

**HIT Policy Committee  
Meaningful Use Workgroup  
Transcript  
September 24, 2013**

**Presentation**

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Good afternoon, everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup.

This is a public call, and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking, as this meeting is being transcribed and recorded.

I'll now take roll call. Paul Tang?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

George Hripcsak? Amy Zimmerman? Art Davidson? Charlene Underwood?

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

I'm here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Christine Bechtel? David Lansky? David Bates? Deven McGraw? Greg Pace? Marc Overhage?

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

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hey, Marc. Joe Francis? Latanya Sweeney? Leslie Kelly Hall?

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

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Marty Rice?

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Marty Fattig? Mike Zaroukian?

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

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Neil Calman? Paul Egerman? Rob Anthony for Rob Tagalicod?

**Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Tim Cromwell? And are there any ONC staff members on the line?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Hey, Michelle. Elise, here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thanks, Elise. I'll pass it back to you, Paul.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Thanks, Michelle. Well, thank you for attending, and I know that we've added some calls because we have added work, and so that may have caused some problems with people attending, but we will try to make some progress. Our goal for today is to get through at least three of the four—or try to get through three of the four categories. Christine is not able to join us today and she certainly led the category two, so we want to wait for her to return next call.

So the idea here is to progress from—as you know, we presented to the HIT Policy Committee earlier this month and got agreement with our Meaningful Use Outcome Goals, to the right, and then Functionality Goals for stage three. Where we're at is to try to progress onto the Stage 3 objectives, functional objectives, that are derived from the functionality goals.

The advice, the counsel we've been given by ONC is to try not to focus in on more of the details like the percent threshold or, as prescriptive about, "Do this many," but be a bit more flexible, now that this is stage three, they've gone through stages one and stage two, and given people more flexibility, more room for innovation to achieve the ultimate outcomes rather than process measures.

That's where we're—that's the work in front of us. Michelle has gone through and, for each of these Functionality Goals, has put together a slide that has the functionality goal and sort of one level up from where we left off in our functional objectives that we worked on before. We're gonna try to reconcile those on this call.

The order we'll go through is category one, then four, then three, and leaving category two for when Christina returns, next call. Any questions about the process, or any comments about that?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Paul, this is Amy Zimmerman; I just wanted to let you know I joined.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you, Amy. All righty, so let's go on with the next slide, please, Michelle.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Actually, Paul, can we start with Sasha?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I'm sorry. You're right, you're correct.

The other thing that came up during the HIT Policy Committee is, I don't remember whether it was an offer or a request, but at any rate, Judy, representing the EHR vendors, thought it would be useful, and at one point in time we also requested this, to understand better what's the level of effort required. It's nice to have high value functions at an achievable cost—that's a good situation. Having lower priority functions at a high developer and provider cost would not be a good thing. We're trying to get some more input in terms of the level of effort required to develop and test and QA and certify these functions. Right now, what Sasha TerMaat from Epic is going to present is sort of an EHR association input or estimate or indication of level of effort required on the developer side. This does not include the implementation costs.

Let's see—was that sent out ahead of time, Michelle?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Kind of—this morning, about an hour ago. *[Laughter]*

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

All right, okay. Sasha was gonna explain how they developed this estimate and the categories they have. We'll ask her questions about the methods by which they developed it, and I don't know how we're gonna incorporate in today's—I guess, hopefully, people will have it accessible at their computer and can refer to it. We just got it yesterday, I guess, so we didn't have a chance to incorporate it into today's presentation.

Sasha, thanks for attending and giving us this update.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Thanks, Paul, and thanks for inviting me to join your call.

I serve the Electronic Health Records Association as the current chair of the Meaningful Use Workgroup of the association, and we undertook the work to put together this table of development estimates that you got this morning that goes through what I know you had put forth in your request for comments back in January, and also some of the items that have been either modified or discussed or added or changed over the course of your discussions over the summer. We tried to use the more current version of your sort of ongoing discussion of what would be proposed to update what we had worked on previously in our request for comment response and put it into this more current document here.

So we sent along the draft copy so we could get it to you as quickly as possible, and we're hoping to finalize our whole project of estimates here by the end of the month. As Paul said, I'll give a quick overview of how we put together the estimates and I'm happy to answer questions or take feedback on this document. We're hoping it will be helpful to you in understanding more about the development effort of some of the proposals.

We based our estimates on the experience that we all had as electronic health records developers in developing meaningful use requirements that were part of stage one and stage two and getting those requirements ready for the certification process. We kind of factored in our, across the whole group, extensive experience with that area into guessing what would be similar in terms of effort for the things that were proposed for stage three and future certification requirements.

As I mentioned, we worked off of—originally this table came from the request for comment from January, but we did try to update it with your more recent discussion, so you'll see some of the updates included in there. That should be very timely in that sense. We estimated projects in kind of a range. We have a table there on the first page of the estimates document, so we have small, medium, large, and anything larger than larger was jumbo. Each developer has maybe a slightly different range of sizes at their company that they would say, "Oh, that's small" versus, "That's large." We collected, from all the developers who participated in the workgroup sort of what their range was of a size of a different project, and then we put the aggregate range and the mean there in that key on the first page, so you can have a sense. I think the mean is actually the easiest in terms of understanding what the scope of a particular project would be, and then we expressed that in sort of how many weeks would it take a developer.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's great. Thanks, Sasha, and of course—

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

Can I ask for clarification on that?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Sure.

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

This is Marc, and this is one of the things I'm learning as being in industry versus academia. We say tester/developer, but of course the testing, implementation and so on is usually a bigger chunk, actually. Is this really total development effort, or is this really the software engineer estimates?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

You know what—that's a great perspective, Marc. We tried in our estimates to include the comprehensive time that would be needed for development, quality of testing, and preparing for certification, though I think sometimes we probably focused too much on the development piece and maybe didn't allow as much time for the certification and testing pieces as we ought to have. We were trying to include all of those.

