

**HIT Policy Committee
Meaningful Use Workgroup
Subgroup #2
Transcript
May 1, 2013**

Presentation

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thank you. Good afternoon 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's subgroup #2, Engaging Patients and Families. This is a public call and there is time for public comment in the agenda. The call is also being recorded, so please make sure you identify yourself for the audio. I'll now go through roll call. Christine Bechtel?

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

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Christine. Neil Calman? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Paul. Leslie Kelly Hall? Paul Tang? Charlene Underwood?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Charlene. And Mike Zaroukian?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief
Medical Officer**

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Mike. And if there are 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 – Federal Advisory Committee Act
Program Lead**

Thanks Michelle. And any other staff members on the line. Okay. Any other Meaningful Use Workgroup members? Okay, I will turn the agenda back to you Christine.

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

All right. Terrific. Well thank you and welcome back to our illustrious subgroup #2. It's been a while since we've met and we have a couple of new members to the group, so welcome to Mike and welcome Paul. As Charlene knows, I'll just give some quick background. We – this was the subgroup that did the original thinking and recommendations around the criteria for Stage 3 of Meaningful Use that are specific to patient and family engagement. And we have, since that time, received many public comments about the criteria that were proposed and so the purpose of this call is to go through and really absorb those comments and consider whether we'd like to make some changes, edits, additions, deletions, to these criteria, before recommending them back to the full Meaningful Use Workgroup.

We're also going to tackle a couple of things that have come out of the recent work that was done to consolidate and create a more streamlined set of criteria for Stage 3. So I know Paul is on the full committee and knows what I'm talking about, and Charlene was part of the work as well, but for you Mike, this was the work that the full Policy Committee approved last month, where we concreted almost 2 potential pathways for Stage 3. One would look very similar to Stages 1 and 2 but have a much more streamlined and consolidated set of criteria and then the other would actually have even fewer criteria, but is called the deeming pathway. And that pathway would have some – would require that providers demonstrate some good performance in the use of their EHR to improve quality, and that if they did that, they would be deemed to be using many functions of their EHR without having to prove that through an attestation process.

So we have been encouraged by Farzad and I think the rest of the Policy Committee to try to be even bolder in our approaches to creating a more streamlined set of criteria for Stage 3. So as we go through today, we should think about the public comments and we should also think about our ability to do some things that maybe could combine, if there is anything left, I'm not sure there is. Or maybe even do some form of a deeming thing within this kind of approach, just so that we can continue to make progress on those fronts. So, what I think we will do, this is the first of – we have three calls scheduled. On this call – and so, let's see here, where are we on the slide deck? Can you guys go to the next slide please? So for those of you following at home, this is slide 2.

Our schedule is we have three calls scheduled, today, May 13 and May 29 if we need it. We're going to try today to get through three specific criterion, that is, view, download, transmit, patient-generated health data and clinical summary, which I think is after visit summary. So we're going to do those things here and then we're going to – and if we can make more progress, we will. We'll continue with the rest of the criteria on May 13 until we're done and we've got the May 29 call date if we need it. So before we dive in to view, download, transmit and looking at public comments, are there any questions from the subgroup members or any thoughts?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

This is Mike. I would just laud the group as a new member for the deeming process. It's highly reflective of some of the comments we made from the American College of Physicians and I think we'll be quite responsive to the concerns and interests of that group.

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

Great. Thanks Mike.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle. Sorry, actually on that note. Christine and everyone I need to go back through the comments and look through and find any original ideas. The Policy Committee had asked for that and we really haven't quite gotten to that, so, it's an IOU. But we've been kind of stuck on the comments and so forth, so.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

What were the original ideas? What was that? What were we looking for?

Michelle Consolazio Nelson – Office of the National Coordinator

It's for the Policy Committee, they kind – Christine had, I think it was you Christine actually who asked –

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

– for us to look for – if people in their comments had identified things that are a little bit outside the box or other ways of going, if we could bring those forth. And I had done some of that a while back, but it's been a while, so –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

I need to rejuvenate those.

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

Yeah Charlene, that's just, you know how sometimes people come up this really cool idea but it's buried in a comment letter.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes, that's right.

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

And some of – having been through this process now, this is the third time I will have gone through it, we lose those a lot, and then we learn about them later because some group comes up and says, hey, we suggested this, and we go, ohhh, had we known. So, that's the idea.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah and trust me, I look for those, tell me what to do comments, too. They're very helpful because they're thinking them through from an operational view, which is really helpful for us.

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

Yeah, exactly. All right, so let's dive in and look at 204A, which is View, Download and Transmit. The slide's a little bit hard to see, but you have it in your email as well. So, as you'll recall, this is, in Stage 3, View Download is a core requirement and so we've continued that on for – I don't know if I just said 2 or 3, for Stage 2 its core. We've continued that for Stage 3, and we've added some things around – through the consolidation process, that I think we should probably review here. So our Stage 3 recommendation was to continue this as core, which actually, I'm not sure that's totally reflected on this slide, right Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

No, we didn't do a good job or I didn't do a good job of indicating what's menu and core, so, I'll fix that.

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

Okay. Well I think – I don't – what I see is the Stage 2 final, but I don't even see the core description of the objective. Is it in here but I've mis – more than 50 percent. I think we just said same thing, offer more than 50% and more than 5% are actually using? Yeah, because we've said potential to increase of both the thresholds, but we were waiting on the experience from Stage 2. Okay, got it. So, that's fundamentally what this is. We did say that EPs should make information available within 24 hours, they have four business days, as it is in Stage 2, so we're moving to much more real time information here, except if it's not available at the time of the visit, then you've got the four days. And then in the consolidation process, our recommendation was, rather than having a separate menu item around collecting high priority family health history, that that become part of view, download, transmit.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Um hmm.

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

I thin – the other thing that we did was to also kind of consolidate that view, download would allow the patient to request an amendment online. Okay. We've got some things we need to talk about there, and we also kind of had a placeholder for images, because it was something that we had a lot of questions about when we talked about it, is it really the image itself or is it a copy of the image, I think Leslie had raised that previously. So Michelle, where's the public comment feedback.

Michelle Consolazio Nelson – Office of the National Coordinator

So there are number of slides following –

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

Oh, oh, got it.

Michelle Consolazio Nelson – Office of the National Coordinator

And, it's a little bit confusing because I didn't want the comments from the amendments to get lost, just in case that could alter the recommendation that it gets consolidated here, so those fall after the comments for VDT itself.

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

All right, so let's go forward. So the next slide basically gives us a sense of what was already in view, download, transmit, in terms of the type of information that needed to be available. And you can make available more information than is listed, of course, but one of the big questions that we had as a subgroup, particularly because if you put family history in, does that become a requirement, for example, a core requirement. So Michelle went back and did some homework and tells us that you can – you, Michelle, do you have to include all of these, or is it only a subset that is required per the CMS directive?

Michelle Consolazio Nelson – Office of the National Coordinator

Only problems, meds and allergies. And those were the things that were required because in Stage 1, those were objectives on their own and rather than have them be required in Stage 2, they put them into VDT and the transitions of care objectives, and so those are the required elements and really nothing else is specifically required.

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

Which –

Michelle Consolazio Nelson – Office of the National Coordinator

So I think that was one of the questions from the consolidation work, are there things that should be required? And we started to talk about that on the last Meaningful Use Workgroup call, and that was as far as we got, I think.

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

Okay. So the first question that I think we need to resolve is what that is on this list, do we want to recommend is actually required, knowing that – knowing two things. One is, if you only require problems, meds and allergies, then what is the point of have – I mean, you can – I guess it creates a functional capacity to display lab test results, for example, and demographic information, but there's not a guarantee that that information will actually be present for patients and families. And what we know from surveys is that the more information that is there, the more value they find in their online access, the more likely they are to use it; and also, by the way, the more likely they are to trust their physician practice to protect their privacy. And I would assume that would extend to the hospital setting as well.

So, I would argue that we should think about whether there's anything on this list that should be optional at all. And the second thing I would say is that we should keep in mind that if, and the way it works today is, that the EP can be excluded, they can claim an exclusion from recording information, either because there isn't any information to record or what's the other – I thought there were two reasons Michelle. Do you remember?

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, I didn't quite make out what you said.

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

So in circumstances where there is no information available to populate the fields that are listed here –

Michelle Consolazio Nelson – Office of the National Coordinator

Um hmm.

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

Oh, it's because either they can be excluded from recording it, so like they don't collect vital signs, so they're taking an exclusion on that anyway or there's no information to record, like it's not available. So you can – you have some flexibility, but I don't know about you all, but it does bother me that there's only three fields that are required, and I think that's something we ought to address. So what do you all think?

Paul Egerman – Businessman/Software Entrepreneur

Christine, this is Paul. Can you tell me again what are the three that are required fields?

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

Problems, meds and allergies. Which means provider name and office contact information is not required? Procedures, lab test results, vital signs, smoking status, demographic information and care plan fields are not required.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So Christine. Oh, go ahead, sorry.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul. So to answer your question yes, it would seem that we ought to require more than that because, I'm thinking about this from the standpoint of being a patient, that doesn't necessarily give me any new information. I probably would want to get at least laboratory – recent laboratory test results that I might not otherwise be able to gain access to –

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

– so, it seems like the list is too small.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, Christine, the other view – the other work that we did previously is, we did the work to harmonize across what's on the transition of care summary with what was available for view, download and transmit. And that's important because in some cases, that summary, the transition of care document, feeds a centralized patient repository or HIE, whatever, in some states, and this – and then the basis of what is then on that document becomes the basis of what can be viewed, downloaded and transmitted, right.

