

**HIT Policy Committee
Consumer Empowerment Workgroup
Transcript
August 21, 2013**

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning everyone, this is a meeting of the Health IT Policy Consumer Empowerment Workgroup. This is a public call and there will be time for public comment at the end of the call. The meeting is being transcribed and recorded, so please remember to state your name before speaking. I'll now take roll. Christine Bechtel?

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

Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

And this is my first time saying some of these names, so if I say one of the wrong, if you could please correct me, I'd appreciate it. Rita Kukafka? Sarah Krug? Jan Oldenburg? Korey Capozza? Patricia MacTaggart? Ann Waldo? Ryan Witt? James Cartreiene? Katherine Kim?

Katherine Kim, MPH, MBA – Health Equity Institute Professor in Residence – San Francisco State University

Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Mary Anne Sterling?

MaryAnne Sterling – CEO – Sterling Health IT Consulting, LLC

I'm here. Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Casey Quinlan? Scott Fannin? Beth Morrow?

Beth Morrow, JD – Director, Health IT Initiatives – The Children's Partnership

I'm here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Clarke Ross?

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup, National Quality Forum

Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Mark Savage?

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Here, good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning. Alicia Staley?

Alicia C. Staley, MBA, MSIS – Patient Advocate, Co-Chair – Tufts Medical Center Patient & Family Advisory Council

Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning. Terry Adirim? Danielle Tarino?

Danielle Tarino – Lead for Consumer Education, Health Information Technology Team – Substance Abuse and Mental Health Services Administration (SAMHSA)

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Cynthia Baur? Teresa Zayas Caban?

Teresa Zayas Caban, MS, PhD – Agency for Healthcare Research and Quality

Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning, did I get your name right?

Teresa Zayas Caban, MS, PhD – Agency for Healthcare Research and Quality

Close enough.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Bradford Hesse? Kim Nazi?

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

Good morning.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning. Are there any ONC staff members on the line?

Erin Poetter Siminerio, MPH – Policy Analyst, Office of Consumer e-Health – Office of the National Coordinator

Hi Michelle, it's Erin Poetter.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy and Planning – Office of the National Coordinator

Mary Jo Deering.

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor – Office of the National Coordinator

Ellen Makar.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning all and with that, I'll turn it over to you Christine.

Jan Oldenburg – Vice President, Patient Engagement – Aetna

Hi, actually Jan Oldenburg joined as well.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks Jan.

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

Great. Well welcome everybody and thanks for joining again today. The first thing I'd like to do actually is welcome a new workgroup member, Alicia Staley. Alicia's brand new to the Health IT Policy Committee. She is a consumer representative, a terrific advocate for patients and families, also has really great technical knowledge of health information technology, so just want to give a shout-out to you Alicia and say welcome and thanks for joining us.

Alicia C. Staley, MBA, MSIS – Patient Advocate, Co-Chair – Tufts Medical Center Patient & Family Advisory Council

Thank you very much; it's an honor to attend. So thank you.

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

Thank you. So if we can advance the slide. We are, oh actually, I guess I should give a review of the agenda, shouldn't I. Can you go back one – I think I thought I had that later on. So if we – so looking at the slides, we had a really great listening session on patient-generated health data. I think we had terrific speakers who gave us an enormous amount of information. So really, what we want to do today is focus on thinking about getting your input on what were the key kind of points that were made. What were the most important, most salient points that we needed to take away from the listening session? The staff have done a great job of summarizing many of them, so I'm going to start by going through those and then I'm going to stop, and pause and ask the group for their thoughts and additions to those takeaways or changes. So, get ready for that, that's our first discussion.

Then we've – using those kinds of key points and takeaways, we have come up with some draft recommendations to present to the Health IT Policy Committee on patient-generated health data. So we want your input on those as well. So I'll review those after our first discussion and we'll come back and talk about those again and we will hopefully be able to finalize them and then move to public comment. So any questions before I jump in? Okay. Great.

So next slide – there we go. So just as background, as you guys recall, the Meaningful Use Workgroup asked us to look more closely at this issue of patient-generated health data and identify any policy issues that we felt needed to be addressed in order to support the criterion that is established in the draft Stage 3 recommendations. So typically, this is a workgroup that doesn't engage as much directly in the meaningful use work, because that's why we have a Meaningful Use Workgroup. But in this case, given the expertise of the members on this group, the meaningful use folks did ask us to weigh in. So that's the quick background. Next slide.

So the first thing we heard was a definition of patient-generated health data and this comes, in fact, from the white paper that was prepared for ONC by RTI. And the definition that was established in that paper was essentially that patient-generated health data are health related data, like history, symptoms, biometric, treatment history, etcetera, that are created, recorded, gathered or inferred by or from patients or their designees, in order to help address a health concern. So that's very different from data generated in clinical settings or through encounters, because it's patients who are primarily responsible for capturing and recording the data, and patients are directing the sharing or distribution of the data to their healthcare providers or other stakeholders. So it's complimentary to clinical data, but it's sourced by and from the patient.