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

Sure. Okay, great. You just used your developer, and I just wanted to know that's what you were shooting for. Thanks.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Sure. Yes, it could be all the staff involved in development, including those who are testing specialists, those who work on certification, and so forth.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

And of course, the person we—it's not as if we have to wait for one person to do that. If you have three people on it, then you divide by three, approximately, I guess.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Approximately, though, of course—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

There's still calendar—

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

- Then you have coordination, overhead, and so forth when you add more people to a task, yes.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Correct.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Then on each line item—oops, sorry, another question?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

No, go ahead.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

For each line item, you'll see that we put an overall estimate, which was the total of that whole row, so for 101, the total became large to jumbo, and then beneath the sort of overall estimate, we put forth what the individual pieces of development projects that we saw in there and estimate each of the pieces, to hopefully provide some clarity as to sort of where the development effort was going to be focused. Then—so that is sort of how we came to the overall estimate is coming there beneath that line.

Finally, most of these, you have been talking about and you'll be familiar with. We didn't want to lose sight of some of the quality measurement work that hasn't always been part of the same tables and so forth. We added, at the close of the document, some rows for the quality measurement proposals that we've heard being discussed to give a sense of the overall effort that would also be focused on the quality measurement pieces necessary.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So Sasha—

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

I have a question. May I ask a question?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yes; go ahead, Leslie.

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

This is Leslie. I have a question. You know, we look at the proportionate difficulty, I wonder if there's also an equivalent task that talks about the proportion of R&D dollars available as a result of the influx of almost from 6 percent to 85 percent or more adoption of EHRs. It's not just a difficulty, but the available resources that should be balanced together. Was that part of your consideration?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Leslie, no. This project was simply to estimate the effort that would be necessary for some of these proposed projects.

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

Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Sasha, I wanted to say, this is really excellent work, and I think it's gonna be very helpful, so I really appreciate the Association taking the time.

Some things that would help us interpret the data, the results. One, the number of vendors; two, actually which vendors—that doesn't mean their individual score, but it would be interesting to know who responded—and three, as you can tell, the range was very wide. In the lower side, it was the difference between 1, 2, and 4 weeks for small, medium, and large, to 18, 48, and 88. That's a really large range, so that's why it's helpful to know how many people responded and just get their names so we have a way of calibrating ourselves.

The other thing that might be helpful, then, is the standard deviation, because the mean can certainly be influenced, of course, by people who are voting 1 for everything and 100 for everything, so. *[Laughter]* Do you have some sense, like the number and maybe list some of the folks that participate in your survey or your estimates?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Sure. So, just for some context, the sizing of the project, sort of what each vendor considers to be what size was accomplished in a survey. We could have information, like the standard deviation, and I will take that back to the group for consideration as we finalize. The actual estimates were actually developed collaboratively in our workgroup meetings. We scheduled a series of special meetings over the last two weeks so we could finish this project specifically for the Policy Committee. That was not based on a survey, it was based on us discussing what would this project be, and then coming to a consensus on whether it fell into a small, medium, or large category. There wouldn't be, on a particular estimate, a range of that sort. It was a collaborative process.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

How do you get a range, then, if you are collaborating and you said, "Well, this feels like it's somewhere between 2 and 48 weeks"—how is that the result of your phone call or collaboration?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Each estimate that we assign to a project—so, for example, when we talked about, what would it take to include ordering a referral capability within the system, we can do that collaboratively.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Oh, okay.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

We did a survey where we said, "What does your company consider a small project? What does your company consider a medium project?" That was done by a survey, and we could take back the feedback of providing more information on, for example, the standard deviation.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So how many people participated in that collaboration?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

You know, I don't know offhand. We could ask the work—we take roll call in the workgroup participation, so we could go back to the notes.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. I mean, is it 5, 10, 50—just approximately?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

I would say, on average, there's about 20 participants in the workgroup call.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. That's very helpful. Other questions about the methods? Well, thank you very much, Sasha. This is really helpful, and then we certainly look forward to your updated file and appreciate you sort of quickly putting this together just to give us an idea of what kind of information can be available, and we'll try to use this as we go through the call today.

When do you think the final might be out?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

We're trying to finalize by the close of the month, though if there is additional feedback that folks have for us, I'd be very interested to hear that, either now or offline, certainly, you can e-mail me. If we get a lot of great suggestions, maybe we'll have to take a tiny bit more time.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Other comments or questions from the group?

Well, this is great. I think what we'll do is, as we go through, one of us will sort of refer to this, and then we can orally tell what the estimate was for the topic we're considering at the moment. All righty. Let's see, if we can go, advance the slide to our first page, then. Let's see, here. This is our schedule for between now and presentation to the Policy Committee in November. Today we just got some EHRA, and we're going to use this as we review and update our previous draft of Meaningful Use stage three objectives. Probably a lot of this is gonna just be refining those, and we'll also discuss whether we have anything we missed or some things we should be dropping from our previous draft.

We'll continue that in our October 7th call. We'll also discuss timing and the feedback from the Care Planning virtual hearing that happened just yesterday and *[Laughter]* if we have enough time, get to deeming. We might adjust—that's a very, very full schedule for the next call, so we might have to make some adjustments, and some will probably fall into the following call.

We'll go on to hear from the Consumer workgroup, because they are also developing recommendations on patient generated health data, hear back from the HIT Standards Committee, which includes their recommendations on imaging, and try to have our recommendations all set by the end of October in preparation for our November Policy Committee meeting.