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

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So we just have to make sure that we keep those things harmonized. So to some extent, that was part of the rationale for just those three ele – well, there were three elements, you explained the rationale for those three elements, and in addition then, we are able to advance those elements such that they were encoded, right. So that we had them tied to a code set so that when that data was actually exchanged, it could potentially be embedded into a system and/or reconciled, so –

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

Right. So Charlene –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

– and we don't want to lose that, that's all.

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

But I don't think we are, because, so tell me if I'm wrong, but the certification rule already set forth the standards that would be used for both view, download and the care summary, not the after visit summary, but the care summary, and there is alignment there. So I'm not sure, but that was done in Stage 2, I don't know that we have to worry about that. I think the issue is there's not a requirement – so everything is standardized, but you only have to have three of these fields filled in, which is not useful to patients. And frankly, I would say is totally counter to the one thing that I think many providers are worried about, which is getting 5 percent of your patients to actually use the online access. If those are the only 3 things that are required to be in there, good luck with that. So, I don't think we're losing any of that. Do you disagree?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

No, no –

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

Because we're not changing the fields here, we're just saying there's only a small number required.

Paul Egerman – Businessman/Software Entrepreneur

That's right. And yes, Christine its Paul. I agree we should require more. I don't know if you want to start going through the list right now to make that decision, but you certainly should at least require laboratory test results.

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

Yeah, I mean I – is there any – I would argue that everything on this list, except maybe care plan fields, because I think that's not – I don't know that everybody needs that, should be required.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike. Let me describe a perspective from a primary care physician, and maybe as a patient, because probably 85 percent of my patients are signed up for the portal for me. So I think one of the first things is being careful that they have what they need, so although I would say problems, meds and allergies are actually the top three, they're necessary, but not sufficient. So I'm with the group on that. I would also say, however, that some of the other things, if I'm a patient, I only want to see them if I'm not sure my provider has them right. So I mean I know my name, so I don't really need it from that perspective, but I do need it to know I'm on the right page. Some of the other ones I think we could be thoughtful about do we need them there because it's possible to collect them or do we need them there because we need the patient to be able to tell us if they're incorrect. So, I think that's another framing part.

One I'd want to focus on in particular is current and past problem list, because as I think everyone knows, Stage 1 Meaningful Use was stipulated as one or more problems on the problem list, or an indication that no problems exist. And there really hasn't been a change, other than an objective statement, that it should be accurate and up to date. But there's really no measure for that and so if one were to try to talk about making progress there that would be an opportunity. The other thing is, if you look at the past problem list, in other words currently inactive, if we're talking past medical history that might be one thing, if we're talking about a past problem list, it could be huge and have a large noise to signal ratio. So in thinking about making sure that patients see stuff that's valuable, but don't get lost in the signal to noise phenomenon, I think we want to look a little bit carefully at just how much of this to include.

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

I think those are fair questions Mike and I think what you're raising are issues that probably live in the first subgroup area, because the current problem list is pulled from the EHR and I think you're right. But it's pulled from the EHR, so I wonder if what we should do is send them a question, through Michelle.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Fortunately, I'm on that group, too, so I can talk to them about it as well. So I'll be happy to do that.

Michelle Consolazio Nelson – Office of the National Coordinator

Well, there is, so we have an interdisciplinary problem list objective, which is actually now in Christine's group, I'm sorry, Charlene's group.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

So, Charlene, do you want to –

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

But that's not what this is, right. Right Michelle, interdisciplinary problem list, is that the same as current and past problem list, which is usually –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

That was a discussion – as we think through care plan; to have a care plan you're dependent upon having frankly an interdisciplinary problem list. So we were going to have that discussion when we talked about care planning. We're going to talk about problem list and interdisciplinary problem list –

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

Are they two different things, because I just don't know enough, so I think they are?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

No.

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

No?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

No. No. Well, it depends on whose viewpoint you have, but no.

Michelle Consolazio Nelson – Office of the National Coordinator

And it's already gotten moved from subgroup 1 to subgroup 3. It's been moved a lot.

Paul Egerman – Businessman/Software Entrepreneur

So, this is –

Michelle Consolazio Nelson – Office of the National Coordinator

So I guess my question is, Charlene we'll bring it up in your group and we can bring forth the comments that Mike just made.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

And I would just –

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul. Mike's comments are good and I don't see any reason necessarily to have past problems and current problems are only useful to list to the extent that they are – they help us create – help us maintain the record. One of the values of view, download, transmit is to the extent you have more patients looking at the data, they can also help you catch errors. It's a double-edged sword because they could also create some basically service kinds of challenges to make sure things are explained correctly. But, that's my comment, is to try to understand things. Things like lab results that are changing, might not otherwise be available or important to have their demographic information, is only important to the extent that it will help catch errors or omissions. That's important.

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

Yeah and Paul, we definitely need to talk about amendments, and that's going to come next. What I'm hearing is, and I do think you want some ability to have a past problem list with some elements of it, right, and I think that because; tell me if I'm right about this, particularly you Mike, as a practicing clinician here. This is really larg – this is view and download from the EHR, so it's going to draw whatever the current and past problem list is from the EHR, it's not creating its own, right. But you do want some past problems, because, at least from a patients perspective, if I'm thinking about my medical history and need it for any reason, I need to know, when did I break my leg again, gee, how long has it been, how's my recovery and trajectory happening; all that kind of stuff. So I think you do want some of that –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

– but I think in our question here is really, there are some issues around the problem list, up to date, interdisciplinary, blah, blah, blah, that other groups need to advise on because it lives within the EHR, whether that's Charlene's group or whoever, we'll let Michelle handle. But is there anything besides the care plan and maybe, I don't know about, we need to think about family health history that should be optional in this list.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So, this is Mike. I'll jump in again and maybe just to finish the last point on current and past problem lists. I think in part of our communication to the other groups, I think the question we want to ask ourselves is, did we really mean the past problem list or the past medical and surgical history? Because EHRs can store those differently. I have a whole large list of past problems, in terms of problems that have been resolved from my list, they don't necessarily go to the past medical and surgical history, unless we deem them significant enough to deserve an enduring place there. So, we just want to be thoughtful about that.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So likewise, for medication history, I'd just be very worried about my patients getting lost in any medicine.

Paul Egerman – Businessman/Software Entrepreneur

That's right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

They've ever taken ever, or allergies versus allergies and intolerances.

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

Um hmm.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So that's a common process that providers go through is the ability to say the difference between the two and since my PhD is in immunology, I bristle a little bit with us calling intolerances allergies and having that confusion. With that though, I would just add a couple of other things. Smoking status, the patient knows their smoking status, again is the reason we're putting it there to be a reminder to them about a health issue, to get them to verify it for us or what exactly is the purpose. If it's a problem, it'll be on my problem list, if it's just their status; the only reason I can think of to put it on there would be if they think that's wrong, they could let us know.

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

Yeah, I think that, this is – if I remember correctly, this has been on this list for a long time, I think it goes back to the original online access in Stage 1, the menu item. And if I recall correctly, this is back when there was a big focus on tobacco cessation, I mean there still is, but it was in the construct of meaningful use we had the quality measure that everybody is supposed to report on smoking status. So I think it was more designed, and I believe George Hripcsak suggested it, to be a reminder to the patient, yo, you're still smoking, as if they didn't know that.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

So, I'm more ambivalent about smoking status, I'm just not sure what the right clinical option is here. But I think what – if folks want to take a look at sharedcareplan.org, to me that's a great view of – or a great display of what VDT elements could be capable of, if you have enough data, and then you of course display it the right way. So, we can make smoking status optional, is that what you're suggesting Mike?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

I'm just asking us to be mindful of the notion that up to a point, more is better; after a point, especially if it's either a distraction or something that causes cognitive dissonance, then we're at the risk of having a patient get stuck or lost down another path that's not really telling them anything they don't know or leading to an action that they would not otherwise take. So I would consider if smoking is a problem, it should be on the problem list. If smoking status is something they already know, then we should think about whether we need it there as a reminder to do something next or instead, that patient portal, that view, download, transmit is an educational piece related to smoking, since we obviously have captured it in an EHR.

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

Yeah –

Paul Egerman – Businessman/Software Entrepreneur

And to take your feedback in a slightly different direction Mike, it seems to me, maybe the approach we need to do is we need to be sure that we go more than this minimal set of 3 items that it currently lists, something between that and simply saying everything. We need to think carefully...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right.

Paul Egerman – Businessman/Software Entrepreneur

– through what are the things that we need to add –

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

Yup.

Paul Egerman – Businessman/Software Entrepreneur

– to make sure we still have a minimal set, because depending on the practice, some of these things might be reasonable to include, and some might not be.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Well said, yup.

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

Yeah, so that's exactly what we want to do in the next five minutes. So, I'm going to put a time limit on it to try force us to be really practical about what we want to accomplish. And I think we need to think about the fact that this is – view, download, transmit is designed to support broader uses – patients uses of health information, but it is still, right, accessed via the EHR. But in this case, they can actually download it and combine it with other data from other EHRs, so, I would encourage us to think about what patients will use this function to do. They'll use it for their health care, like monitoring their care, managing their care and frankly, coordinating their care. So they'll send, well gee, here's my primary care information and I'm sending it to my cardiologist, so I don't have to recreate the wheel over there. They're going to use it for wellness, right, to monitor their own health. And so – and they may upload it into apps, for example. They're going to use it to access resources that are relevant to them; again, lots of applications that I think will come on the market. So the question is not – there are really two issues here. One is, what do want view, download, transmit capable of doing from sort of like certification only perspective.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right. That's right.

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

So I think we want, for example, you want the patient's name, because they're going to need to have their name associated with the data when the download it, in order to probably use it in some applications and match it up with other things, right. They're going to want their procedures and their lab test results and dah, dah, dah. But the care plan field doesn't necessarily apply to everybody and they don't always need it, but you want the VDT concept to be capable of doing it. So that might be something that we would say, let's make sure that stays in as a certification piece, but to Paul's point, what else besides problems, meds and allergies. And again, I'm leaning towards – should be required to actually have of either have a value in it, from the EHR which means that they have to collect the data in the first place, right, docs do. Or, if it doesn't have a value, it's because the information just isn't available or there's some legitimate reason, and they can have an exclusion, which is how this works today. Does that make sense to folks?

