm just typing that.

**George Hripcsak, MD, MS – Columbia University**

But they're future anyway, so it's easy.

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

Right, all three of the ones that we've just recommended are future. Okay. All right, so that's good. So, health care event notification is a new one for Stage 3, and I think that still remains separate because it's a functionality more like a secure message, etcetera, etcetera. So, any disagreement with that? Okay. All right. So now we're into the population health subgroup, moving right along. So immunization registry is the first one, on line 41 of your spreadsheet. So again, this is something that I think Steve was saying could be a part of the subgroup 302 med rec if we change it to reconciliation. Steve, do you want to talk more?

**George Hripcsak, MD, MS – Columbia University**

Christine, one second. So what would – I'm trying to remember what health care event was.

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

This is ... it's ...

**George Hripcsak, MD, MS – Columbia University**

Oh, oh, I get it.

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

This is the ... be received about how useful, even an ADT message could be or something that so a group would know that in fact, some new event had occurred with a patient.

**George Hripcsak, MD, MS – Columbia University**

So it's the closest thing

**Michelle Consolazio Nelson – Office of the National Coordinator**

The measure was for the EH side and so it was for 10 percent of patients with a significant healthcare event, the EH will send an electronic notification to at least one member of the patients care team.

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

Right. So if I show up in the emergency room, my primary care doc gets notified, we hope.

**George Hripcsak, MD, MS – Columbia University**

So if we were going to merge it in the future, it would have been decision support or referral or something is the closest I can think of in there, if we were to.

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

Yeah, and I guess I wasn't, but I was seeing it more as a function than sort of like a data set, like you've got to do something ... so it's really ... does that make sense? And it's really only an EP, I mean sorry, an EH measure, so I think it makes sense to leave it separate, even in the future, unless it's getting really used and it gets topped out.

**George Hripcsak, MD, MS – Columbia University**

Okay, is this one Stage 3 or future?

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

This is Stage 3. But you were saying if we were to integrate it in the future, but ...

**George Hripcsak, MD, MS – Columbia University**

Oh yeah, yeah, yeah, okay.

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

... it's in Stage 3.

**George Hripcsak, MD, MS – Columbia University**

All right. Okay.

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

And I'm going to actually look up the full thing really quick here. Yeah, it is an EH objective and it is 10 percent, it's only 10 percent of people with a significant health care event, arrival at the emergency department, admission to a hospital, discharge from an ED or death, then the hospital will send an electronic notification to at least one member of the patient's care team, such as PCP, referring provider or care coordinator, with the patient's consent, if required, within two hours. That's meaty. That's a good one. Okay. So let's move on to immunization registry.

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

Christine, this is Leslie, I'm going to have to log off. Thanks.

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

Okay, thanks Leslie.

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

Okay, bye guys.

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

Bye. All right, so on immunization registry we talked a little bit about this.

**Steven Waldren, MD, MS – American Academy of Family Physicians**

Hey Christine; this is Steve. So, in – a couple of comments real quick. So in Stage 2 it's really about submitting data to the registry. In Stage 3, just talking about the measure, it's about receiving that information from the registry, but when you look at the objective, it talks about using that information in the clinical workflow. So again, the notion of if you want to have the certification criteria to allow the receipt of that information from the registries, then that functionality is going to be capable of the system. And then if you look at the objective, again I think it's the same thing that we were wanting from the medication reconciliation, is to incorporate that in the information. So that was my thinking is that if you expand it to chart reconciliation, you would get the intent of the objective and then if you had the certification criteria to make sure that the data could be received from an immunization registry, then it's there. I think one of the issues if you think that people still won't pull that information from a registry, then I don't think my recommendation for advancement works.

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

Say the last part of what you just said again Steve.

**Steven Waldren, MD, MS – American Academy of Family Physicians**

So if you think that people, although that capability being present in the certified EHR technology, would not use it to pull data from immunization registries, then I think the option for advancement really doesn't work and that you should be very explicit about, again, just focusing on the current measure for Stage 3, which is being able to pull information from an immunization registry.

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

I got you. Okay, I understand what you're saying. So what you're saying is you could integrate this into the broader sort of reconciliation measure in a way, but that doesn't necessarily get you to the Policy Committee's stated requirement, which was to use the data from an immunization registry into your clinical workflow.

**Steven Waldren, MD, MS – American Academy of Family Physicians**

Yeah, I think ...

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

They need it in both places.