You can see, this is a very full agenda. We're trying to meet this timeline of getting our recommendations out, at least the next round out in front of the Committee. Questions about that?

Okay, let's go to the next slide, please. We're gonna dig in, and the Meaningful Use Outcome Goals—you want to click one more, please—that was approved, are those columns in green. That is, the HIT Policy Committee agreed that the Meaningful Use programs, outcome goals, would be that all patients received evidence based care, they're not harmed by the care, and they don't receive inappropriate care. That translates into functionality goals, not directly into objectives on the middle column. That would mean that providers and patients have all the information they need in order to make decisions, and that they're supported by the systems to produce, to make optimal, timely, effective, safe, efficient care without ordering inappropriate care, for example.

Those are the Functionality Objectives. Next slide, please. That appears on the right hand column, and what we're gonna work through is the middle column. The left side is where we left off in our Draft Objectives, the middle column is a modification, given sort of our new guidance of saying, "Be less prescriptive and not worry about percentages"—although there may be actually a little bit of just difference of opinion, I think. *[Laughter]* Rob, on your last call, was saying, "Well, sometimes at least giving some kind of indication is helpful to CMS as they go through their rule making process.

As an example, and this is probably a complex one to use as an example, but we had previously said for CDS, we had been in stage 1, 5, and stage 2, and now we're proposing to have 15 CDS interventions or guidance that are related to 5 or more quality measures, and that they would have, they would cover these five areas, each of which would have 2 or more interventions. You can see, just by listening to the statement, it was fairly prescriptive on how you had to distribute—what kinds of CDS interventions were required. There were certification criteria such as the ability to track how your CDSs are being used to be able to flag preference sensitive conditions, to check for does weight calculations when you're doing drug ordering, and in order to do that, of course, you'd have to have structured SIG, and that you'd be able to consume external CDS interventions.

What we mean is, we're trying to move towards a world—one of the biggest complaints was that every organization, every provider organization is having to reinvent the wheel from a CDS point of view, even though there may be national guidelines on what's appropriate. They're just not written in a way that can be consumed by each of our EHRs. We're trying to move towards that kind of functionality and, in future stages, we imagine there being some repository. It could be on immunizations or it could be on some of the prevention measures that could be developed and maintained nationally and then consumed by EHR, and that we have the ability to use CDS functions in whatever EHRs that we use to support the maintenance of the accuracy and completeness of the list, like problems, meds, allergies.

That's where we left off. The middle is a draft for us to discuss of trying to preserve a lot of the concepts and remove some of the details. For example, it says, instead of 15, it says, "Multiple CDS that apply to quality measures in each of the 6 National Quality Strategy domains," which largely mimic our categories, actually, but that they include the same 5—1, 2, 3, 4, 5, 6 [*Laughter*] categories.

Let me just open that up for discussion in terms of this translation between a more prescriptive, do 2 or more in these categories to total 15 and moving towards the goals of having multiple CDSs that serve your performance in quality measure areas that you choose.

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

So, Paul, this is Mike Zaroukian. Having missed a little bit of the recent activities, I'd like to use maybe the problem list as the example of getting a little clarification. If—and I like the wording, I like the way it looks, I'm just trying to operationalize it. If we were to say, for example, improving accuracy and completeness of the problem list, how do we envision CMS operationalizing that so an individual could know if they're achieving it?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Actually, that isn't an objective, the goal. Where are you reading here?

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

So the middle column is a goal, so it's functionality needed to achieve this goal. Is that—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Ah, yes. Okay, right. The functionality is that, how would you improve the accuracy of a problem list? Now, this is where sort of we're trying to let the organizations decide how they do that, but they want to have the tools to do that. What's an example? Your problem list, you want to make sure all the common problems are on there. Diabetes is a common problem. Hypertension is a common problem. Hypertension—let's pick on a simple one—it may not be on the problem list; hence, it won't be on your patient list, it won't be on your quality measures, et cetera. It's good for everybody that hypertension is on there so that the system can help prompt you and then the reports can be accurate.

What's one way the system could help do that, using clinical decision support? It could pick up, you could code the rule if the blood pressure is over 140/90 on two readings over the past six months or whatever that rule is that you all decide locally, then put up a prompt saying, "Hey, look, I noticed they had elevated blood pressures on these two dates. Would you like to add it? Should we add this to the problem list? That would be an example of the functionality. So the vendor would be responsible for having the ability to code in their CDS system, whatever that is, that kind of a rule.

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

Right, so just trying to use additional examples and determine what vendors should be support or what might count things like duplicate diagnoses on the same list or a problem that hasn't been assessed in three years but is still there—that kind of thing. Would that also likely count as the kind of functionality needed?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yes. I think all those things count. They might count in a different areas of those six listed. Let's say you have an address, that was one of your examples—that might count under chronic disease management. All you have to do—so this is listed here as a recommended intervention to say, "Hey, look, I've thought about using CDS in prevention. I've thought about using it in chronic disease management." The way it's listed here, it would not require you to go, "Oh, you gotta have two in each of these."

You figure out what's needed in order to support your organization's performance. It could be in prevention, it could be in chronic disease management, but you all decide locally. That's part of the objective here is, we're saying, "Let's not, at stage three, having gone through stages one and two, let's be less prescriptive. Let's still make sure we have the functionality, that's one of our prime objectives, in order for you to do things that are necessary for your local priorities, but let's not dictate what those priorities have to be across the board."