On the next slide, so as you guys recall in Stage 3 draft recommendations from the Meaningful Use Workgroup providers can actually choose what kind of patient-generated health data they want to focus on. So it is a menu option, we actually have a slide on this a little bit later. But the menu option essentially is focused on using structured or semi-structured survey questionnaires to elicit particular types of patient-generated health data. That could be anything from functional status to patient experience to whatever. And we structured it that way because the broad range of providers in meaningful use makes it very difficult to narrow down and focus on any particular data sets, because everybody has different practice, and everybody has different needs for patient-generated health data that are important to them locally and to their patient panel. So there's a great amount of flexibility there, which I think is a good thing.

But what we heard in the hearing was that the most common kinds of mechanisms for incorporating PGHD included not just surveys, but also secure messaging and biometric or device data, and that could be directly from devices or it could be data that lives in the cloud. And those – secure messaging and surveys are in Meaningful Use, but biometric or device data is not yet. So we also heard that there were four things that providers need to be able to do with patient-generated health data. First, they needed to be able to receive it. They needed to be able to look at it, review it. They needed to be able to acknowledge and respond back to the patient so the patient or family member knows that the data was received and is being looked at and used. Then they needed to be able to record the important elements of the data that they've received in the electronic health record. Next slide.

So if we think about those four areas, we believe, and we want the workgroup's input, we think that Stage 3 does set up at least the receipt and recording. Whether it needs to set up the review and the acknowledgment, in other words, whether we need technical standards to do that and certification criteria, or whether that's sort of an inherent part of systems, is a question that we want to get input on today, and potentially from the Consumer Technology Workgroup of the Standards Committee that Leslie Kelly Hall chairs. We also heard, and this is a direct quote from one of our speakers, that when patient-generated health data is implemented appropriately, concerns are addressed and PGHD use becomes routine. Well that left us with the question what does appropriate implementation mean. What we heard from the speakers was that providers had developed very clear workflows around how was the data going to be collected in use and clear policies and procedures for both clinicians and for patients, so that everybody is operating from a set of mutual expectations for how this data will be recorded, used, acknowledged, reviewed, etcetera. And that we also heard that communicating those policies and expectations to patients and families was a pretty essential part of making the patient-generated health data use very routine to the practice. Next slide.

So we know that people have a lot of concerns about liability, right, they have concerns about the volume of information they could receive and their obligation to review that data. And what we heard though in the listening session was when providers are in the position of selecting the type of patient-generated health data they want to solicit, the way that they're going to use it and the mechanism that they're going to use for doing it, the liability is significantly reduced or eliminated, because they're in the driver's seat. So they're not opening themselves up to massive volumes of patient-generated health data under meaningful use, they're focusing on an area that means something to them, and therefore, they've built a workflow around how it will be received and reviewed and recorded and that's going to really address a lot of the liability issues.

We also heard a lot about HIPAA and we had talked before about whether HIPAA could provide a framework, a policy framework for this, and it does, to some extent, although I think it's a little more limited than we anticipated. So what we heard from our colleagues at OCR was that HIPAA really is a floor, not a ceiling, but it does establish rights around corrections. It establishes some rights around amendments as well and the ability to append information in the event that there's a disagreement between the patient and the provider. But at the end of the day, I think one of the key messages that we heard was providers and patients are in absolute alignment around wanting their medical information to be really high quality and to be really accurate. But we just need to make it easier for them and so that's a big focus for us today. So, next slide.

This is just a reminder of the PGHD recommendation in meaningful use. So it is focused fairly exclusively on structured or semi-structured survey questionnaire instruments. And even though we did hear from speakers that secure messaging is another mechanism that could be used, secure messaging is part of Meaningful Use Stage 2 already, it's – I would expect it to continue to be part of Stage 3 as well. I think it was simply harder for the Meaningful Use Workgroup to envision how you would build an objective and a measure around the use of secure messaging for patient-generated health data when obviously we're making it available to patients and providers for many other uses as well, basic communication, etcetera. So the criteria for meaningful use is fairly specifically focused on the survey instrument idea, or the questionnaire, and that's what you see on your screen here. And so we can talk about that if folks want to as well. Next slide.

So, that's our summary, but I want to open it up for discussion now and get your guys input on other key takeaways that you picked up on or thoughts and comments on what we heard. And then we will use that discussion to inform our next discussion, in a few minutes, around the draft recommendations. So, I'll open it up to the group.

Beth Morrow, JD – Director, Health IT Initiatives – The Children's Partnership

Christine, this is Beth Morrow.

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

Hi Beth.

Beth Morrow, JD – Director, Health IT Initiatives – The Children's Partnership

Hi. One thing that I thought, I mean it's a little bit incorporated in your summary of takeaways. But I felt that it might benefit from adding another bullet about the fact – what Joy Pritts was speaking to about the need to record provenance of the data to ensure trust and that there's a need for greater consistency and standardization, since then that might lead to work by the other committees.

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

So something on provenance, that we need to record the provenance and we need to make some – continue making progress, is that the essential points?

Beth Morrow, JD – Director, Health IT Initiatives – The Children's Partnership

Yeah.

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

Okay. Thank you. Good.