**Steven Waldren, MD, MS – American Academy of Family Physicians**

Yes. Because I think my recommendation for advancement fulfills a lot of the objective of that for Stage 3, but it has the potential of not fulfilling the measure.

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

Ah ha. Because the measure is, let's go look at it...

**Steven Waldren, MD, MS – American Academy of Family Physicians**

So the ...

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

... capability to receive and to enable health professionals to use structured historical immunization events in the workflow, except where prohibited. Well that's interesting, because then what – so the objective is capability, which – so I see what you're saying, and then the measure is documentation of actually doing it for 30 percent of patients who got an immunization during the EHR reporting period. Because we're assuming that in Stage 2, we will have been submitting immunization data to a registry, so therefore you could do it on 30 percent of patients?

**Steven Waldren, MD, MS – American Academy of Family Physicians**

Sounds like a valid assumption.

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

George or Marc, I mean I want to make sure this is right, because this is not...population health group was...we don't have Art on the phone do we?

**Michelle Consolazio Nelson – Office of the National Coordinator**

No, but Christine that was the intent, so they wanted to move away from just getting the data and not doing anything with it to in Stage 3 actually having to do something.

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

Okay. Okay, so we probably need it in both places.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yeah, I think this one is a high priority one that we don't want to lose.

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

Okay. All right. So we'll say keep as separate objective, but also include as part of the broader reconciliation. Okay. All right.

**George Hripcsak, MD, MS – Columbia University**

Okay.

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

Thank you guys that was – I got it now. Immunization clinical decision support. You can – so I think Steve, your suggestion here was that you could integrate it, and we talked about this on the first call, that we could integrate this into the existing decision support measure above, which was ... somewhere up here, I'm looking for it, ah, subgroup113, which is on row 16 of the spreadsheet.

**George Hripcsak, MD, MS – Columbia University**

I guess that's fine by me.

**Michelle Consolazio Nelson – Office of the National Coordinator**

This is Michelle. So this is something that was discussed before and then it kind of got lost. I honestly think that it was discussed between Paul and Art, and I don't – I think there was a little bit of confusion, but had we really followed it through, it would have gotten integrated before the RFC even went out.

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

Okay, so we need to put ... back here in, for subgroup113, that needs to say integrate ...

**Michelle Consolazio Nelson – Office of the National Coordinator**

... 401B.

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

Thank you.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yup.

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

Okay. Great. Well that was easy. I'm going to get the Staples button. All right, so public health labs, high priority, so leave as is. Anybody else have an idea on that?

**George Hripcsak, MD, MS – Columbia University**

I'm thinking.

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

Still thinking.

**George Hripcsak, MD, MS – Columbia University**

I'll let you know ... oh, this is the old ... is it becoming a stupid – is it still like testing capability or what are we doing, actual ...

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

It's umm, the objective – well, let me give you the measure. The measure is attestation of submission of standardized initial case reports to public health agencies on 10 percent of all reportable disease or conditions during the entire EHR reporting period and according to the law.

**George Hripcsak, MD, MS – Columbia University**

So why is this becoming certification only by Stage 3? Like do we need to keep – like is it menu or ...? I'm trying to remember, sorry.

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

No, we're on 402B, which is brand new to Stage 3, actually, it's not even, it's a future stage.

**George Hripcsak, MD, MS – Columbia University**

Oh, I was on 402 still.

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

Oh, I'm sorry, you're right, and I actually ...

**George Hripcsak, MD, MS – Columbia University**

... 402A I mean.

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

Right, so ...

**George Hripcsak, MD, MS – Columbia University**

So you guys, Michelle, any feeling on 402A why it can't just be like have we achieved it and we don't need to do any objective anymore? Like I can see why with 401 we want to keep as an objective, but on 402 ..

**Michelle Consolazio Nelson – Office of the National Coordinator**

Well 402 is a hospital only one ...

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

Yeah.

**George Hripcsak, MD, MS – Columbia University**

Oh.

**Michelle Consolazio Nelson – Office of the National Coordinator**

And it's – for Stage 3 they didn't make any changes, I think because it's just hard. So, right now it's just successful ongoing submission of electronic reportable laboratory results.

**George Hripcsak, MD, MS – Columbia University**

So it's not killing us to have the objective, it just seemed like it's...

**Michelle Consolazio Nelson – Office of the National Coordinator**

I think from a public health perspective, if we take it out then we might be going backwards. But maybe it could become certification criteria only, they'd still have to do it.