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

Okay, and then just one more point to try to clarify—does that then mean that both the vendor and the customer get to decide which ways that they consider to be improving the accuracy and completeness of the problem list, for example, they would like to use for that, and neither ONC nor CMS would be highly prescriptive about which kinds of those decision reports would count?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

These are good questions, Mike. I'm gonna give an answer and open to the group that I might suggest. Yes, so one, just as we've been talking about, it really makes it more flexible for the provider. Two, in general, the vendors have had to supply functions to address each of the things that the provider may select, so that's one of the things that they—these options, these menus turn out to be requirements for vendors, but they might have a different way of improving the accuracy of the problem list than what I just described in the example. One might imagine that could be, if they can demonstrate how the function they're proposing for certification would be used to improve the accuracy of the problem list, for example. That's one way of having this qualified.

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

Okay, so that's great, because that fosters innovation around—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That fosters on both ways, right.

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

That's excellent. Okay, thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Now, let me get the other group's opinion on that. I'm just giving an example of how we'd respond to questions of that sort.

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

Paul, this is Charlene.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Mm-hmm.

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

I did want to reinforce kind of what you just suggested, because I think one of the challenges of the current certification process is it gets so prescriptive and that it dictates what the providers are gonna have to interact with. The more the certification can be about accomplishing the task, on how it's done—and I don't know how they're gonna do that—that would be, I think, better for the whole process.

Not only initially challenged from the Meaningful Use workgroup, but certification requirements need to be put in that same context, and it's gonna be harder, so I think that's really important.

**Leslie Kelly Hall**

Yeah, but Charlene, oftentimes we're told that the vaguer the certifications, the more difficult it is to achieve them. I think we have to find that balance.

We are suggesting—and correct me if I'm wrong—that certification, the criteria that we have and former objectives, is still being carried forward or being modified to reflect the functionality we have here. Is that correct? We're still going to ask for certification criteria.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's correct. Let me get some more input on this question that was just raised because it's interesting, so Charlene, representing a vendor, gave that feedback that that was a good direction. Marc, Siemens, and Sasha, you may be able to speak more broadly for the EHRA. What's your opinion of that kind of different flexibility for the certification process?

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

Well, and obviously you're getting two \_\_\_\_\_ from the same vendor, so. *[Laughter]*

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Oh, I'm sorry, yeah.

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

I agree completely with Charlene. *[Laughter]*

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Or you'd have to take it offline, *[Laughter]* right. Okay, Sasha, are you still on? Is there, are you authorized to speak for the rest of the vendors? *[Laughter]*

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Well, I think that one thing that can be helpful is that, when a certification criterion is vague, but without explicit guidance that it's intended to be vague, that causes a lot of confusion. If it's unintentionally vague, then certifying bodies tend to assume that it's intended to be specific in different ways and different folks read in different interpretations. If it were very explicitly flexible to say it is intentionally left open to multiple ways to do this and we will test it in a way that permits multiple methods, I don't think the same concerns about having it be vague would apply, given that it was very explicitly that way.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's a really good point. Can anybody from ONC speak for Steve about the way we could implement this in the certification testing?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Paul, this is Michelle. I don't think we can speak for Steve, but maybe we can follow up with Steve and see what the right way to go about this would be.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah, okay. Because I mean, that's the challenge we heard, both from CMS initially about how many details would be helpful in stages one, let's say, and two, and from vendors, because they also explained that it was more helpful to be explicit, but then the cost of that is then you're, by definition, being prescriptive, and that has unintended consequences. In our deliberate attempt to be more flexible with the purpose of encouraging more innovation on both sides, let's make sure that we don't end up with just a different set of unintended consequences. That would be great if you could follow up with ONC folks directly involved in certification and give us some feedback.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Will do. Thanks, Paul.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you. Good discussion.

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

Paul, this is Leslie. I have another question on the functionality if you're ready to go there.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Sure, yeah.

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

We talked about the shared decision making in preferences of care earlier on, and I don't see those called out or the ability to include patients and their families in decision making, which is being worked on right now, the concepts under the Healthy Decisions Group. How are we going to address the shared decision making and preferences of care, and where would that come?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I think that's under—Michelle might know better, but I think that's under Patient Engagement. It is somewhere in here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Well, it's in the—right now, it was in the former Objective in the Certification Criteria, the ability to flag preference sensitive conditions.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's one aspect of it, but there's more in terms of shared decision making, yeah?

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

Yeah.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

There's not much more here.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Okay, so now shared decision making, of course, is a process, a human process, not a machine process. I think one of the enablers, however, is to flag preference sensitive conditions.

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

Yeah.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That is on the certification criteria that we had had and it's still there. I think the bullet that says Certified EHRT should have functionality to enable intervention tools refers to the list on the left.

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

I think if we capture it under the CDS, it helps avoid inappropriate care goals, which would include shared decision making with patients. Is that some place we want to articulate this? Because I don't want to end up with only clinical decisions being made and reinforced when there can be those clinical and shared decision making events together.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I wonder if one possibility is to add—I hate adding, but [Laughter] one place where, it would be along the lines of the six, quote, recommended interventions. Another way CDS could be applied is to help with shared decision making. Would that capture it?

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

That captures it. Thanks, Paul.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

We'll try to respond—

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

Paul, this is Marc. One other thing I want to make sure we think about is the sort of flagging and identifying in a formal way, whether it's NLM or whoever of those preference sensitive conditions. I just wanted to say, you should be able to find them. Well, the EHR might be able to do that, but we need to get some consensus somewhere about what those are in order to make that work. I know those kind of value setpieces can sometimes get lost.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yep. That might be something we want to ask the Standards Committee in terms of the value set. I think, Marc, what's covered is, what's listed as number four on the left, is the ability to flag, so independent of where you would get this list, the system, we're saying, needs to have the ability to—you marked that coded field that this is one of those conditions.

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

You're thinking that the provider is gonna select this as a sensitive condition?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Well, right now it doesn't say who—that certification criteria doesn't say who selects these. As you point out, we'd like to have some centrally maintained list, so that we could ask the Standards Committee about where we might get that value set.