Katherine Kim, MPH, MBA – Health Equity Institute Professor in Residence – San Francisco State University

Christine, this is Kathy Kim. I don't remember if we had the discussion about this but it struck me when we were talking about secure messaging. And I – it seems that most of the secure messaging that's happening is happening just within one EHR and there's not really messaging that allows a consumer to go between the multiple providers that they might actually be seeing. And so I wonder if there could be a comment about that, the ability for a consumer to message with multiple providers without having to go to multiple EHRs. And one of the areas that I know there's just started to be talk about was whether the Direct standard and direct email addresses would be available to patients and not just clinicians.

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

Yes, and Leslie's on the phone, or maybe any of the ONC staff.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

Do you guys have thoughts about where that's at? I think, I mean you can, a patient can get a direct address today I know through HealthVault.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes. So when – in the Blue Button standard, when you go to transmit, most of the vendors are saying please enter the direct address you would like that to be transmitted to and it implies that that will be a provider direct address at this point in time for transmit. And the questions about where does a directory live, does a directory live, are still being thought through. The assumption is that a patient would ask their provider, what are your direct address? Can I email you and send you information; I'd like to transmit that. So that whole workflow is still to be discussed and worked out. The directory service of a provider direct address for other providers are still being discussed. How will that work? Is it regional? Is it national? Is it private? Is it public? Now adding the patient to the mix, that adds a whole new level of discussion. So that's still being worked on and I invite anyone else to comment on that.

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

So Leslie, where is the work stream happening? I know we've heard from the IE Workgroup of the Policy Committee around directories that are really physician – I mean, they're directories of physician direct addresses, right? And people have talked about using the meaningful use attestation process as a way to either capture or issue a direct address, and then therefore build a provider directory. Is anyone – I guess I have two questions. One is are there any other groups other than the IE Workgroup working on that that we should engage or make a recommendation to?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Um hmm.

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

That's my first question.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Oka, so the Direct Trust Group is working on some of those questions, the technical solutions and the trust framework that would allow that, and that's being discussed today.

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

And they're part of what? Are they –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The Direct Trust is under a coop – what are the right words for that Mary Jo you would know that?

Mary Jo Deering, Ph.D – Senior Policy Advisor, Office of Policy and Planning – Office of the National Coordinator

Yeah, I was going to say, well Direct Trust, of course, exists as an independent organization led by David Kibbe, and they received one of our two governance grants. And so they are working on provider directories as a specific task as part of that cooperative agreement. And I know that they'll have some deliverables over say the next six months or so.

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

Oh, great.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

And this is Kim Nazi. So, at the same time, concurrently, there are several projects that are aiming to draw on the decisions made as this discussion evolves. For example, VA is aiming towards a proof of concept that enables that transmit and kind of tracking with the decisions about – some of the decisions that were just brought up about the provider directory. I think our experience so far has been that recipients have a domain and an identity within that domain, so the HealthVault example you offered is right on track. So, if a patient were to want to transmit VA information, let's say, to a non-VA provider, if they had the direct address, which is comprised of both the domain and the identity of that provider, they would be able to enter that into the system to authorize that transmit. The other piece of it though, I think is that doesn't enable a direct response to the patient.

So therein, I think, is where the discussions are kind of playing out to say, do we do this at the system level to authorize that transmit and the certificates are handled that way or do we anticipate the need for patients to have direct addresses as well. And then the second question would be direct addresses within domains or independent of domains, right? So –

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

Well I think I would add to that, this is Christine again, that it does raise some issues that are not in play, for the most part, in the context of the way the meaningful use recommendation is structured in that it is structured so that the provider is very much in the driver's seat of selecting, well what kind of data? Which patient's do I want to ask for this from? How do I set up the mechanism to receive, record, review and acknowledge that data, etcetera? If consumers have direct addresses and they have access to provider directories, then they could potentially send unsolicited patient-generated health data to providers, which I think calls back into play some of the liability issues, if I'm not mistaken.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's also – this is Leslie. The big questions are when you begin a dialogue with a patient and you give them the opportunity to view and download or transmit, that implies a certain level of risk, which is very, very low. And you know who the patient is, you've seen their driver's license, you've had a relationship with them. When information comes from a patient that's unsolicited, is there a way to know who that patient is? Is it, in fact, that patient and what do I do with that data? So there is continuing discussion, and I think it would be worthwhile to have this group maybe take some time with that at a future time, about how do we handle that inbound information, that isn't in response to a provider, that's either initiated by the patient and what do we do with the information.