**George Hripcsak, MD, MS – Columbia University**

Well let's go through the rest of the public health and see where we end up.

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

Okay. All right, so the next is a future stage only, it's access case reporting criteria. And that was the one I read you, sorry. That was attestation of submission of standardized initial case reports to public health agencies. But that was a future stage only, I wouldn't begin to know what to do with that here. So go on to the next one? Okay, so public – the next one is that public health syndromic surveillance and that's again the same as Stage 2, at least. I don't know if it was the same in Stage 1, but it's capability to submit electronic syndromic surveillance data to public health agencies.

**George Hripcsak, MD, MS – Columbia University**

Probably the same answer as 402A really; they're kind of parallel.

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

Uh huh.

**George Hripcsak, MD, MS – Columbia University**

Can – Michelle, can we merge the two, just to make it one objective or does that not make any sense, 402A and 403?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Umm, so you want to merge it with ELR?

**George Hripcsak, MD, MS – Columbia University**

Merge 402A, public health lab reporting and syndromic surveillance.

**Michelle Consolazio Nelson – Office of the National Coordinator**

So on the – so right now, syndromic surveillance is still a menu item for EPs...

**George Hripcsak, MD, MS – Columbia University**

Oh, oh, oh, oh, oh.

**Michelle Consolazio Nelson – Office of the National Coordinator**

But you could possibly merge it...the hospital item the ELR and the syndromic surveillance, but right now it's only menu for EPs.

**George Hripcsak, MD, MS – Columbia University**

It says syndromic surveillance is menu for EP and not EH at all?

**Michelle Consolazio Nelson – Office of the National Coordinator**

It's core for EH.

**George Hripcsak, MD, MS – Columbia University**

Oh, oh, okay. I see. All right. It's just that you wanted to reduce the number of objectives, it would just okay, core is these two for ... EH is core for these two and EP is menu for the second one. Because I think the technical infrastructure, I mean what you're – it's almost the identical system, it's just this one comes from lab and this one – ah, depends. One of them maybe has more user interaction, one of them is directly off the lab and the other one might require a – it depends on how you do the syndromic surveillance. I forget how it's ...

**Michelle Consolazio Nelson – Office of the National Coordinator**

Well maybe we make it a recommendation that we bring to the full workgroup where ... are, and others will be available to ...

**George Hripcsak, MD, MS – Columbia University**

So we're not changing really anything, we're just making 402A and 403. And then 402B would be the future version, so it'll all become one objective. And it can be partly – we've done before where EH is core and EP is menu.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Right. Okay. So Christine, does that work for you?

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

Yeah, as long as you track what you all just pointed out.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yes, I will.

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

Great. So we have cancer registry is next and I think. So the cancer registry, specialized registry, associated infection registry, FDA registry, some of them are, only one of them actually, the FDA one is a future stage only. So is there a possibility to merge the, all the external registry submission measures into one, which would make sense to me.

**George Hripcsak, MD, MS – Columbia University**

Yes.

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

So you could just say external registry submission and then here's a list of approved registries or whatever specifications need to govern. Right?

**George Hripcsak, MD, MS – Columbia University**

You mean those four?

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

Yeah, cancer, specialized and, well, at least the three. I mean the FDA registry is future stage only...

**George Hripcsak, MD, MS – Columbia University**

Anyway. Well, the third one, it – I'm fine with merging them. In fact, in practice, the third ones a little different from the first – nah, maybe not. I mean the third one we know exactly where the data are going and kind of have an idea of the format, and the first two are little more open.

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

Yeah.

**George Hripcsak, MD, MS – Columbia University**

But that doesn't mean it couldn't be one objective, like the registry objective. And so you need to do a cancer, something else and if you're a hospital, infection. And then FDA is off to the future.

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

So, I guess – the question, and I'm – maybe need to pull the broader ... here, but it wasn't clear from this, the 404 and 405 are EP, they just have really a registry submission EP regis – well no, it's still just one, right. It's just that some of them are going to be appropriate to EP and EH. I guess how do you word it is the question that I have. So, there's the capability to submit standardized reports to an additional registry beyond any prior meaningful use requirement, that's what this says, e.g. immunizations, cancer, early hearing detection intervention – this is I'm reading you on 405, specialized registry. Is that materially – I think it's – it's not clear to me because I wasn't on that group, in that 404 is capability to electronically participate and send standardized, commonly formatted reports to a mandated jurisdictional registry, cancer, children with special needs, early hearing detection. And then there's like – so that's one. And then the next one is, and also capability to do ones beyond that. But they're both menu objectives for EP. So it seems like they could potentially be combined into one line. Michelle, I don't know if you have any thought on how to do it and preserve the intent, or if we need to reach back to Art.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Maybe I can make a stab, but I'll have Art review it.