Paul Egerman – Businessman/Software Entrepreneur

Yeah. And so, yes it makes sense, in answer to your question. I guess one answer to your question is I would say – I want to add to the list lab results. I might say recent lab results, I'm not sure I know the definition of recent, but recent lab results. And I would also make a comment that maybe we should look at what's in the CCD as a guideline for what should be available to patients.

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

Right. All of these things are being collected by the EHR already, so this is not –

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

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

– a new –

Paul Egerman – Businessman/Software Entrepreneur

Understand. So I'd say laboratory results and I'd say possibly something that might be of value that's not listed here which would be immunization status.

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

Yeah, actually that's a good point Paul.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So for me a procedure that would be updated in the office would be a new immunization, so I think – this is Mike – so again, the notion of the fullness versus the updates during that visit, especially if you're going to make a 24-hour requirement for it to populate. So for example, I'd be much more interested as a patient, and probably for my patients as a provider, that what they're seeing within 24 hours is all of the problems that were assessed during that visit. Sure, the current problem list should be there, but that update is what's really important.

Paul Egerman – Businessman/Software Entrepreneur

So you're really looking more for like an encounter report or visit report, for the most recent visit.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah. Or again, the signal to noise issue. Yes, you may have 12 issues on your problem list, but to the point of what you're getting in 24 hours is you can somehow see that the three that were addressed at today's visit were hypertension, diabetes and asthma.

Paul Egerman – Businessman/Software Entrepreneur

Right or I went in for a –

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

So Mike, how do we do that? I mean, it's like – it's the same thing as like, so let's just – if you have an – portal, then it's pretty straightforward. If you start to share – transmit it somewhere, then that other portal will be aggregating, will have some past history in it and that kind of thing. So I'm just trying to think through how we make this work in terms of –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So maybe at the standards level one of the things you would do is, every problem assessed has the date of the encounter and the date it was assessed in it. So if you, for example, required that part of the information that transfers through is the date last updated or reviewed or done or whatever. And then the portal that the vendors make for us has the capacity of being able to organize by date, and the things that were assessed at the last visit rise to the top from that perspective, and can be organized in other ways.

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

So I think, we have to remember too, I guess I'm – the market is going to play a major role here –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

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

– and we don't want to be in the position of trying to dictate like workflows and things like that. So I do think that the market, particularly coming out of Stage 2, where there will have been a two-year experience with patients saying, hey, that's like not helpful to me, but that is and dah, dah, dah. And so I want to be careful about that. I also want to be – suggest that we're very careful in thinking about what kind of data that we would want to limit, in terms of display, even when it's available. Because there are going to be a lot of times where patients are going to want to take the data – that even though it is older data and past problems, and look at trending over time. Because I think we can't know what other types of data they're going to want to incorporate and then how they want to display that and how we can trend it over time and look at past history and think about how it relates, for example, to my functional status.

So I want to make a pitch for leaving this list mostly as it is, but knowing that other subgroups need to tackle some of the issues that Mike has raised. And what I heard is care plan, smoking status may be coming out as a requirement, but it's still available. Are there any other ones, I mean I heard Paul say lab tests, I heard Mike say procedures, those are good things to have. Problems, meds and allergies, I'm not sure about immunization status if it gets coded as a procedure, if everybody does that Mike or is that just some people put it in the procedure list, I'm just not sure. I'm not a doc.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

No, it's a good question and I think there is some variability around it. So, it depends on how you define it, yup.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right.

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

Okay. So I think given like the Surgeon General's real emphasis on immunizations, we probably want to suggest that that actually be added to the list, so we're just – I mean, it's in the EHR so it shouldn't be too hard.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and – this is Paul again. Because it would seem to me from a standpoint of patient and family, knowing the status, especially if you were somehow able to display the duration, this immunization is good for 5 years or something. That is perhaps useful for families to be thinking about for themselves or perhaps for their children. And I think this is a good discussion, I think about your summary Christine, I think also, I think Mike has valid comments about medication history and past problem list. I mean that could be a lot of information that may not be useful for view, download. I think we can simply report this discussion though, simply by saying that concerns were expressed that perhaps those should not be required items, so we don't necessarily have to define everything unanimously and definitively.

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

Yeah, I mean I think – so let's report both sides of that, because I definitely hear Mike's concern and we can share that with other groups. But I also would say that I don't have that concern, because I think people are going to want trending data over time. So I think I'm probably more inclined to rely on the market and maybe that's a question that we ought to ask other groups for their input on. So I just did a quick cross-walk between the conversation and this list and I think we're – the only one – there are two that I'm not sure where the group has landed on, one is vital signs, height, weight, blood pressure, BMI, growth chart. It's hard for me to imagine that not being a requirement because boy, you could really do some cool trending stuff with weight, blood pressure, BMI, growth charts, that I think patients would really benefit from in their wellness.

Paul Egerman – Businessman/Software Entrepreneur

Yes, you could if you're a primary care provider, but perhaps if you're an ophthalmologist and none of that's useful to you.

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

That's true, but there's the exception that's at the bottom of the screen, they would qualify for that.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, certainly and if you've collected it and you can share it, I think that's good. Growth charts I'm a little less clear on, just because growth charts in one practice might be well done and not so well done in others for Down's syndrome and things like that. The other part I'm just going to make one more comment about is the issue of the signal to noise ratio. I definitely agree with what Christine's saying about the notion of, if it's for viewing, maybe I don't want to see smoking status. But if I need to be able to download it and transmit it to somebody else who's going to use it as the medical history that changes everything. So there might be a little bit of a difference of that notion – it is an "or" statement, right? View, download and transmit –

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

Yup.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– you don't have to do all three and it doesn't have to all be displayable in all those ways. So, I think we might have a happy medium in that ability to do that. But I'd really be concerned about getting a transmission from a patient of all their past problems, all their past medications and all their past allergy history and then figure out, how am I supposed to deal with that when I get it.

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

Right, which I understand. I think, though, I don't think it's the right – I think the better strategy is going to be to rely on the ways that it's currently done today, when you try to have a patient fax you a 300 page medical record or they bring in a brick for you to look at. And the practice is really saying or the hospital's really saying to the patient, you know this is – nice try, but I need something different here's what I need. I don't want to rely on meaningful use as a policy mechanism to try to control that.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I agree. It's Charlene.

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

So one thing – so the other thing that we haven't talked about is family health history. This is a little more tricky because it was a – it's a menu item in Stage 2, it was originally slated to go to core in Stage 3, which is the collection of family health history. And one of the things that we did in the consolidation work was say, well why do you need to have that as a separate objective, you could include it in view, download and in the provider-to-provider care summary. And then it would have to be collected as though it was core, but you don't have to have a separate objective to it, or for it. Michelle – so what I want the group to sort of think about is that still the right approach and then, Michelle, did we – do we have public comments on family health history that we could consider at this point, because they would have said something, presumably, about core and blah, blah, blah.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, I apologize that I had put that together for the other group, for subgroup 1 to go back and make sure that it should be consolidated, but I don't have them ready for this group.

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

Okay. Okay, so do we need to come back to that then maybe?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, I think we should come back to that. Sorry.

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

All right –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

Hi guys, this is George. I'm just listening in.

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

Oh, hi George. Welcome.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

Thank you.

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

George, we have Paul Egerman on the phone, we have Mike Zaroukian, who's new to the workgroup as well on the phone, Charlene and me.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

Very good.

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

And of course our rock star ONC folks. So everybody, that's George Hripcsak from Columbia University, not the country. All right, we're finally ready to move off this slide, yeah?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

What did we decide on family history Christine? I forgot, I missed this – this is Charlene.

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

We need to come back to it because –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay, all right. I just didn't know.

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

Yeah, we should be considering the public comments on it, they would really help us, I think, with the decision and we don't have them quite available right now.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

All right. Okay. I'm with you. I'm sorry I missed it.

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

That's okay.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

This is Mike. The other question I would just ask about that though, from a logistic sense is if it's no longer a measure, how do we make sure people are doing it? It's consolidated –

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

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

It's consolidated into this, but how do you make sure people are actually collecting it?

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

Bingo. Yes.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Bingo. Bingo.

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

So, the whole – the discussion we've been having about required data or not goes exactly to that point. If it is a required element here, then it must be collected, because they wouldn't get credit for it if it's not, either the field isn't populated or they say, the information is not available, for example, like in case somebody's adopted or whatever, or they say there's just no information to record. So they have those two exceptions, but that's exactly the point –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

– which is, if we consolidate it, is it a good idea? Because it makes sense if it's going to remain core, and everybody's going to do it, then you put it in VDT, you make it a requirement there and then you've got one less thing to worry about, but you still have to record the data. But if the public comments came back and said, no, we're not ready, we can't do that; then we would have a different challenge.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, and the other part of this is, is that if it's a menu item and everybody's doing it, then you know it's ready to go there, because everybody's already in the habit. If only 10% of EPs end up doing that as their menu item, which I doubt, but if that were the case, then maybe it needs to go to core first, to prove that everybody's doing it and then incorporate it. Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And this is Charlene. I think, and this is the other piece I'm interested in. I know a lot – most vendors support capture family history today in their systems, and I don't know the extent to which it's done, so I think that points relevant. But they capture it in a lot of different ways, some ways even better than what Regina Benjamin has put up, and so I know there was some framework of standardization suggested in Stage 2, so I think we need to get our arms around that – those elements of it too, as we kind of move forward here.