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

I know that the—this is Leslie—the Institute of Medicine is working on the discussion paper on that right now.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

You can imagine, the functionality is there, anybody can set it, you can imagine that either some external group or even the vendor says, "Hey, look, and if you want us to automatically default the things in this IOM list, we can do that."

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

This is Mike. I really like where the conversation is going, and I resonate with the notion of putting it in. I'm having a little trouble, as a primary care physician, imagining the condition that patients don't have preferences about, even though I understand there's perhaps some external definitions. I don't know that we're in any position to be able to say things about patient sensitive preferences. I think about the airline industry in the aisle and window seat, something really trivial, but the notion that says they do have preferences with regard to certain approaches to therapy or diagnosis or whatever, and the ability for vendors and customers to innovate around that and have that count, would be great.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I think this is—the intent here, Mike, is to do almost exactly what you're saying. We're picking up on something that has some industry recognition and interest—and by industry, I mean sort of the health care sector, like PSA, for example. Really, we're hoping that people innovate in saying, “What other preferences, like preferred meds, not preferred meds, et cetera, do they have and can we work those in so that it can be coded in the system, captured, coded, and then used in clinical decision support?”

That's where we're headed, but this is sort of the initial foray into that and the initial signal.

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

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

This is the kind of thing, this is the kind of approach we're trying to take and not saying, “You must do this,” because it's very limiting.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow**  
Right, and I'd be careful about anything that sort of requires physicians to indicate whether or not every condition they see is patient preference sensitive, so—that would be bad.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Correct. That—this is the rationale, this discussion, this is a rationale for saying, “This is, we see how this could be used currently, but also we can see the innovative ways it could be used to more appropriately engage patients in shared decision making,” but we're not saying, “This is exactly how, and we're not saying everybody must document the following.” That's what we're trying to get away from.

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

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

How is that playing with the rest of the workgroup members? Are we on the right track? Okay, I'll take that as a mute or yes. *[Laughter]*

So where we are right now is, how does this middle column look? It basically uses the term multiple, and that equals more than one. It talks about the six NQS domains—now, one question is, should everybody, meaning every specialist, be able to fulfill all six NQS domains? We talk about recommended interventions—in large part, that's sort of a signal, and yes, the vendors would have to use this as a checklist. Yep, I could write an intervention that deals with preventative care, I could write one that's chronic disease management—but it's very open and flexible to innovation. That's sort of what this statement is saying, and then you have to accommodate the certification criteria three through eight on the left. How does that feel? Are people ready to accept that as our latest draft?

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

Paul, this is Charlene. The only thing I think—and again, I know this is stage three and we're gonna be further down the pipe a little bit, but does that imply that you've got to do one in each of the six? Because I know that's, I think that's probably gonna be a stretch, I'm sure, in some cases and some scenarios.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I think that's the one—I'd agree with you. That's the one thing that we might want to back out. We might say three of the six or something.

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

Yeah, or—yeah, because just given where the measures are at and the complexity and all.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. What do other people think about one, the whole column, and two, going with three out of six versus six out of six? Any other comments?

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

This is Mike. I can obviously see the benefits of all six. I really would turn to the vendors to try to get a sense of whether they think they could support all of that. The more that we allow, at least, and the more the vendors can support, the more different specialties and specialists can resonate with them and do them, but I'm sensitive to the vendors' stress.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Well, so the vendors would have to do all six, as they always have in any menu. I think the bigger concern that Charlene was raising is, it's not true that every specialist would find all six relevant to their specialty.

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

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right. I think that's true.

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

Well, some of the measures and some of the new domains will be relatively new, so again, you'll have early adopters of those, but—so at least there's some concept that would seem to make more sense, at least, you know—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Do you want to test a number less than six?

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

Yeah, I was okay with your, at least three of the six or something like that, but again, I know CMSs that don't use the numbers at this point, but *[Laughter]*—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's right.

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

You can put them in a folder, anyway.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I like the concept that Sasha threw out—if we're exclusively flexible, then we would say three out of six. Of course, the vendors have to make sure they could do something that touches each of the six, and also, by the way, that would define the lower bound of quote multiple, and that would automatically make that three or more.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

So Paul, just a question on that flexibility from a development perspective—if you look at the certification criteria and in the past kind of all the criteria become applied to all types of interventions. While each of the certification criteria that are proposed have definite advantages and use cases that I see as being really practical, is the intention that for each of these six areas, you'd be able to consume external interventions in each of these areas, use the information in each of those areas to improve lists, have it be dose based? I can picture there's some cases where three, the ability to track triggers, if you're turning something a color on a screen in certain circumstances, the tracking of that is different than if you're popping up a box and saying, "Choose A or B."

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Our intent—and what you're saying is, it may not be interpreted that way—but our intent was that this does not, these certification criteria do not apply to each one of the things, the domains. I think this raises another question. It's possibly really helpful for MU in particular to meet with some kind of counterpart on the Standards and/or the ONC to talk about how some of these quote policies or objectives get translated to certification criteria and testing and auditing. We certainly heard feedback that there can be a disparity in each one of those, in that chain, and that causes a lot of consternation, I think. Does that—

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

I trust that it [*Cross talk*] pending facility—oops, sorry.