So today, when we do view, download and transmit, we transmit from – we ask a provider to transmit data from them to another provider, there's a relationship established, there's identity and there's trust between those providers. That information might come inbound to them, and they might not have a relationship with that patient yet, but it implies to that second provider, hey, something's going to happen, I've got more information about this patient, I can expect further action. So there is discussion about that inbound information that's unsolicited from a patient, how do we manage it and handle it. Most organizations have found that there isn't the noise they anticipated, but it's still something to be worked through, a lot of it around the level of identity and assurance that the provider has that this data coming in is from the party they say they are. So that still has to be worked through.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

So this is Kim and that also speaks to the recipient end. So one use case, right, is that the provider provides the patient with their direct address for the purpose of being a recipient via a secure channel, right?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right. And I think that use case where if the provider is the intermediary for the creation of a direct address for a patient, there's a high level of trust. However, if a consumer wants an independent relationship with any other provider, do they feel that they have to go through that intermediary to establish trust or establish identity. Those questions need to be worked through. I think that VDT gives us a lot of opportunity to learn and to hear how is transmit being handled, how is it being received? Now how do we incorporate new data? And the questionnaire and response will give us a tremendous opportunity to learn and see what additional value can come. But many patients would say, I want to say more than just what my provider is asking of me, so, we have a lot to do.

Jan Oldenburg – Vice President, Patient Engagement – Aetna

This is Jan Oldenburg and I have a question about whether we need to think about something regarding aggregation and summarization of patient entered data. Because it seems to me that whether I'm doing blood pressures or peak flows or blood sugar readings or whatever, that it's not the individual readings that are most important, it's the trend that it shows. And both honestly for the patient as well as the provider, to make sense of it, that realistically we really do need some ways of aggregating, displaying, graphing the data and that's nowhere covered in this, but it feels to me as if it's real – that it's a necessary step if it's really going to be useful data. And I don't quite know where you'd put the reg, but what to other people think about that?

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

So Jan, its Christine. I think – so in my head right now, I'm starting kind of a section on PGHD 2.0 recommendations. I think that most of our key takeaways we heard in the listening session and our recommendations for this conversation are going to focus on 1.0, how do we do this now? How do we get it started? But in 2.0, there are some real issues. So the first is what we've heard around the need for some group or groups to examine the policy issues, the workflow, the liability issues around unsolicited PGHD, whether that's from secure messaging or devices or whatever.

But as to your point, it is definitely one thing that we heard in the listening session. I would tend to link that need to biometric and device data, so not only, and I think that's our second kind of 2.0 recommendation, and we're going to talk a little bit about whether we can get some foothold in Meaningful Use Stage 3 here in a second. But if we can work through – the standards are the problem with biometric and device data. But it just seems to me that that's the area where you need the summarization and the aggregation, you need the trending. The providers do not need to download all of my FitBit info into their EHR, but they do need to see the trends, and that's one thing that we really want to enable. I'm not sure we can do it in Meaningful Use 3, but that's a point that we want to talk about.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Christine?

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

Yeah.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

This is Mark Savage. To your question about any other key takeaways, there are three that I would add. I think we heard that patient-generated health data is not new and its value – say family history for example, its value that's incorporated in the clinical record. So this is just a helpful reminder that there are some ways that this has already been used and trusted. We also heard some examples of what I would call patient reported outcomes and the use for quality measurement. I think it's good to flag that given all the effort around quality. And also there was a chart in the National eHealth Collaborative presentation, page 11 that sort of captured some of the breadth of use already in place and it might be good to add a sentence about that.

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

That's great Mark, that's really helpful. I li – yup, I think that's right.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

This is Kim. I also wanted to add something.

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

Um hmm.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

So what I – one takeaway that I think is probably part of this, and I would ask the group to consider where it fits is, the patient authorization of data sharing. So the reality is, you've got devices, apps and patient portals and patient authorization of data sharing with appropriate degree of granularity I think is kind of a key foundation for that. We know from the literature that there is some data that shows that patients will download apps, but then abandon use of those apps when they discover the degree to which their data is automatically shared. On the other hand, we have patient portals and one approach would be to provide the patient with an effective means for also expressing their data sharing preferences, one of which would be enabling a view of the data for – within the clinical information system for the healthcare team. So is that something that belongs here somewhere?

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

I would say, I think that's a great point. My instinct, unless people have other thoughts, is to put it under our kind of 2.0 recommendations, which could form sort of a roadmap for the future work on this issue. Because I think authorization of data sharing in the context of the way the Meaningful Use Stage 3 PGHD item is set up is not necessary because it's inherent to the process, right? The provider's going to say I want this kind of data and I'd like you to submit that to me, and then the patient has the choice of whether or not to provide that. But I think when it becomes – where it's going to become much more important is where there's either unsolicited data or its device data or things like that. So I think – I would probably put it under the 2.0.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

And Christine, this is Mark. Once the provider incorporates the information in the record, it becomes subject to HIPAA, where there is sort of disclos – there can be disclosure without having to go back to the patient around authorization. So we would want to think through whether there's any cross-connections there.

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

So you're saying, even – so if I come back to the point you made, which I think is a very good one, where PGHD is not new, it's already valued and incorporated in the record today, under basically a similar workflow just involving paper or conversations. Do we need to worry about those issues today, in this context, given that HIPAA covers disclosures for treatment, payment, operations or is it more of a future state issue in your mind?

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

What I'm thinking is that when it becom – when the doctor uses it, incorporates it and say wants to pass on some of the patient's family history to a specialist in a referral, that can happen under HIPAA, it's part of the treatment prong. And so there's not an authorization – there's a legal permission and not an authorization requirement in that context. I'm just pointing out that some of the question's already been handled.