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

Yeah, I agree with that. This is one of the areas where I think we're going to struggle to make a decision on anything, menu, core or whatever because we just don't know how the experience is playing out in Stage 2. And how easy it is to get the data standardized and represented in a way that can move around.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right. Exactly.

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

So, I agree. All right, so next slide.

Michelle Consolazio Nelson – Office of the National Coordinator

Christine, this is Michelle. You can tell me if you want to defer, but I am looking at the comments, and that is actually what they all said, we need experience with Stage 2. They didn't really want – most commenters didn't want it moved to core. But we had also suggested to increase the thresholds, so they thought doing both was too much, so, we can go back to is. But, I just thought I'd let you know.

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

Well, that's – I mean, there's no point in going back to it when our heads are around it now. So what do you guys think? I mean, I think what the public comments would seem to suggest, based on what Michelle is saying, is that we may not want to consolidate it here, because it may need to stay menu. But there's just no way to know, at this point. I mean, Stage 2 hasn't even started yet. So –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah we really need to get some experience with the standard, I think, too. It's like – I really think this is a space where the variability is so great out there, in the products as well as in the practice that we need to see where some sweet spots will start to fall out of this.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Christine, could we put in the recommendation that it was recommended that it was moved here, but you need the experience in Stage 2 and most of the commenters didn't want it moved to core, so, it may not be feasible, or do you –

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

– this taken out?

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

I think that's right, because I think that optically that's the better approach. We did say, may increase threshold, depending on Stage 2 experience for VDT overall. So, I think if we took a similar approach and said, may consolidate it here, depending on experience in Stage 2. I think that solves our problem. But we may not want to consolidate it as well.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. Thank you.

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

Okay. Thanks Michelle. All right, so on to the next slide we've got the overall comments about view, download, transmit. One is about the thresholds, so some people said, we sort of signaled like, hey, the threshold might increase, but it depends. And so some people said they were worried about that and others said it should absolutely be higher. So I think we can't do anything with that yet, because we need to see the experience and what we've learned from a lot of the thresholds is that there needs to be a threshold, but what it is, within reason, doesn't have a big impact. So if, for example, it turns out that people are wildly exceeding the 5% threshold and they've got 60% of their patients actively using it at least once a year, which I think is actually a reasonable assumption based at least on our national survey data, then we wouldn't – why would we bother with it at all? Right. So I just don't think we can do anything with this yet. Do you guys agree?

Paul Egerman – Businessman/Software Entrepreneur

Yes.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yup.

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

Great. Perfect. So, the concerns that we see on the slide are definitely not new. And again, I think we're going to need experience in Stage 2. Labs available within 4 days, most thought too soon, but some thought this was too long. But Michelle, aren't labs within 4 days, isn't that part of Stage 2 and wasn't it even actually in the Stage 1 menu item?

Michelle Consolazio Nelson – Office of the National Coordinator

I think the suggestion was to shorten the timeline, sorry.

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

But I think four – unless we went to calendar days?

Michelle Consolazio Nelson – Office of the National Coordinator

It was four business days in Stage 2.

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

Yeah, that's what I thought.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, it's still – it's the same.

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

Okay. All right. So again, I would say there's nothing to react to here yet. All right, AVVI, audit – this is automated blue button.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Can I make one comment about the 24 hours first? So this is Mike. So the issue is, if the view, download, transfer information is all reasonably expected to be collected before the patient leaves the office, and can be done at a high level, then that's okay. The care plans I worry a little bit about not being done within 24 hours, 5 o'clock patient, Friday afternoons, or even other times when it's just going to take a few days to get this care plan finalized, and I'd rather get it to your portal intact and correct, rather than getting it to you fast. I would just say that 24 hours, one business day would be a little easier to manage, and if we could make that suggestion, that would be great.

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

So one business day instead of 24 hours.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

Okay. I think that's fair. Anybody else?

(Indiscernible)

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I think that's good.

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

Okay. So Michelle, I think that's fine and that's a good one to make – but Mike, with respect to the care plan example, let me check my logic on this, and I'm going to ask Michelle to double check me here. If it is not a required field, then would it still be subject to the 24-hour time line or one business day timeline?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

That's a great question.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Everything else that I saw, just at a glance, looks like you would finish those before the patient left the office.

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

Yeah, that's the idea.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So that part looks okay to me.

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

Yeah, but I do think you're point about well what about Friday, you see a patient at 4 or 5 o'clock or even 7 o'clock, because hopefully the medical home model is going to open up some access, right. So I think the business day piece is a good call. But even then, I think the care plan, I don't think would be subject to that, because it's not a required field, but I want to check with Michelle.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Appreciate it.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, I agree.

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

Okay. So I think we're good with both. Moving right along, automated blue button. So for those of you who don't know what this is, this is kind of automated transmit. So this is essentially like you could go in and set your preferences and say, look, any time something significant happens, like I have an office visit or whatever, I want to you automatically send a copy of my information to my cardiologist. That's what this – it's just an automated ability to do that. Or you could go in and have a one-time request to send information from X to Y, which kind of, I never probably understood the difference between that and transmit, but whatever. So – but it's a set and forget piece, that's what auto blue button is. So overall, it looks like people were supportive of this. Michelle, can you speak more about the concerns about provider liability and privacy and security risk?

Michelle Consolazio Nelson – Office of the National Coordinator

I think it's the 42 CFR Part 2.

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

Yeah, I don't know what that means.

Michelle Consolazio Nelson – Office of the National Coordinator

I think Privacy & Security Tiger Team has kind of already talked about this. But, let me follow up with Deven or –

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

We have Paul.

Paul Eggerman – Businessman/Software Entrepreneur

The issue here is –

Michelle Consolazio Nelson – Office of the National Coordinator

Oh, you have Paul. Yes.

Paul Eggerman – Businessman/Software Entrepreneur

The issue is, first off, provider liability is separate from the privacy and security risks. These are like two different issues. The 42 CFR Part 2, Deven is the attorney, but basically this gets to some of the issues of sensitive data and segmentation –

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

Ah ha.

Paul Eggerman – Businessman/Software Entrepreneur

– which is a controversial area, controversial is sort of like an understatement. What we just normally do is say, yup, there's an issue there.

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

So – and this probably is informed by the work – the pilot that ONC has around flagging sensitive data?

Paul Eggerman – Businessman/Software Entrepreneur

That's correct. And Joy will be giving an update on that next week at the Policy Committee meeting. But again, as it relates to the automated blue button, you have a concept here of automatically transmitting data and so the concern is, well suppose there's some data that you don't want to transmit automatically, how do you – how does the patient express that desire, to transmit some, but not all data.

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

Okay, so.

Paul Eggerman – Businessman/Software Entrepreneur

But that's just an explanation, I don't think we want to talk about that issue; it's just an explanation of what that means.

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

Okay, so is there anything that we need to do about that now or do we need to kind of kick that to your group Paul, the Tiger Team and say advise us on. Because the other thing is, I'm – and I know we don't have Leslie Kelly Hall on the phone, but in the automated blue button pilot, is the patient able to go in and can they only say, send my whole record or can they say, send my med list when there's a change, send me this when there's a change, which would help address this.

Paul Eggerman – Businessman/Software Entrepreneur

It doesn't help address this, because if it's the med list has a change, but it's an addition of an antidepressant drug, medication –

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

Oh, uh huh.

Paul Egerman – Businessman/Software Entrepreneur

– then you don't want – it's possible that you don't want that transmitted, or the patient doesn't want that transmitted. But to answer your question, I would simply say, we just need to be aware that this is an issue and there's nothing more that this group really needs to do on this topic. We've got enough people struggling with this issue.

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

Okay. Good, we'll let you guys continue to struggle with it. The only thing that I would say is, this might be a little different because if I do have a med being added to my list, then I wouldn't – either I wouldn't sign up for this service in the first place, or I would say – or I would go in and unsubscribe immediately. So, because this one is patients choosing to automate who gets the information? Okay. So Paul, do you want to talk about – is the provider liability piece, I mean, this isn't you Paul. Provider liability meaning, what's their liability for looking at the data they receive?

Paul Egerman – Businessman/Software Entrepreneur

I don't know what that issue is there actually. I mean there could be liability, I suppose, on both sides, right, on the transmitting side and the receiving side. But, I don't know that issue.

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

Okay. I don't know if Michelle or Mike have feedback, but I believe this is the – and I know only enough to be dangerous. But I believe this is the issue of – that providers have encountered sometimes when they begin to participate in a health information exchange and receive data from and HIE which is what's my liability for having to look at the data and make sure I keep it in mind as I am now treating this patient. Because if something was told to me, and I ignored it, and then I commit a medical error or it contributes to a medical error, does that trigger my liability and is there going to be such a volume of data that I am looking for a needle in a haystack. I believe that's the issue. So, any comments on that, or Michelle, how – this doesn't feel like in – it's something that's in our scope, but it is something that the ABBI folks are probably thinking about and somebody's done some work on. Can you advise?

Michelle Consolazio Nelson – Office of the National Coordinator

So I'm just quickly reading through the comments in more detail to see exactly what they're talking about. I think part of it too is providing guidance to patients about what they're actually downloading, because there was that piece of this. But I think your point, other people are probably covering this, I'm just not certain, so I'll follow up.

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

Yeah, okay. So let's put that in our parking lot, because I do want to make sure – I'm positive that the ABBI pilot folks have got to be thinking about this, but, we don't want it to fall through the cracks, so if you wouldn't mind, that would be terrific. That is true that it has been another concern that was raised about warning patients about the download and like making sure that if you're about to download your data, you're not on a public computer, you understand that you're taking on the liability for protecting your data and giving them an opportunity to confirm. But Paul, I think your group; the Tiger Team did some work around this previously?

Paul Egerman – Businessman/Software Entrepreneur

That is correct.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

Yes, that's correct.