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

This is Leslie—sorry, this is Leslie. Where we're expanding on functionality that already exists, and there's a standard already named that might provide us really an easy win, right, but where we are asking for functionality, that may not be building on something. Then, not being specific and not offering very narrow certification, we can create more havoc.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's a good point, too. Okay, can we put in the parking lot, Michelle, this whole notion of certification criteria, test scripts, and auditing, just to have a discussion potentially with some group with standards to try to get on the same page there?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Sure.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That would be in response to feedback that we've received.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Okay.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, great. Let me try to restate where we are with this one. I think the only change we're imposing is less than six, and that's really because of the current limitations and measures applying to every specialty. Let me pick a number right now—four? [*Laughter*] We can come back and revisit this as we finalize it, but the notion was that it probably is not six, and then we need to find some number in between.

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

That sounds right to me, Paul.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Paul, this is Michelle.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Thanks, Mike. Michelle?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

I was just gonna say that, for stage two, for the quality measures, it was three of the six, and part of it could be because of the lack of measures for some of the different domains, I'm not sure—but just something to consider.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, so four would be one more than three. *[Laughter]* Mike thought that was about right. Anybody else want to weigh in?

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**  
Yeah, clinical.

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

Specifically, the preventative care and chronic disease management are two easy ones to imagine orthopedists don't care about or whatever, and that would be valid for them, but even if you don't prescribe much, the others are gonna be all relevant, and if you find one that isn't, you should be able to go back to one of the others and do it.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right, and like preventative care for dermatologists could be sun screen.

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

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, so let's—we can do a little bit more homework, but right now, we'll put on the straw man at four.

Okay. Let's move on. That was the hardest one, actually, or one of the harder ones. We'll skip the next slide, which was just providing details of what we said before. Now we're on Advanced Directive. You know what, we may want to just skip on this until we hear back from the folks on Advanced Directive, based on their hearing. Let's skip over that.

We'll go to Reminders. One more slide, please. Okay, so the goal is that we take advantage of everybody having access to all the data, and the system can help, quote, calculate what might be useful for this patient at this time. This functionality we had was that we'd be able, the system would help us identify people who qualify for a reminder. It could be about preventative care, it could be for follow up, and so in the surgeon's case, it could be postop follow up, it could be postop functional status in the PRO sense. There's lots of ways you can imagine that almost everybody could benefit from this. We added that the Reminder would be shared in the format that the patient prefers, whether that's cell phone, text, e-mail. I don't know what text means, but anyway, that was just an example.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Paul, can you clarify—this is Amy. It says, "If the provider has technical capability"?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah, I was just reading that, too. Does anybody know what text—I hope that doesn't mean—

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow**  
It does, Paul.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

It means text on, like, a phone text—yeah.

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

It means unsecured text, which was part of the controversial discussion we had earlier.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Is there a reason—can we get rid of that?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah, so this came from a conversation with Christine. It started in Patient/Family Engagement, at least where we started the conversation. The discussion was that the same language, essentially, is used for reminders, patient education, and the, after the Summary so that it's provided in a means that is part of the patient's process. It's also added to what was formerly the Demographics Objectives to capture what the patient preferences are for each of those types of communication, and then based on the provider's ability to provide it in that means, they would be able to provide those three communications within the patient's preference.

There was discussion with Deven and Christine—hopefully all of you remember—about, and there was a bit of controversy about that text piece, but if the provider has the capability, then that was the discussion, that it could be provided in that manner.

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

This is Leslie, and Deven reminded us that if the patient seeks information and says, “Yes, send it to me, and I understand that it's text in the clear, or e-mail in the clear,” you're still obligated to provide that information to them, so this isn't inconsistent.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's correct. The patient can request you to do such and then explicitly approve that. Now, if the provider has technical capability, Mike, is saying that, “Well, my system actually can't configure an SMS text number in that,” then you're not obligated to go buy—that was the caveat in terms of, these first are e.g.s, these are examples, and you can decide based on your technical capability whether you would implement any one of these.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

So Paul—this is Amy—my question is, could you say you have no, I mean, I don't want to give an out to a provider to say you have no capability to do reminders at all because you don't have technical capability.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

No, no, no. This was only the kind of. If you don't have a way of programming the text message to go out, then you don't have to, obviously, do that. It wasn't to say—so no, everybody has to do reminder of some type, but if your system doesn't provide you that outbound text capability, you wouldn't have to do that.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

So however this comes final in wording, I think it's either the parentheses or the comma or something has to change to make sure that that phrase refers to the capacity of the patient preference and not to the reminder component as a whole.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Correct.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Okay.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you; thanks for the clarification. Other comments about this?

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

This is Mike. I'll try one more approach to this. We had a fairly significant discussion about this, informally, at HIMS board and on the Hill and with Judy Murphy and so on and so forth. She was actually a little surprised to hear that, but the key question, I think, that I still need clarification on is, I think there's a difference between providing—what the omnibus rule talked about was providing copies of patient health information in the format, even if it's unencrypted, that all makes sense.

That's, I think, a little bit different, however, than communicating with the patient sort of, if you will, in real time, as opposed to sending copies of protected health information. I know the HIMS Legal Aspects Task Force has a meeting coming up where they're gonna be debating this issue and looking at the rule, and I think they've invited Deven McGraw to that conversation, so I think they'll be able to provide some additional feedback.

I think, again, one of the other clarifying points is the difference between being absolutely sure what we're talking about is, does your EHR system and any secure messaging you would be doing through your EHR system or other certified EHR technology constitute that aspect for which there must be technical capability and again, does that mean, if it's certified for it, you must implement it, you must use it, or does that mean that if you choose not to implement it in your system for whatever reason, you are therefore not obligated to send a non-secure text message and, to be even more explicit, if you could literally, manually send a text message, would you be obliged to do that? Which is really outside the bounds of this, but it's back in the bounds of it if we're talking about whether text messaging with patients in a nonsecured method is something we expect providers to do.