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

Got it. Okay.

Ann B. Waldo, JD – Wittie, Letsche & Waldo LLP

This is Ann Waldo. I would just echo that. If you create a mechanism whereby patients can express their preference about data sharing, but then the data is going to be going into the medical record, HIPAA takes over. And I think you would end up with some mismatched expectations if people say, share my FitBit with Dr. X, but not Dr. Y, well once it goes in the clinical record, it can be used exactly as HIPAA allows and it can't be used in any way that HIPAA doesn't allow. So I think given the setting that you're talking about patient-generated data going into clinical records, my inclination would be to just let HIPAA reign as it reigns today, rather than create new expectations that couldn't be fulfilled.

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

Okay.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy and Planning – Office of the National Coordinator

This is Mary Jo Deering and I just wanted to mention that I think this also touches on the concept of meaningful choice, that the Tiger Team has brought forward, which certainly isn't in meaningful use per se, but it's a policy recommendation that's out there, which certainly would bring us into that question. But again, it's not specifically part of Meaningful Use Stage 3 right now.

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

Okay, that's a great point Mary Jo.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I would just add in our future use cases of patient-generated health data that that's already being discussed today, is that patient-generated health data today considers pretty much a binary relationship between the provider and the patient. But yet we know as care teams evolve and become much broader than just that individual physician or that individual patient, to include non-traditional care team members and provider – or patient families and caregivers, that that care team concept presents another level of how do we handle generated data from any team member and provenance issues and so forth. So that becomes maybe our 3.0 issue, although it's already being discussed today.

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

And so how patients would set preferences for that, is that what you're suggesting?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I'm just – I wasn't talking specifically about preferences, I was talking about the next – you had some buckets –

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

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– kind of the version 1, version 2. The natural conclusion of having people starting to communicate is that the communication expands to a broader audience and the care team, including their family and caregivers, is an important concept and that collaboration platform is something that's being discussed and will be important to think about for future stages.

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

Okay. Great. Thank you. All right, other thoughts on key takeaways before we kind of jump into these draft recommendations?

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

Well this is Kim and I just share a reaction I had on slide six in the bullet providers, under Meaningful Use 3 draft recommendations, can choose. And I think I had the same reaction when we – we were at the listening session. So I'm assuming that's kind of at the organizational system level, if you will, rather than implying that an individual provider within an organization would kind of accept or reject patient-generated data, because I think that implies the power dynamic is only on one side, do you know what I'm saying?

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

Yeah, although I'm not sure that I totally agree, although it would be – so right, policy is kind of a blunt instrument sometimes, so it certainly could set up that dynamic, but the idea, anyway, conceptually was to create the capacity within the EHR to do that. And if it's an institutional policy that the system level is the one that sets the priority, and said we're going to work on functional status, and all of our EHRs need to collect this for these types of patients. I don't know that we have any control over that. But the way the criterion is set up, it would absolutely not preclude at the individual provider level, so if you have a specialist or someone who – or even a primary care doc who really wants to focus on back pain, for example. And does that patient reported score of pain and other ways that their function is impacted, it would not preclude that at all. So it's really going to be up to the provider and the systems to figure that piece out, and I think we can't control that really in meaningful use. We just need to enable the ability to do it. Does that help?

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

It does and I agree with those concepts and would just caution us to be sure that the language that we use doesn't imply the reverse, right, so –

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

Right.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

– okay.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Christine, this is Mark with a question in a similar vein. The definition that's on slide 5, do you see us using that in our presentations, because if you do, I had a suggestion about it.

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

Well what's your suggestion.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

On the first – on the definition, I would add environmental factors to the list, so things like lead abatement, the knowing that there was lead in the house, it would be –

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

Yeah. I think it's a good question Mark. I mean we're sourcing the white paper, so I don't know how much we could change that.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Okay.

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

But I think what I could do is as we present this, in the category of and other information, I can at least verbally say, including things like environmental factors, etcetera, because I think that's essential. I just don't know how much leeway we have to change their definition.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Right. Or we can – if you think it's important that we have one, and it's going to get used and referred to down the line, we could just do our own.

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

Okay. Thank you. All right, so I'm adding a point on that. Okay, so let's jump into the recommendations, because we've got about 20 minutes left. So, if we can go to the next slide. Okay, so based on all those key takeaways, here's where we're at. So I'm going to do a run through and then I'm going to go to my own notes, add a couple that I've heard you guys talk about and then we'll have a discussion.

So the first recommendation is that in order for this to work, provider organizations really need to establish policies and procedures for handling PGHD including what's the content that they're seeking, what are the mechanisms by which it can be submitted, received. And how it will be received, acknowledged, recorded and reviewed. That's the first. So we'll really need to get the information we heard out to the provider community. Second is, once they've established those workflows, policies and procedures, providers need to really communicate those to patients and to their fellow providers and clinicians, so that everybody's on the same page and has mutual, common expectations. The third is, ONC should work through its channels to do these things, to educate providers. So certainly they have the website, certainly they have RECs, they've got the HIT Resource Center, the national piece of that. And you guys are more than welcome to add more. Next slide.