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

Yeah, so – what – and I remember that the Markle Foundation has some nice sample language –

Paul Egerman – Businessman/Software Entrepreneur

And again, I don't recall exactly, because those were warnings as relates to like computer security and safety and –

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

Yup.

Paul Egerman – Businessman/Software Entrepreneur

But that's not the same as provider liability.

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

No, I know, but correct. Michelle's raising –

Paul Egerman – Businessman/Software Entrepreneur

And that's a totally different issue.

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

But it's one that we need to, I think, make sure that someone has eyes on, just in case –

Paul Egerman – Businessman/Software Entrepreneur

Yeah, but that's already been addressed.

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

Okay. So we just want to maybe go back and look at those recommendations and make sure that – like do we need to include something in certification. I can't remember if there was a recommendation that we would need to include here. Because I remember asking the question myself, and I can tell you what hotel we were in in the Policy Committee when I asked it, and the question was, well did we need to make the systems capable of displaying that warning through a certification criteria? But I can't remember the answer.

Paul Egerman – Businessman/Software Entrepreneur

I don't remember the answer either, but I don't think we should necessarily repeat that, I mean, I think that it would be helpful for us to focus on what we can do to make the view, download, transmit function useful to patients and families and useful to clinicians also.

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

Right. So Michelle, maybe you can just go back and grab that Tiger Team recommendation, just to double check that there's nothing that we – that the meaningful use group needs to do to act on that recommendation. I don't think there is, but just in case.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. Yeah. Paul, do you have any idea what timeframe that was, just to narrow my search.

Paul Egerman – Businessman/Software Entrepreneur

Ummm –

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

It was more than a year ago I think.

Paul Egerman – Businessman/Software Entrepreneur

I do not remember the timeframe. We've done a lot of things and it seems like just yesterday.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. Thanks.

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

It was in the Marriott Wardman or the Omni, one of those two, I rem – because it's a weird room they put us in I remember it.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you. It was before my time, so that helps.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

I don't remember what room it was, but I know it did not have windows.

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

That's correct. Although none of them do –

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

We don't like you all to see daylight in the meetings.

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

Yeah, exactly. All right, imaging and radiation dosing. Okay, most were supportive of including imaging and/or radiation dosing levels for patients. Concerns were about the availability of standards, educating patients on radiation dosing and providing a link to PACS to avoid bandwidth issues. Okay.

Paul Egerman – Businessman/Software Entrepreneur

And how are we supposed – these are just the comments, are we supposed to be reacting to these or –

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

Yup. Yeah, so, it sounds all – I mean, it's all sounding like there doesn't – I'm trying to remember if this is a – I think this was a question. Yeah, we asked a question which was, exploring the readiness of vendors, the pros and cons of including certification for the following: which was images, actual images not just reports, radiation dosing information from tests involving radiation exposure in a structured field so patients can view the amount of radiation they've been exposed to and then add a menu item – hold on, I can't see it – ah, to enable patients to view provider progress notes. So, that's in the right hand column of the word document you guys were sent.

Paul Egerman – Businessman/Software Entrepreneur

Okay. So, I mean if I were to comment on that, I would say that the radiologists interpretation might be useful to include, but the images seems to me to be problematic from lots of different standpoints, one of which is the healthcare provider may not have the images. If they use a separate imaging center, plus the images these days, because there are CT scans or MRI or something, I mean that's a massive amount of information.

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

I think what they're saying is, providing a link to a PACS system, to avoid bandwidth issues. Is that right Michelle, is that what – am I interpreting that correctly?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes. Exactly.

Paul Egerman – Businessman/Software Entrepreneur

Even so, I just don't know how useful that is to a patient or a family to look at that stuff.

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

Well, I think if they don't find it useful, they won't use it, but I think not having it is potentially problematic. But also remember, this could be a huge driver in reducing unnecessary and repeat testing. Because if you're new provider doesn't have the image, I mean, I get asked all the time, I have back problems and I have a bum ankle, to bring image copies with me. And what I do is I go into my closet and I get these giant things that are like half the size of a door and I lug them with me. It would be very nice to be able to say, here's the image, here's the link doc. So this could be something that people could use for care coordination that was the idea. And I don't – I mean it sounds like the public comments were mostly supportive of the i – were totally supportive of the idea. Is that correct Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, just a few concerns that are noted there, but yeah.

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

Okay. So, I think the idea – the question – when we – when the subgroup here, Charlene will recall and George will as well, I think our question was, should we include as an optional field, so we can create the capacity of the view, download to do it, to have images, either copies of images or links to image reports. And it sounds like the public is saying yes, that's a good call. And it sounds like even radiation dosing levels, although the availability of standards on that – did the Standards Committee comments come through here on these?

Michelle Consolazio Nelson – Office of the National Coordinator

They're on the next page.

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

Oh. Thank you. Ah, okay, let's look, okay, perfect.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So meanwhile, this is Mike. If I could just comment again from the primary care perspective of with patients who are asking for – so clearly they're interested in their radiology results. They're main interest, probably 90 plus percent of the interest in the images is because somebody else needs them and they need a mechanism to get them to them. Most of the patients I ask, even when I tell them about their results, if I ask them do you want to see the image, they go "no." And because of that, one of my concerns in this is again the sort of bang for the buck on the one side and on the other side; it's the issue of letting patients into my PACS system –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

And all the security issues related to them getting into there and then what else could happen if they're linked in to it and I don't have robust mechanisms to keep them from going somewhere else.

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

So once they're viewing an image, I mean, they're actually viewing it like in your PACS system, they can navigate your PACS system?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Well, that's the concern. So in order to get into the PACS system, because that's the word I heard in the earlier part of the discussion, they would have to be able to log into the PACS system, that's correct. We don't have any mechanism right now in any of the organizations I work with where they're outside of the PACS system, but seeing their image.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I'm not aware of patients currently doing this in PACS systems. Maybe there are places where they are, but this is sort of new to me that patients do this.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

What they are interested in is the endoscopy image or the arthroscopy image of their knee when the doc was in there cleaning up the cartilage and so on and so forth. So I think there is definitely some role for images, I just –

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– I think we have to be really careful about any image that isn't exportable as a single PDF that is manageable in size to be able to convey to them, and that instead requires they get into the system. And these days, unless it's a chest x-ray, and even then, at the resolution necessary to be helpful without a tour guide, it sounds pretty problematic.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

It's a pretty high bar to reach.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah, I agree.

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

So the Standards Committee said the following, images are currently required in Stage 2, so – I mean, I think they're actually a menu item –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

But not to patients.

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

What?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

But not for patients.

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

No, no, no, I know. But what – I'm just reading the bullets.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Okay.

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

They're being implemented in EHRs and what their comments were is they are being uploaded today to inpatient records, I assume that means the EHRs as opposed to the PACS system, early stages for cardiology and other images, and then what you said Mike, eligible providers and patients may not have the need or the desire to view the image. Concern was expressed over the ability of patients to be able to receive large images. So, yeah, I feel like we definitely have some kind of interesting technical problems here and then on the other hand we have some public support for it, so I think we need to reconcile those. My suggestion would be that we – I'd like to – I wish Leslie was on the phone because she's very good on the technical side of this too. But we might reach out to a couple of folks and figure out is there a way to do this that would be useful to providers and patients, to make the image available to the, but given the caveats that I think Mike did a good job articulating, which is needs to be clear enough that if I am going to send it to my orthoped, that it's an image quality that is useful, for example.

So if the uses are really around care coordination, because I agree, I'm not sure how many patients are going to – they're certainly not going to want to interpret their own x-rays, but they may really want to do that – is share with their other providers. So, my suggestion, unless the group has a different thought, would be don't make any changes to – don't add it into view, download at this time, let's go out and talk to some technical folks and find out how this is being done, if at all.

Paul Egerman – Businessman/Software Entrepreneur

Yeah. This is Paul. I think that that last comment is really important, is it currently being done, are patients currently doing this. And that's important to know.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this harmonizes with the view I've been trying to express on behalf of the ACP since Meaningful Use started, which has to do with is there already enough evidence that this is a proven technology out in the field that's working, that could be easily adapted or incorporated in order for it to be a requirement. And when the answer is yes, I think you're on a reasonable glide path for it. I don't know a single orthopedist that would accept an image from a patient, from a portal, they would want to get into the PACS themselves, or they would want a CD. So we have that cultural aspect of what they need for quality to wrestle with as well.

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

Yup, agreed. So we'll do the looking into that. I'll just make one small clarification Mike, and that is, this was not proposed as a requirement, this was proposed as, should we create the technical capability. But, it's only – we should only ask the vendor community to invest time and resources in creating the capability if the capability will be useful to people. So that's what we need to figure out.

Paul Egerman – Businessman/Software Entrepreneur

But does the government create technical capabilities?

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

Yes, that's certification.

Paul Egerman – Businessman/Software Entrepreneur

No, I would just say certification is simply testing; it's not creation of the technical capability. I mean if this exists and people are using it, that's one thing, but for government to say vendors go out and create this, that strikes me as odd.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well you know what – this is Charlene. We're starting to see and this is from Siemens, the emergence in their marketing again, you as a patient come in to an imaging center, of putting your images in a cloud so you can go look at them. So again, it's not – you'll get a subscription and can go look at them for a period of time or something like that. So again, I think that – the industry's moving to a more consumeristic view of that, but I think the points made whether those would be accepted and what's the value of that, I think are still valid in the process. But you do see the industry changing.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

The other think I would just say in support of the vendors is, I'm also mindful vendors can't do everything and we often ask them to, so our apologies for that. But if I had to prioritize my – what would my patients be most interested in, the image or the radiation dose exposure they've had, they would have if we proceed with this test, etcetera, more of my patients at least would be much more interested in how much radiation have I had and how much would I get, and what would the risk of that be.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

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

Right. So that sounds like a good transition point. It looks like both the Standards Committee and the public are in agreement here on that point, that current software applications do provide the ability to capture radiation dosing data and it could be made available to the pa – through view, download, transmit. Again, I think this is something that would be a certification only criteria, it's not a field that's required to always be populated, unless you guys disagree. Unless it's actual – I almost – ask you guys, I'm not familiar enough with the current software applications. I mean, if they automatically calculate that, then it's not a data collection burden on the provider, but I'm not sure how it works. Are you guys familiar with it enough? George Hripcsak, I know you're on the phone, too.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

You have to ask again, it's hard to see.