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

Okay. That would be great.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Okay.

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

And then the associated infection registry, that is the EH one. So again, I don't know if it makes sense to say, there's a registry objective and then for EP the measure is this and for EH the measure is this. I think it makes sense to do it that way rather than have two lines, you've got one, but you're, they're treated a little differently. Does that make sense to you Michelle?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yeah, it makes sense.

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

Okay. All right. So, all right. So then the next one is IE Workgroup 101...

**Michelle Consolazio Nelson – Office of the National Coordinator**

Christine, I'm not sure – I'm sorry, I should let you finish, but I know the IE Workgroup has already started talking about this one and they've kind of already started to come up with a completely different concept.

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

Oh really?

**Michelle Consolazio Nelson – Office of the National Coordinator**

So I'm not sure how much time you want to spend on this, because they're already thinking about this.

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

So what are they thinking?

**Michelle Consolazio Nelson – Office of the National Coordinator**

They're last conversation they came up with three different approaches for this ... tell you ... if you ...

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

All right, so I think it makes sense to put it off.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yeah, I would suggest that.

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

Okay. So I'm going to just delete kind of ... all right, got it.

**Michelle Consolazio Nelson – Office of the National Coordinator**

So their three options are a view capability, a push-push and a query response. I'm reading from an email, so ...

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

Oh, okay. All right, well we'll, so we'll wait and see what they come back with. Then there's query provider directory, which is 102, so that already is a certification only criteria. So I don't think we need to worry about that. And then here – IEWorkgroup103 is the export summary. So that is, it's a certification criteria only.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yup.

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

Enable a user to electronically create a set of export summaries for all patients in EHR technology formatted, according to the standard adopted, that's somewhere. My God, most current clinical information about each patient includes at a minimum the common MU data set – wow, who wrote this. Michelle, can you translate this? In English.

**Michelle Consolazio Nelson – Office of the National Coordinator**

So basically they, what they did is they just provided with a certification, and they were just asking the public, is there a way for, to provide data portability.

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

Oh.

**Michelle Consolazio Nelson – Office of the National Coordinator**

... in the future. And they're still talking about this a lot, too. So I think the IE Workgroup ones we should probably wait on and see where they're at.

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

All right. Okay. All right, that sounds good. Anybody have a different approach on that one? All right, good. So the – we have ... new capabilities at the end, one was the population health dashboard, but I actually think we changed that and I think it's my fault for not taking this out. I thought I deleted it. But I think we actually changed the generate patient lists; we had suggested that that change to population health dashboard.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yes.

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

So I'm looking at that. Michelle, do you have hand what line that was?

**Michelle Consolazio Nelson – Office of the National Coordinator**

It's line 18.

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

Oh, here we go. Yeah, line 18, subgroup115. So that's good, so I think we can take it out of the bottom, but this is probably where I would put the care plan idea in. And Michelle, maybe we can do some work offline or you could start the work anyway, that kind of the, if we had a care plan, here's what we could put in it in Stage 3 that would allow us to simplify some things. So we'd touch on patient education materials, there's probably a lot of stuff that could be in a care plan. And I think, it also looks like the Consumer Empowerment Workgroup of the Policy Committee, the new one that I'm working on and also the Consumer Technology Workgroup that Leslie's working on, may take up care plans, not in a meaningful use construct, but just sort of, how do we – what's going on in the S&I framework and how do we build those out? So, and then to get it to a place that it's ready to hand off to the Meaningful Use Workgroup. So do ...?

**Michelle Consolazio Nelson – Office of the National Coordinator**

I think that makes sense, because also we don't know...maybe there's a way based upon public comment that we could change the care plan and actually get it into Stage 3. So, if we keep the concepts alive, I think it will make sense.

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

Yeah. Okay. Okay, great. All right, so that takes us to the end of the spreadsheet, and enormous thanks to you guys and also to Steve for his really great brainpower on this. So Michelle, can you talk to us about what the next steps are?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Sure. So, well first, based on today's conversation, there's a few follow up items that I'll do offline with Christine and a few others. But the plan is, on Friday – so as you all know, we had intended to have an in-person meeting, but it will be virtual. But the plan is for the first two hours we will break into...essentially your group will go first, the Consolidation Workgroup, will present what you've talked about and what you've found to the full workgroup. And then the deeming group will present their findings. Then we'll have a break for lunch and then the thought will be that if there's an opportunity to combine the two efforts that the work would start during that second half of the meeting.