We also want to make a couple of requests to the Standards Committee in the form of recommendations. So first is asking Leslie's group to examine the standards and the market for the feasibility of including device data in Stage 3. This is not a new issue and we – the Policy Committee was told by the Standards Committee pretty early on that the answer is like no, we don't – the standards aren't ready. But given what we heard about some more modern approaches using the cloud, we want to ask the Technology Workgroup to really think about, are there some innovative ways that we could at least create some certification criteria to enable that for providers. And I think going back to our discussion earlier, it would include looking at, do we have – what's the best way to do that in a way that shares aggregated trending data rather than getting every piece of granular data into the record and overwhelming providers.

So the second ask is, since we're not the standards and technology folks, meaningful use as I mentioned, set up a way to solicit and receive the data. But we want to make sure that the ability to acknowledge back to the patient, your data was received and the ability to – I think review is covered, but the ability to then record it is also capable today, whether that means standards or its potential that I know several EHRs do have the ability to do that today. I recall Mike Zaroukian talking about how he takes patient-generated health data in, he looks at it and then he creates a mirror image where he picks the pieces that he needs to incorporate, and then the record has a way to suck that in and ingest it into the EHR. So we just want to make sure that bef – as we set this thing up, we've got those capacities in place, if they need to be. And then the third, back to Leslie's workgroup, sorry Leslie, is to identify any necessary standards for that – for those ideas, right, so the ones that I just covered. So it may be that three is a little duplicative of one and two, as I'm looking at it.

All right, next slide. So, thoughts on that – actually, let me go back and add the others. So, we're adding some new takeaways, which I won't necessarily cover, but we do have some recommendations around the 2.0 kind of roadmap here. So the first is, we need to recommend that some group, and I don't know if it's Direct Trust, if it's us, if it's Leslie's group or otherwise, need to examine policy, workflow and liability issues around unsolicited – what we talked about was patient secure messages that contain patient-generated health data. We might broaden that to just say unsolicited patient-generated health data. The second is biometric and device data, figuring out how to summarize and aggregate it, get it into the record. And then the third is the patient authorization of data sharing and setting those preferences. So that's – those would be added here. So, thoughts on these recommendations, is there anything missing? Is there anything that you would change?

Katherine Kim, MPH, MBA – Health Equity Institute Professor in Residence – San Francisco State University

This is Kathy Kim. I wonder on the education piece of this if we should add sort of marketing and education to consumers, not just providers.

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

Umm – that's a great question. And I think the question in my mind is, who does that? I would imagine that it's the provider, because that's where the trust relationship is. But are there others you're thinking that should explain this?

Katherine Kim, MPH, MBA – Health Equity Institute Professor in Residence – San Francisco State University

Yeah, I think just at a policy level that we know there's already so many obligations on the side of the – that we're expecting from providers, that at least we could be provi – be offering materials or messaging or something that the providers can use to get that word out to them. Rather than expecting that providers are just going to do all the education of consumers.

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

Okay. Great.

W

And if there perhaps were a role for public policy education on this kind of thing.

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

And what do you mean when you say public policy education?

W

Well, I'm thinking about the kind of advertising campaign associated with the food pyramid or nutrition facts or seatbelts, etcetera. I mean we – whether it's a broad educational campaign associated with helping consumers understand both their rights and obligations. And just wondering whether somewhere in this we should be thinking about those kinds of aspects of the cultural education, if you will, about the promise and potential and consumer responsibilities associated with health IT.

W

You're talking about with public service announcement kind of things.

W

Thank you. That's exactly what I was looking for, I couldn't remember what it was called.

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

So there, and you said – I missed the last where you said education around their rights and obligations when it comes to was it health IT generally, was it PGHD specifically.

W

Well, I think there is – we know that probably health IT generally would help them, but I was thinking specifically around PGHD.

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

Okay. Great. And I know OCR has done a lot of work around what I think is probably the underlying issues that you're pointing out, underneath PGHD, which is more around your rights with respect to the information in your medical record. So we can talk with them and see if there are gaps that they think need to be filled that we could include.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup, National Quality Forum

Christine, this is Clarke Ross.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Christine, this is Mark –

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

Uh huh, hi Clarke.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup, National Quality Forum

Hello. Health plans and their providers are required to do consumer assessments and that would be a vehicle, CAHPS and ECHO, would be a marketing vehicle to remind both systems organizers, providers and the consumers who are participating in ECHO and CAHPS of this dimension, where the healthcare system is moving. So just offered as another vehicle to get the message out that's consistent with what systems and providers are already required to do.

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

Great.

Beth Morrow, JD – Director, Health IT Initiatives – The Children’s Partnership

Yeah, similarly – this is Beth Morrow, I’m a little bit worried about not having some reference here to the HIPAA requirements regarding corrections, too. So that as a developer, for instance, is looking at this one place to identify what needs to happen, that might get left out of the picture and providers don’t – we sort of need to somehow wrap that element in. Even though maybe it’s already addressed by HIPAA and ensure that in this context that you get the corrections made in the electronic format, where there are need to do so.