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

So, radiation dosing is the issue here and both the public feedback and the Standards Committee feedback seem to support its inclusion in view, download, transmit. And what it says is that the current software applications do provide the ability to capture radiation dosing data and it could be made available to the patient portal. Lots of consideration of course needs to be given to patient's ability to understand it, there needs to be education. But if we think about including – I'm just asking you if you know enough about radiation dosing and the software applications that if it's automatically something that could be part of view download, or if it requires an additional data collection burden on behalf of providers.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

Yes I don't think we send from our PACS system or our – yeah, our PACS system to our EHR information about radiation dosing. I mean maybe its hidden – the DICOM images stay in the PACS system, the EHR maybe gets some report from what the radiologist read, but they don't contain it. You can maybe infer a little bit, but you'd have to do a lot of work to figure out what the radiation exposure was. I don't think you could actually figure out the actual radiation exposure. So that information's in a different system, it's in the ancillary system.

Paul Eggerman – Businessman/Software Entrepreneur

That's right.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

And furthermore, I don't know what the st – how each system differs, one GE PACS versus another versus another PACS system. So this seems like –

Paul Eggerman – Businessman/Software Entrepreneur

Yeah, and this is Paul –

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

...it would be fairly big thing to do.

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

Yeah, I agree with that.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah, I've not seen radiation dosing come across from a PACS system into an EHR, although I haven't seen a lot of these things. But, what's written here surprises me, if it really exists.

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

Um hmm.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, I –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike, I'll just put my patient advocate hat on though and say, images come from PACS because we need them, if we deem radiation dosing is available or enterable, we should decide whether we think that's important enough to do. I can tell you that having just sat through some cath lab experiences with people for go-live at a hospital, they certainly are recording the variable radiation that a patient may get during cardiac catheterization and putting it into the system and so, the whole issue of meaningful use including radiologists I think is an interesting question here. But I think one question is, how important is it to know the dosing and then with that, what do we need to do with standards, certification and eventually, if we must, at least for some circumstances, workflows to enter those data, just like we enter medication data when medication is potentially hazardous.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So that presents more burden if we go in that direction, right.

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

So let – this is Christine, let me jump in because I want to try to facilitate a decision. And the decision doesn't have to include radiation dosing or not, it could be go get more information. But where I'm struggling is that the public comments were supportive of including radiation dosing levels for patients and the Standards Committee seems to think it's a good idea, too, but we're skeptical. So how would you guys like to approach this?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike. I would say from our perspective we would just need to – we'd need to see what helps give others confidence that this is a reasonable expectation as opposed to a bridge too far, and see if we can support it at this time.

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

And this would be also around the workflow, I think that was the other point that came in is if it requires additional data entry, I mean, because I think the suggestion was that it goes on the report, right. If the PACS system could put it on the report?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
(Indiscernible)

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

Then in theory, we could like find it on the report and store it in our system, so there's ways of getting that data, but it would put a requirement on the PACS system I think.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and this is Paul. What I'd be looking for is some examples of organizations that are actually doing this. I mean I'm reading this again, it says the current software applications provide the ability to capture this data, and it could be data available to the portal. Well, what I'd like to know is, is anybody actually doing it, is anybody actually capturing the data and putting it into the EHR system?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

Oh, I doubt that.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

And if that's the case, I still think this is – if nobody's actually doing it, then it's sort of interesting and I'd sort of shrug my shoulders and say well does this rise to the level of a requirement.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University

You now, it's one thing for a hospital to link to its one PACS system, it's another thing for the EP to link to any outpatient –

Paul Egerman – Businessman/Software Entrepreneur

Oh, that's right.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

– every outpatient facility that does x-rays on their patients.

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

So why don't we do this, Michelle, we kind have this other parking lot item around images, can we add this to that list and see if we can find – well, I'd first circle back to the Standards Committee and figure out who the notes came from. And whether – like what their experience is and what they know, and then maybe potentially ask some other experts in this area about who's doing it today, utility to patients, etcetera.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

The other – this is Mike. The other way you may want to parse it as you're doing exploration is do we need to record every radiation dose of everything or do we need to be selective. So, if people believe some of the research that has come out in the last few years about CT scans increasing your lifetime risk of cancer by 1/1,000 lifetime risk chance per CT, then if we had that for a medication, we'd probably be recording that medication, because it's too important to miss. But a chest x-ray, on the other hand, is orders of magnitude less radiation and maybe it's not the first place we go for those things that we do require entry for.

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

Okay, great. All right.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And what do we do about those machines we walk through at the airport?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

They're microwave.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

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

All right, so the last one on this slide is, actually I think a question that ONC must have added; because I don't even understand it and we never discussed it. Does the group need to discuss this for you Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

Well, you got it Christine we added it. We could discuss it –

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

Did you get what you needed?

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry?

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

Did you get what you need in the public comments?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, I think the hope from ONC is always that the workgroup will put something forward if it's needed.

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

Okay, well, do you want to explain this one to us, because I have no idea –

Michelle Consolazio Nelson – Office of the National Coordinator

Well, I can only do it at a very high level myself, basically it's when you view a website there are certain requirements and I believe right now we're at a double A requirement and they want to move to a triple A. Or it could be we're at a single A and they want to move to a double A, I forget which one it is.

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

It's single to double.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. So, but beyond that I don't really know too much. I was ignorant to it when they added it as well. It's basically so it can be – so more people can view a website. So when you go to view, download, transmit, what criteria does it need to be at.

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

So it's for – well, okay. So the question is written in the language of EHR technology, but if it's a website that you're talking about, my suggestion would be that, and I can help you do this, but we can ask Clarke Ross and Rhonda Newhouse from the disabilities community. My guess is that this is about disabilities.

Michelle Consolazio Nelson – Office of the National Coordinator

Correct.

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

Okay. So they will know all the latest and greatest. Clarke is on the Consumer Empowerment Workgroup and perhaps we could help you reconcile and interpret some of the public comments.

Michelle Consolazio Nelson – Office of the National Coordinator

Great, thank you Christine.

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

Okay, we'll do that, unless any workgroup member wants to comment on double A conformance requirements. Okay, me neither. Next slide. All right, making progress. Okay. So, this is an interesting issue. So in the original Stage 3 recommendations from this group and from the Meaningful Use Workgroup, we realized that patients are going to be viewing and downloading information from multiple sources and that they will, very likely, catch problems; outdated information, incorrect, whatever. And so they needed to have – it would be most responsible for patients to have a way to offer an amendment to the record or an update or an addition or something, for the provider to then review. This is already a right they have, of course, under HIPAA.

And so the language we originally used was provide patients with the ability to request an amendment to their record on line through view, download, transmit in an obvious manner. And this was really basically like a certification criteria, we did not propose or consider having some artificial requirement about the number of patients who would have to use the function, because that made no sense. So this is just a certification criteria that would create the capacity for patients to submit an amendment, but we also didn't want the amendment capability to be like buried somewhere; we wanted it to be in an obvious manner. Well the public comments came back basically saying what does that mean? Fair question. So during the consolidation discussion, we had an idea proposed that this subgroup liked, which was to ask ONC to create like a branded icon, it could be a button, it could be a square, it could be whatever. But some sort of an icon that is ubiquitous and that patients could recognize from portal to portal or platform to platform, that if I click on this, I can let the provider know of these issues that I found in my information.

So what do you guys – so that was the idea that we had, sort of create a common user experience, and I think at this point, mostly what happened was, when we brought it forward, I think Paul Tang didn't agree with it and so asked us to consider it again, and so, here we are. So is there better, new, different way?

Paul Egerman – Businessman/Software Entrepreneur

This is Paul Egerman, the other Paul.

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

Yes, indeed.

Paul Egerman – Businessman/Software Entrepreneur

– which was why I gave my last name. I'm trying to understand what problem we're solving. Why isn't – I can understand why you would want to make it convenient or easy for patients to report additions or omissions or updates, but why as a common experience across all platforms. What's the – why is that important? What is the problem that that solves?

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

It's the first problem that you articulated, which is, making it easy for patients to do that, and not creating a burden on every provider and every vendor to have to create custom ways of doing it. That if ONC were to help kind of create an icon that everybody can just use, then it would make it easier for providers and vendors as well as patients.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and my response is, I would be opposed to this, I think that's overly prescriptive. We don't have to go that far. You can provide some best practices and guidance, but there are a lot of dangers in trying to do this kind of design work, it's not the kind of thing that I think ONC should be doing, is trying to design how the screen will work, what the button should look like. And the risk is it's awful hard to understand how it would work in an environment where the kinds of devices that patients are using are in rapid evolution. Read the literature right now, the laptop seems like nobody's buying laptops, everyone's buying tablets and what is the relationship between a tablet and your PDA and to try to figure out, ONC's going to develop one branded button, I think could be possibly harmful to technological innovation.

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

Okay. So, are there other ways that we can think of that would give us some – here's the challenge Paul. So if you look at the slides, the part that is the excerpt of the table from our Stage 3 recommendation, there's – how would that be implemented practically speaking?

Paul Egerman – Businessman/Software Entrepreneur

Well, the way I look at it is what you're trying to do here is you want to make sure that somehow the users are able to easily and conveniently amend their records.