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

I also—this is Leslie. I also think we need to acknowledge the evolving technology around text messaging as it's getting used and used more in health care. The opportunity for security around that might be a moot point by the time this is actually point into effect.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I think these are good points, and I think—I'd be very interested in what comes out of the HIMS discussion with Deven. Your point about, it's one thing to walk up and say, "I, the patient, am wanting you to give me all my information in the following way;" it's another to not knowing what's about to come out, what's about to be pushed out, whatever the content is to allow that to prospectively say everything should come over text messaging, for example. Of course, everybody understands that your number actually—who owns your number may change over time.

It would be good to get Deven's answers to those questions.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

This is Amy, I have one more question. If someone sent a reminder for an appointment—like, I get text messages when prescriptions are ready at CVS, I get them from my dentists, for my kids. Is that sufficient here? Would that be enough to be sufficient to meet this criteria, just an appointment? Because it says Prevention and Follow Up Care, so any sort of appointment reminder—I mean, that's being used a lot now.

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

This is Leslie, and that was definitely discussed. That was a use case that was definitely discussed as one of the most high value use cases.

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

Yeah, and this is Mike, and I remember that, and I also remember explicitly being told that those would not count as reminders for follow up.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's correct. We explicitly did not count appointment reminders.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Somehow I think that has to be clearer.

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

Yeah.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Because, not having been consistently on all the calls, I would've looked at that, and automatically I was thinking of use cases where I get text messages now on actual, "Your kid has a dentist appointment, you're coming in at 2:00 today" or "Come pick up your prescription, it's ready for you."

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right. Okay. I think, are we in agreement with this, with the follow up on text messaging, as an example? The other question was, does technical capability equals the capability of the software, or what's been turned on? *[Laughter]* Let me go to a default and go the latter. The provider should not be accountable for, let's say, the system, whatever the system administrator decides that, by policy, they've decided not to turn on automated outbound text messaging. You certainly can see a lot of inadvertent things that happen, so if you don't keep up with the number or the number changes, the owner of the number changes, and you understand the OCR prosecution of the privacy violations, it's possible that an organization would decide not to turn that feature on, and would the provider be accountable for needing to honor that request?

I'm thinking out loud, talking out loud—that probably means that whatever the provider has available, that's what they would—

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

That's what we discussed in the meeting, Paul.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, good. Thank you. Okay, so we need to provide clarification on the technical capability, and that's what's available to the provider, and that applies to the method of executing a patient's preference, not that they can opt out of reminders.

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

This is Mike. Let me carry it one more step, though, because I could imagine my own organization opting out of Meaningful Use if, through their legal counsel, it is determined that they have to send unsecured text messages and they have to send unsecured e-mails. The key question, from my perspective, is—if this all means sent from your EHR, if it's technically possible to send an unsecure e-mail from your EHR, I got it, from that perspective, because we don't have that capability to send it. We send them all through the secure messaging portal. If the EHR vendors have to make the capability to send from the certified EHR technology an e-mail in an unsecured manner, we might implement that and we might use it.

If what it's saying is that, "No, you need to use your standard e-mail system to send it to patients when they ask for it, if you can do that," that's outside the certified EHR technology, and we would, if you will, get out of that process by saying, "The only way we send e-mails to patients is through our certified EHR technology, and that's always secure."

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right. I think the answer that we just discussed would satisfy your question, and what Leslie said, it's been discussed in—I don't know which group, but. If the organization can make—the provider is accountable to making available things that he or she can make available to the patient. If the organization, either the vendor can't technically make it possible, or the organization who implemented the EHR has made a policy decision not to make that capability accessible, then the provider is not accountable for having that. Do you see what I'm trying to say?

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

Yep. I just would like to—I'd be more reassured if that was made explicitly clear by CMS in its final rule.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right, so we're gonna try to clarify those two pieces, what technical capability means. It's really the capability accessible to the provider, and that this is only adjusting what kinds of methods are used to communicate with the patient, not—you can't \_\_\_\_\_ reminders.

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

Paul, this is Leslie. Remember we were still discussing the use of direct to patient from an EHR, so that would be secure, but it would still be able to have a patient use their e-mail address that's given. That was another additional way to make it a little more palatable.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. Okay, so we have to clean up this language, but I think we're in agreement with this; is that correct?

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

With those caveats, I'm okay with it.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

With those caveats, yeah. Okay, let's move on, then. Go to the next one. Now, we're talking about EMRs. Basically, this is continuing—am I correct, Michelle, this is just basically continuing stage two?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

It's continuing stage two, but there was a lot of discussion—I'm sorry, the only thing was the addition of the mismatches that you were saying, which is that second bullet.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Oh, right, right, right. That's right. This was giving people a way of QA-ing the process, really, and saying, "Get feedback from the EHR on where are people overwriting such and such."

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

This is Sasha; can I ask a question?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Sure.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

You used the word "dispense," but in stage two, the focus was on administration. Is the focus extending to include dispensing? I think that's a big scope change.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Got it, got it. No, I think this is intended to be administration.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Thanks.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Good catch.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah, it was originally just provided as a suggestion to help clarify, because there were a lot of questions about what that meant in the RFC, so we can fix that.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Okay, let's move on, and one more. Here, we are waiting for feedback from the HFC Standards Committee about imaging results and the standards needed for that. Is that right, Michelle, and that's what we're getting reported on the next call or the call after?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, exactly.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Okay, let's move on, please. Okay, so here was *[Laughter]* a rather heated discussion about family history. No one debates whether family history is useful. The problem is that we don't have standards for family history, at least that's supported in the EHRs; that's why this was a menu item. I think that's where we left off. I don't think there's any further discussion on this one.

Okay, next one. Let's see, where are we on electronic notes? Probably the only change here is taking out the threshold, and this falls under the goal of all relevant data is accessible through the EHR, so that seems well aligned.