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

Thanks Beth. So I think we can do two things on that, unless ONC blows the whistle on us, which is one would be expand on that notion in the summary of the hearing, right, because we did hear a lot about it. And then the other would be in the recommendations around setting – provider’s setting and communicating clear policies, maybe beef up the references to understanding consumer rights for amendments and corrections, etcetera.

Beth Morrow, JD – Director, Health IT Initiatives – The Children’s Partnership

Yeah.

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

Because my sense is we do have to be careful of not running afoul of the – of our scope here –

Beth Morrow, JD – Director, Health IT Initiatives – The Children’s Partnership

Right.

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

– which is not privacy and security, but it is engagement and this is fundamental to that. So I would probably add it in those two areas, if that makes sense to you.

Beth Morrow, JD – Director, Health IT Initiatives – The Children’s Partnership

Sounds good.

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

Great.

Mary Jo Deering, Ph.D – Senior Policy Advisor, Office of Policy and Planning – Office of the National Coordinator

And this is Mary Jo and we didn’t point out that there is a separate MU recommendation regarding the capacity for EHRs to accept corrections. It just happens –

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

Oh, that’s right.

Mary Jo Deering, Ph.D – Senior Policy Advisor, Office of Policy and Planning – Office of the National Coordinator

– it just happens to be in a different MU recommendation, it got associated with VDT because –

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

Yup.

Mary Jo Deering, Ph.D – Senior Policy Advisor, Office of Policy and Planning – Office of the National Coordinator

– under the assumption, the correct assumption that once patients can begin to download their information, they’ll see more errors or gaps and so there is indeed a requirement in there already.

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

That’s a great point. Thank you.

Beth Morrow, JD – Director, Health IT Initiatives – The Children’s Partnership

Oh great.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Christine, this is Mark.

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

Mark, did I hear you trying to say something?

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Yes. On the slide 11 where the – I’m wondering if we want to make some recommendations around time frame? Like when do we – when would we like to see this happening or whether we just want to be silent on that.

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

Hang on, I’m going to slide 11, oh –

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

This is the one about policies and procedures –

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

Yeah. Yeah, so I would – yeah, I think that’s a good point. So, it’s probably in advance of or during implementation of Stage 3, for those who choose the menu item.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Right.

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

That’s a great point.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

And then on the next slide, the request for help from the Consumer Technology Workgroup, just wanted to call out that special attention to language access and assistive devices will be especially important on the patient-generated side. So I think it’s included in the request, but just wanted to at least mention that on this call.

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

And you’re on slide what?

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Twelve.

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

Okay. Thank you.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration

And this is Kim –

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

And I have a question for an appropriate time here, do we circle back with these recommendations to any implications for what’s currently before the Policy Committee from the Meaningful Use Workgroup, that slide that you had on there on the Stage 3 recommendations?

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

Yeah, so Michelle can help me. We will present, if we can agree on these recommendations, we'll present them I think in September, is that correct, Michelle?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Sorry. In September actually the – so at the last meeting, there was a lot of feedback, it was almost too much detail –

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

Yeah.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

– so the framework will be a bit different when – in what's presented in September. So I don't think that we'll get into the details until maybe November timeframe. So, September will be a much level than what was presented at the last meeting.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

And Christine, this is Leslie. The Technology Workgroup might be able to provide feedback as early as September or the first part of October –

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

Okay. Great.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– because we're starting to think about these things already.

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

Okay, great, so that wi – because I was about to say, I'd love to still present in November just – I mean in September or October, just so that we have this on our plate and in our mind and we can carve it out and not – I don't think it necessitates going into the whole meaningful use category of everything. But I think given what Leslie just told us about timing, it would be – maybe what we can do is, you have the recommendations from us now, Leslie –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yup.

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

– so if you can work those through, then maybe we can present everything together in November.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Okay, that'd be super.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

But just to be clear about my point Christine, some of the recommendations we're talking about today are broader than what is in the current slide 204B that we looked at on slide 9. And I don't know if you want to talk about that or if that's for another day.

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

Well, yeah. So I think I do want to talk about that briefly, which is, I think it's – and I don't know the answer, so let's see what you guys think here. But, I think in some ways it's a matter of conceptualization, we started with the survey idea, but obviously secure messaging can be used as well. As I mentioned though, I think it's going to be a challenge to create a meaningful use criteria on secure messaging that is specific to PGHD because the use of secure messaging is so broad. So I think the question is, and we can bring this back to the Meaningful Use Workgroup and give them our input as well, should the PGHD criterion be broader? And if so, how would you structure it? Or should it remain separate, and we acknowledge the fact that you can use secure messaging, but it's a real challenge to make secure messaging be specific to only one use, which I don't think we want to do. Is there a way to give folks credit for using secure messaging or PG – or surveys or device data, if that were to make it in?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I think that there's no way to distinguish, because there will be messages that come in relevant to care and a provider will cut and paste if necessary, into the record. The patient-generated health data assumes a structure that allows for the automatic integration into the EHR. Now that doesn't mean someone hasn't approved it for inclusion, but it means that things like a questionnaire response have field level values that are now integrated into the chart, like how you feel and what's your pain level, what's your weight. So there – I think it would be an "and" situation, so we should consider both use cases, I believe.