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

Yup.

Paul Egerman – Businessman/Software Entrepreneur

And that's a variation of a broader statement, which is, you want to also make it sure that patients or consumers are able to easily review their medical information and that this is convenient to deal with. And it's just a very tough area to deal with, some of that has to do with how certification works, which is it's really not necessarily intended to be like a good housekeeping seal of approval, it's just supposed to say, you meet the minimum requirements. And some of that comes about through the marketplace, I think, selecting people and I think some of it also comes from you have percentage requirements, what percentage of the patients have to be using these things in order to qualify. And hopefully that causes a reasonable user experience. But that I don't think you can go too much more beyond that.

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

Well and so we didn't actually go that far, in terms of what you're suggesting. Where we started, is really helpful. Where we started was offer, so you see this has an objective and it has no measure, that's the problem we're trying to solve.

Paul Egerman – Businessman/Software Entrepreneur

Yeah. I understand. We're not talking about measure; I was talking about simply accessing, patients having access to their record, the view capability. You do have the measure around view, download, transmit. You don't have a measure around amendments, because you can't. I mean, maybe Mike does such a good job with his records that nobody ever amends them. So – it's – you can't really have a measurement around this one.

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

Well, so that was I guess the first thing we started with was, a requirement that people offer to patients the ability to correct. So this is the same process that we used with view, download in the first place where we didn't want people to do what we knew was happening in the field. Where you just sort of turn on a portal function or you set up an agreement with HealthVault or whatever it is that you're doing, and you don't tell anybody about it, and therefore it's not useful. So that was what we were kind of trying to avoid here was – I think folks were very worried that the landscape is about to change dramatically for patients. I mean in January, if your doc is doing Meaningful Use Stage 2, presumably you're going to have the ability to download your health information from multiple sources, it's going to be a Dave deBronkard moment where you see lots of issues, how do we make it easy for consumers to offer corrections? And how do we make it easy for providers, as well, to have communication coming into the practice instead of a huge phone call volume? That's where we're stuck.

First we talked about, okay, you've got to offer it. And then folks said, well that's not very meaningful because – well, some people were okay with it, but other people said, well, yeah, but then you're just sort of checking a box on the survey that you offered it, which is a fair point. And that's how we got to the branded button. So, is there any other way that folks can think of to make this visible for patients?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So maybe I – this is Mike, if I can just also take the other side of this, too. So, a major reason that physicians resist of course, is that there's a workflow burden, there's the issue of explaining why you do or don't agree and you're going to change or not change. But I think one of the things to talk about again is how do you make it easy for a patient to offer something? How to you make it easy for the provider to digest something, or their delegate? And so again, when you can tie it to something that then creates some actionability to it, that's a great thing.

Vendors I think will be challenged to set something up, because I don't know that anything exists for such a thing where the patient doesn't have the ability to say, well my diagnosis isn't trochanteric bursitis, it's hip enthesopathy, sorry. But the notion that says and we have this somewhat in our own portal where a patient can request an amendment to their record, so it does exist out there, but it's pretty free text and it's pretty clunky. We actually don't get patients asking this much, but we do get some, and so I don't know how big a solution is needed. But I at least resonate with the notion that it's a real issue that has to be addressed in some form or another, I just don't know, number 1 whether we're ready and number 2, if we have the solution that's going to work.

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

Okay. All right. So let me make this suggestion. I agree it's a real issue that needs to be addressed and I hear what Paul is saying that the design work like a branded button could be problematic, for all the reasons that Paul just articulated. So, why don't we – so the Policy Committee just formed a new workgroup on Consumer Empowerment that is separate from the Meaningful Use Workgroup and does not operate in the meaningful use arena, but perhaps this is something – and I actually Chair it. So perhaps this is something that that workgroup could take on relatively quickly to answer some of the questions that Mike just articulated, how do we make it easy for patients to offer amendments? How do we make it easy for providers to digest them? What's the actual step? And to the extent that the group comes up with anything related to meaningful use, we hand that off to the Meaningful Use Workgroup. But perhaps there are other ways of giving consumers, and giving ourselves, some assurance that this is a feature that's going to be well implemented and used. Does that sound like a better approach at this point?

Paul Egerman – Businessman/Software Entrepreneur

That sounds good. This is Paul. Yeah, that sounds good. I also think that this issue is interrelated with the issue of secure messaging –

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

– which we haven't discussed yet, but that's also an important aspect of view, download, transmit.

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

Right, and it was actually why, it was a huge reason why we included secure messaging in Stage 2, because we know about – .mechanism for folks. Okay. All right, so Michelle, we're going to put this one on hold, I think, until the Consumer Empowerment Workgroup can take a peek at it.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. So we're assigning it to you, thank you Christine.

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

Yeah. Thanks, right, I'm so excited. All right, next slide. Oh, oh this is the amendment slide. So 95 comments, supportive. Oh, okay. I think with respect to the – so we'll still take this on, but I'll just say that with respect to the last bullet around clarifying whether or not the provider has to accept all the amendments and if not, what parts of the record could have amendments, that's governed by HIPAA. So I don't think we need to get into that, that's not our domain right now. But I do think, Michelle, we should take those – that bullet and the 3 sub-bullets and probably clarify with Paul and Deven what, if anything, the Consumer Workgroup might need to take on, in the event that there's some issue here that's not already covered by HIPAA and what the Tiger Team might need to take on. Because I want to make sure that if the Consumer Empowerment Workgroup takes this amendment issue on, we stay very clear of the legal issue – privacy and legal HIPAA related issues, because that's not that group's domain. Does that make sense?

Michelle Consolazio Nelson – Office of the National Coordinator

Yup.

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

Okay, cool. So, next slide. All right, so here we are at patient generated health data. I think this is one where there were lots of questions about how to do this, what we meant, etcetera. So since two of our callers are new, I'll give you some background. So we originally as a subgroup there's – lots of people are really excited about patient-generated health data right now and they want to begin to have electronic health records have the capacity for accepting more types of patient-generated health data. We originally had started with like almost like a menu list where I think we had 5 or 6 different types of what we considered high value patient-generated health data. Which could be things like functional status or risk assessment, like the HowsYourHealth tool, or even patient experience, that we would say, pick one of these from a menu, based on what's most relevant to your practice. That didn't really work out very well because the lack of – we have standard vocabularies, but we don't have a standard, like technical standards, for that information. So after feedback from the Standards Committee, this is what we ended up with, which is a menu option to provide 10% of patients with the ability to submit some kind of patient-generated health information that supports the practice or the hospital in improving their performance on high priority health conditions, or in like patient engagement of care. We gave some examples, and we were really talking about a semi-structured questionnaire and then the EP or the EH would tell the vendor, okay, we want to collect health risk assessment. Or we want to collect pre-visit information or we want to collect information – we have a big diabetes project; we want to collect home glucometer readings, or something like that. And then they could customize this semi-structured survey information. And John Halamka basically said yes, good idea, to that approach. And Charlene, you were a big part of helping us get to this different approach, but he also said this should stay a menu item in order to just create the functionality.

So that was what we proposed. And on the next slide we should see the public comments. Okay. So mostly supportive, but they wanted to know what high priority health conditions meant and how it would be measured. There were concerns about being accountable for patient actions and burdening providers with too much information, which I think there – I think people didn't totally understand how this would work, so we can talk about that. Oh right, differentiating provider and patient data and then some really wanted it to be core, some thought it was menu, others thought we weren't even ready at all. So we've got a little Goldilocks kind of problem.

Okay. So I think the challenge before us is there is – so let me back up. ONC also has a technical expert panel that is looking at best practices for patient-generated health data in terms of workflow, how the data's being collected in practice, etcetera. So, their work may be helpful to us as well in thinking about this. But the idea was it's a menu item, so if you don't want to do it, you don't have to, number 1. And it is a menu item to offer patients the ability to submit their health information, which is not being accountable for patient actions, because all you're doing is offering the ability, which is a very common thing that we've done in meaningful use. It is not a percent of patients that actually have to submit the data. So that would be something we would need to clarify if we kept it in in this format. So thoughts about how we could make this a meaningful menu item for folks, because you definitely want enough people choosing the menu item, and if they don't understand it, they won't select it. So maybe if we can go back up one slide again, to slide 9, and give some thought to how we might clarify or improve this. So, questions and thoughts.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah and Christine, I wanted to add on a little bit. I'm actually excited that people supported this one. We had heard, the other piece of this one is we had gotten some pretty ... to the new members, some standup testimony around this concept. I don't think it was patient-generated data, I don't know if that was what our topic was Christine. But it was at the Hearing where people who have really been researching this area were pretty clear that again, if you – especially if you start to reach out and engage patients and capture data directly, if it's targeted, if there's a design principle, if you're trying to do something with it, you can put the framework around it so that it's useful, it's secure and all those types of things. And that seemed to be the current state rather than just making it less specific. So again, in light of what we're trying to do, and I was just on the Public Health call, trying to reach out and manage populations and putting that infrastructure in place, aligning this one to that same end – and again, we've got all these piece parts and they're supposed to fit together to help us do that. I think this part of that thought process, so I hope we can work this through to kind of get it aligned with these other pieces that we're trying to move towards.

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

Yeah.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So, this is Mike, if I can jump in. So this is actually something I've been doing for a long time in my EMR, it's something that if it's framed right and worded right, docs actually get excited about and even may demand. So I think part of the echoes that you're hearing with regard to concerns may be in large part because of the sense of the slippery slope of what will be required later –

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

Ah –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– and then, what liability might they have, etcetera, etcetera. I'd be eager to hear what vendors think about their capacity to do this, but both EMRs that I currently use can both do this and both do do this. And one of the powers of the Meaningful Use regs is it, number 1, helps shine a light on what's encouraged and again, I think this was one I was excited about seeing become a menu item because it'll move the organization to do more of a good idea, in very much the way you've got it described. So, I think language might be the biggest part of it.