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

Okay.

**George Hripcsak, MD, MS – Columbia University**

Well yeah, I mean, what we're going to do is work on – wait a minute, we're working on deeming for the second half with the full ...

**Michelle Consolazio Nelson – Office of the National Coordinator**

... as a full workgroup.

**George Hripcsak, MD, MS – Columbia University**

Right.

**Michelle Consolazio Nelson – Office of the National Coordinator**

And we're working on deeming, the discussion was that most likely part of the deeming discussion would include the work that this group has done.

**George Hripcsak, MD, MS – Columbia University**

Right, because we'll have had our last solo meeting, unless we're called back again, right?

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

Yeah.

**George Hripcsak, MD, MS – Columbia University**

Because we're presenting on Friday, here's what we thought, and then it's up to the group to decide which they're willing to accept, for an hour, an hour, and then we go forward with full group working on deeming since that's not going to be done.

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

Yeah.

**George Hripcsak, MD, MS – Columbia University**

And so that'll be in, so obviously part of that is to figure out, okay we just consolidated these three, if this one can be deemed and that one can't, then we've got to figure out what that means. Do we – are we doing any homework on that Michelle?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Umm.

**George Hripcsak, MD, MS – Columbia University**

Like the implications of consolidating and deeming or are we figuring that out on the fly?

**Michelle Consolazio Nelson – Office of the National Coordinator**

I think first the thought is that we'd get everything fleshed out in concept and I mean hopefully – there were discussions even here we talked about, well what do lose if we do this, so hopefully they've been thinking about that throughout the process. But I'm.

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

Well I think we do have to give some thought to it Michelle because I think I was assuming that deeming wasn't going to be the only track, right, it was going to be one optional track, so you've got to know what the second optional track is, rather than force everybody into the deeming approach.

**George Hripcsak, MD, MS – Columbia University**

Right, right.

**Michelle Consolazio Nelson – Office of the National Coordinator**

I – yeah, I agree. I just – I think that – I guess I've always assumed, and maybe this is just an assumption on my part, that it would be some combination of the efforts of both groups, not just deeming and not just consolidation.

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

Yeah.

**Michelle Consolazio Nelson – Office of the National Coordinator**

But that's up to the workgroup to decide on Friday.

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

Okay. So I think what we could really benefit from, Michelle, I'm hoping that you have a couple days to do this in first draft form is, I think we need a new, either some sort of a summary sheet or a new grid that does the integration and so it shows us how many fewer items do we have, what are the other changes that we need to make. But...so we're kind of been able to start out with a summary statement about, we've found "X" number of ways to simplify by advancing these criteria and this is what they would like now. Sort of a ... so the people can see the difference and so we know kind of where we ended up at the end of the day.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yup.

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

Would that be possible for you to work on and I can help as you go, if you need?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yeah. And I think we're going to need that for Friday, so ...

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

Yeah, exactly. Yeah, that's what I'm thinking too. So if you can help with that, and I'll send you the spreadsheet and the notes that I have from today, and then I'll be able to better present something Friday, it sounds like.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Okay. I'll share with you as I go.

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

Great. And I'm just confirming, because I didn't pay attention, but the Policy Committee meeting on Thursday is it in-person only or, I mean is it in-person and virtual or is it virtual only?

**Michelle Consolazio Nelson – Office of the National Coordinator**

No, it's virtual only.

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

Both the Policy Committee and the Meaningful Use Workgroup are?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yes.

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

Ahh, okay. Got it. Okay, great. All right, so shall we go to public comment? MacKenzie?

**Michelle Consolazio Nelson – Office of the National Coordinator**

If not, is there someone from Altarum...

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

Sorry, I was on mute, trying to get off mute. Can you hear me now?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yes.

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

Yes.

## **Public Comment**

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

Okay. Operator, can you please open the lines for public comment?

**Caitlin Collins – Altarum Institute**

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

**George Hripcsak, MD, MS – Columbia University**

Thank you guys.

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

All right, thanks everybody and I'll talk to you Friday.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Thank you.

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

Bye.

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

Thanks Michelle. Thank you Steve.

**Steven Waldren, MD, MS – American Academy of Family Physicians**

You're welcome. Thanks.