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

So, I'll say, I understand that conceptually, but I'm really struggling with first of all, we have two things. One of the things that we heard and we may need to add this as a key takeaway Erin, which is, focus on structured data, structured or semi-structured, but we heard loud and clear in the listening session, we need to have structured data. Secure messaging doesn't necessarily facilitate that. Number two, the thing I'm struggling with is, how do you provide a clear objective in meaningful use that providers can see immediately how to use and benefit from, without enabling their ability to game the system, right? Because we can't view the content and know whether the data we're looking for is something that a) could be structured out of secure message, b) is really the more robust type of patient-generated data we're looking for as opposed to just a hey, when is my immunization due kind of a message and things like that. And so it's hard for me to see how you could give people the option of using either a structured or a semi-structured questionnaire or secure messaging, without also enabling them to game the system or not have a meaningful way to measure the use of secure messaging and – because you'd have to know it's content.

So my inclination, unless you guys see another way, would be that the priority is structured data, or at least semi-structured data, so we are recommending they continue to focus on two things. One would be the questionnaires and two would be device or biometric data, if we can figure out the standards issue.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Christine, I agree. I think perhaps what we can say for structured data for secure messaging in the future is that when secure messaging, have the capacity to be ingested easily, so it is structured, that could be part of the work. So envision a time where a secure message itself is a template that allows to be ingested. Today it's not and you're right, there would be no way to do it. But that could be a future assumption where we design it so that secure messaging could be another source.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Christine, tying this back to the listening session, we could just – there were – I mean, there was questionnaires, there were secure messaging, there were other ways too that people already are ingesting. So we could just talk about patient generated information, give examples of ways and try to broaden so that all of that can be made available if the doctor wants to incorporate it, rather –

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

Right, I'm just struggling –

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

– than just focusing on two.

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

Right, but I'm struggling with how you measure the content of a secure message, whether it was an actual patient-generated health data or simply a question back to the care team or a request to make an appointment.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think you could measure it – you could measure it if it's taken in and the provenance is attributed to the patient –

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– so the mechanism becomes irrelevant if the provenance is noted.

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

Okay, so here's what I'm going to suggest –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah.

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

– since we have one minute left, that we put this in our sort of 2.0 recommendation, which is get some experience in Stage 3 with the questionnaires and potentially the device data and look in the future about how you could adapt to the secure messaging piece. For example, it may be that once the provider's been doing this for four years, which by the end of Stage 3, you would be, you don't need to – you could restructure the secure messaging to focus exclusively on PGHD as an option without harming the earlier objective.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Or Christine, on this particular point, maybe when we hear back from the Consumer Technology Workgroup there will be some ideas about how this is already possible and we could actually wrap this up in this go round.

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

Okay. So we are at the hour and we do need to do public comment, but, before we do that, does anybody have any other very quick items that they want to add or suggest with respect to the draft recommendations?

Terry Adirim, MD, MPH – Director, Office of Special Health Affairs – Health Resources and Services Administration, HHS

Yeah. Hi. This is Terry Adirim. I just wanted to ask if this is going to go through another – the recommendations, another iteration or we're going to have another call?

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

Yeah, I think, yeah, it really depended on the call today. I think we will, given the fact that we don't need to present until November. What I'd like to do is revise the recommendations and send them out in advance of the next call and then we can go through them again. We also want to jumpstart the shared care plan work stream, so let's – I'll work offline with ONC staff to figure out how to sequence those and whether we spend half of the next call working on these and half starting to organize ourselves around care plans, or maybe we push off the care plans for another month. But we'll definitely come back to these with a revised set.

Terry Adirim, MD, MPH – Director, Office of Special Health Affairs – Health Resources and Services Administration, HHS

Good. Sounds good.

MaryAnne Sterling – CEO – Sterling Health IT Consulting, LLC

Christine, this is Mary Anne Sterling and I just wanted to point out real quickly that we are focused right now on receive, review, record. I think we're going to run into a perception problem if we don't deal with respond –

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

That's the acknowledge, yeah.

MaryAnne Sterling – CEO – Sterling Health IT Consulting, LLC

– yeah, you have consumers that expect response today.

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

Yeah, I agree with that, that's one of the four, it's acknowledge, so maybe we need to call it respond or maybe we've called it both places, but that is in there Mary Anne, you're absolutely right.

MaryAnne Sterling – CEO, Sterling Health IT Consulting, LLC

Got it.

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

So guys, let's go to public comment. So let's ask the operator to open that up and then if you've got more thoughts on this, send an email to me and to Erin around what your thoughts are and then we'll incorporate those in the next draft that we'll get back out to you for next month.

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Operator, can you please open the lines?

Ashley Griffin – Management Assistant – 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 have no public comment at this time.

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

All right, great. Well thank you everybody for yet another productive call. I feel like we should start scheduling these for 90 minutes at some point, because I know we jam a lot in, but this was great. And as I said, we will come back to you with a revised set of recommendations and key takeaways for next month. So thanks and have a great rest of your week.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you.