But we've also sorted through and solved the issue of being able to separate the difference between data attributable to the patient, the ability to present that to the provider. The ability for the provider to accept it and then create another data field that says, this is now the physician accepted one and it's distinct from whatever the patient entered. So I think we have some examples, including the ones that I have that this is feasible, at least for some subset of EHRs. And especially as a menu item, therefore a little bit less pressure, but it is an encouragement to organizations that would like to do this, but need the encouragement of Meaningful Use menu items as an option, this is a nice way to get started.

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

Thanks Mike. So it sounds like we need to reframe it, and we'd love your help on that –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Sure.

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

Can you talk a little bit about the kind of patient generated data you have collected and –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Absolutely. Sure. So I give feedback to my staff whenever a patient coming back in for a comprehensive interval exam for whatever reason, preventive care, whatever, has not gone to the portal and completed their interval past, family, social history, review of systems and any problem-focused issues they have. So we have questionnaires for all of those things and all of the data from those go into structured data fields in the EHR, but our data entered by patient can only get accepted if we accept them –

(Indiscernible)

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– yup, exactly. And then, so there's two layers of data elements, one from the patient that never gets lost, but is not – is or isn't validated or changed by the provider, and then those that are saved. The other part that we have, of course, is the equivalent if you will of a patient monitoring process, so average blood sugars, daily weights, blood pressure readings, peak flow readings for asthma, etcetera, etcetera. So we have that whole series of at home, ongoing monitoring processes that – Stage 1 of that process is enter it manually, Stage 2 of course is, start to get device integration. But we span all of that here in mid-Michigan.

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

Okay. So yeah, and we actually started with trying to get the at-home monitoring device data included and the Standards Committee told us no.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, it's too early.

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

It's a non-automated way anyway.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, it's probably too early.

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

Yeah, although it's frustrating that it's –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Getting better.

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

Michelle, I'd like to reach out, I know you've got a lot on your plate, so let us know how we can help, but, I think it's worth reaching out to the Continua Health Alliance because every time their members speak with me, the Device Standards Group, they go, oh yeah, we have standards. So I just don't get it and I'd like to get it.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

So could you put that on our parking lot and we can divide and conquer later and reach out to what's his name, Chuck Parker, I think he's the executive director.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. Yup.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Christine, the other piece that I saw West Institute just published this incredible report in terms of the value of its medical device integration, so it's broader, broader than just at home devices, but still, in terms of workload and efficiency within institutions and all, in terms of how it increased productivity, it reduces gaps in care, it reduces redundancy. It's just like – so this is from – it seems to make sense that we need to move this one along, this whole concept, in some way –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yup.

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

Yeah –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

– on the broader perspective, not just within – at home, but we could certainly drive it from here.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, it's a huge win for providers, caregivers, every time we put a new one in, they love it.

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

So I think that also calls up the issue of the unique device identifier, the UDI stuff, which you know Pew Charitable Trust has been pushing, and it was actually a theme in the West report that you described Charlene.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Oh, yeah, you saw that then. It was a good report.

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

Yeah, well he testified at the same hearing on FDA –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay.

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

– yeah, as I did. But anyway, so I think – Michelle, is someone taking on, another group taking on the UDI stuff, because it does make some sense here if no one else has it, but somebody's got to put that in.

Michelle Consolazio Nelson – Office of the National Coordinator

MacKenzie, I don't know if you know, but there's a new FDA group being formed, I'm not sure what they're doing.

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

I mean in Meaningful Use, as a Meaningful Use subgroup –

Michelle Consolazio Nelson – Office of the National Coordinator

No, not in Meaningful Use.

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

Okay. I think we need to add that in here. There are enough public comments that do support it, by the way, and we've had a lot of public comment in the Policy Committee and on the Meaningful Use Workgroup, etcetera, so I'd like to propose that we begin to – it's a certification only criteria that we need for capturing unique device identifiers. Okay?

Michelle Consolazio Nelson – Office of the National Coordinator

Yup.

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

So turning back to kind of how should we – so it sounds like, because Mike, I agree, I mean every provider I talk to, they're like – whether it's a pre-visit agenda or whether it's an SF-36 or a VR-12 or whatever it is, the depression scale, the pain measurement. I mean, there is some really great stuff that they're doing. So the first issue is we need to frame this differently and since we don't have very much time left on the call, I'm wondering if you might help us offline, take a crack at how to describe this differently, within the menu parameter that you see on the screen right now.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Sure, I'll be happy to.

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

That would be awesome. And maybe Michelle can send you the word version and copy me or just send it back to her and copy me or whatever, that would be awesome. And then the second thing is though, do we need – I also heard you describe sort of two layers. One is these issues around – so the data – so let's say you have a semi-structured questionnaire that you can custom code and make it into whatever kind of history review and symptoms or whatever. You need the ability for the EHR to sort of accept – to store it, but then also the ability to trigger the physician to review it and either accept it or edit it and then accept it again and display it that way. I'm just not technical enough to know, do we need some certification criteria so that capacity exists across EHRs for this function?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

It's a great question. I wish I knew the answer to that. I don't know. I mean, in the systems that we've done it with so far, it literally was just making sure that we created a new database field that we could label for the same purposes that would duplicate the same item that would be entered in a structured manner by the provider and just give it a database field name that clearly identifies it as data entered by patient.

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

Okay.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

There's probably some work that has to be done and Christine, I've also seen out there for quite a while, products where they are these patient generated questionnaires where you capture your own history, it asks you all these questions. And it does – the provisions are in the EHR to accept that data and do that validation step, I don't know if – and then what Mike was saying is then it retains that consistently from the patient generated data as well as that data that's accepted in the system. But again, it's a workflow enhancement because – like it's patient self-service, the patients doing all the work and the doctor can just kind of integrate that information in with the records so, there's value to doing that.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So one other thing I need to add though, the elephant in the room on this that has been a new concern, I haven't validated it with my reading of CMS stuff. But there's at least the rumor out there that says that in some of the audits that are happening, physicians are not getting credit for data entered by patient.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Oh my goodness –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, right. So we have to either kill that rumor because it's not true or we need to address it with CMS, if it is true, because obviously it's the issue of validation and acceptance that makes it a part of the medical record, it's otherwise historical information that's not yet part of a note. So, I just want to make sure somebody can help reach out offline and get validation that if we do all this wonderful stuff, we won't be at cross-purposes in terms of accounting for the encounter billing.

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

Yeah Mike, can you reach to whoever you're kind of hearing that from and ask them to track down the source and come back to us. Because then – you're absolutely right, I mean, I would – but I'd like to understand what is it that they're not paying for because the data was entered by the patient. What does this mean?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yup.

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

It sounds a little fishy. So if you can help us pinpoint it with enough accuracy that we can take it back to CMS and ask them to dispel it or acknowledge it, that would be very helpful.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Will do.

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

Okay. Great. And then, by the way, this conversation it's really terrific, but it's really reminiscent of the correct/amend issue, that it sounds like a similar approach might work there as well, of creating a here's the ability to distinguish physician accepted data, for example.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, so Christine, I think there's going to have to be provisioning put in place in the system to do that functionality, to accept –

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

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

– and I mean whether they build – I wouldn't go to like – if they take it from a third party system and they can bring it in, that's fine too. I don't think we should perhaps say that you've got to provide – be able to build questionnaires and all that kind of stuff. But at least the ability to support that and let them figure out how it'll get fed.

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

Yeah, you're right. I agree. I don't think it always has to be the EHR; it could be ability to accept from another system or another type of platform.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right, because I think there'll be a lot of different places that'll get spawned out in the industry, right.

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

Uh huh. So, I think that's part of the framing, the reframing we would want to do, and I can add that in to whatever Mike works on. So the other thing I think we need to do, and I know we're at the witching hour here, so before we accept public comment, we also probably should reach out to Leslie Kelly Hall and some other kind of technical folks about this other question. And maybe Charlene, maybe you can help with this too, but –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Which one?

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

Well, this is, do we need – like, so if we need to have – what Mike described about there's a duplicate set of fields, but that are clearly labeled physician accepted somehow. Do we need to do anything from a technical perspective in Meaningful Use to create a certification criteria? Or, is it fine just to create the menu item and we don't have to worry about another type of certification criteria?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I think if you create that as a menu item, there will be a fall out of a certification criteria. We're going to have to put some capability in there, if we don't have that today.

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

Well we'd have to –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

But, we don't want to say, build the – you don't want to tell them to build the work sheet or to build the data collection, but it's really the ability to be able to collect that data and then support the integration within the record and maintain the provenance of each.

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

Okay. Yeah, so that's more what – I think we need to explain that too, because that's just –

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So maybe when Mike writes this up, I can look at that and then we can see what I would add to that, without –

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

Yup. Okay, that sounds good.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And I can get it validated by someone on the technical front I'll –

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

Perfect.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay?

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

Yeah, perfect. Okay good, so the three of us will work on reframing and tightening this up. Okay, great. All right. So, I think that gets us – well, that gets us certainly to our witching hour, that's for sure. And it has been a very productive call.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Very productive.

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

So let me first ask, we didn't quite get to clinical summary, which we were hoping to get to today, but we have the May 13 call to go through the rest of the comments and we'll add clinical summary to that. And then again, we have May 29, if needed. So let me ask MacKenzie to facilitate public comment and then once we're done with public comment, if any workgroup members have any other questions or final comments, and then we'll close. So, MacKenzie –

Public Comment

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Sure. Operator, can you please open the line 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.

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

Okay. Any comments or questions from the workgroup members? All right. Great. Well thanks you guys, really productive call. We made a lot of progress and we'll talk to you on May 13.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks everybody.