We go on to the next—okay, so this is structured lab, and I think the only change here, one, it fits the goal of all relevant data; and two, it's just removing the threshold.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Paul, this is Michelle. I did have one question.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yep.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Based upon the RFC feedback, people had—the public had asked that we specify that willing to be used, but I wasn't sure if that should be added, because that is then being prescriptive, so, to the function—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

No, I think that's prescriptive in a good way. *[Laughter]*

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

*[Laughter]*

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

How do people feel about that? That's what we had in the past, and we've certainly heard feedback. We want single standards to be identified. Are people okay with that?

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

This is Mike. I'm a little lost on where you are in terms of—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

You see, the middle column, it just says structured lab? In the left column, there are two things that we had added. One was raise the threshold, but two, added the use of link as a requirement. We're just adding that phrase back.

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

Okay, thanks.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Yeah, I think if you go to the next slide, it's actually there, *[Cross talk]*.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

But that's our old version, so we're just making sure that we include that in the—yeah.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Oh, okay. Yeah, yeah.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Are people okay with that? Okay, I'll take that as a yes. *[Laughter]*

Next slide, please. I think the only change here—so there's two changes, one is the threshold, the other is within three business days. Is that right, Michelle?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yes.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

My guess is that we'd want to maintain the three business days, but what do other people think?

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

This is Mike. I support.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Okay. Let's continue to move on.

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

Paul, this is Marc. A minor one on that one—I wonder if we might want to tweak the middle thing that says, "Abnormal as determined by the laboratory," since we're entirely dependent here on the results as delivered, it might be cleaner to say, "As indicated in the laboratory results," because there's some issues with labs not finding abnormalities. *[Cross talk]*

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Wait a minute—so how would you edit that \_\_\_\_\_?

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

It now says something about, “As indicated by the laboratory”—I don’t have it up on the wide beam, here—“As indicated by the laboratory” could be something like, “As indicated by the result message” or something like that, because that’s the only clue that the certified EHR technology will have that the lab determined this as normal. Then you can put pressure back on the labs to fix their flagging.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I've lost a little bit of the nuance. So you're saying, “As determined by the lab results,” that's the word you're adding?

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

Yes, as opposed to, “By the laboratory,” because the laboratory can say it’s abnormal, but if they don’t send out any result messages—and they frequently don’t.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. I guess I would've read that in the way it says here, but if there’s a way to clarify that, we certainly want to do that.

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

I think if it would just say “lab results” or “lab result message,” it would be pretty fair.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. “As indicated in the lab result message”?

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

That would be great.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Because the message is undetermined. The lab determines what the message indicates.  
*[Laughter]*

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

Good point.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Okay, any other comments on that?

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

This is Mike. I just agree that without it, it’s easy to be, to make a mistake.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yep. Okay, thank you. The next one is on the screen—UDI. I think this is unchanged, except for the threshold.

Okay? Next. This one we—so, I guess the question on the table is stage three or future. The issues that were raised in the past were, one, the coverage was not all that great, but this is certification only. There’s two pieces—one is that the EHR accepts the feed about refills, and the second is that the EHR have the capability of identifying patients, of indicating if patients aren’t taking a drug, or that there’s a gap in their refills. It looks like it’s *[Cross talk]*.

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

This is an opportunity to start working with PBMs that we talked about early on, and that we felt having the certification, that owning this might help to move that agenda.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I guess the only question is, is the coverage good—well, if it's certification only, it doesn't matter, right?

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

Correct.

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

Yeah, I—Paul, this is Charlene. I'm having trouble going across multiple papers. Does Sasha have any comments on both this one and the last one that follows? I think those would be—and the UDI piece, the only piece I thought about, again, depending on scope, we might want to consider that menu, too. That would be the other thought. I know—I'm back one, I'm sorry.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. Actually, since these aren't cross referenced, does anybody know the number?

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

Oh yeah, that might have been.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

UDI, I believe, was 123. I'm not sure—it's a newer add, so I'm not sure if—

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

This was adding the UDI specifically from \_\_\_\_\_ devices, correct? Many organizations are gathering this right now, they're just not doing it in a structured way. This is also part of another federal requirement going forward, so we wanted to align those under UDI.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, so I can't find UDI on the list, sorry.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

So, in the EHRA document, if I'm reading it—the overall estimate is small to large.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

It's on page 17.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yep.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

We had a lot of questions that would help us estimate better.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Well, that's interesting. I assume it would have to be bar coded, right? *[Laughter]*

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

Yes, it's a bar coding process, it's already identified in the FDA and regulatory requirements for future, and this is now making sure that it can be bar coded into EHR, so—

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

What would happen if you have a surgical system where the device is implanted and bar coded, and then the patient goes back to another care provider who isn't actually implanting the device but wants to enter the information about what the device is? I don't know, I feel like there's some complexity to that.

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

Yeah. It's been thought through and perhaps we could have a separate discussion offline with the EHA or EHRA group, but the whole idea is to capture in the EHR something that would be available in the discharge summary, just as today the product number is. This would actually include the unique device identifier, which would be important for transitions of care or if recalls existed, because the recalls would not just be products and \_\_\_\_\_ specific to a specific UDI. It's a safety issue.

The patient groups who have implantable devices feel very strongly about this and generally consider it a patient safety issue, which is not recorded, but yeah.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

I would love to have a separate discussion. I think one of the confusion points for us was that an earlier draft said it was both EP and EH, but if it's primarily a surgical workflow, then we weren't certain sort of how it went between the outpatient and inpatient world.

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

It was designed to be captured when an implantable occurs, and if you're not getting an implantable, you have no reason to document it.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. It's on the insertion of the device—

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

Correct.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

- so that could be either the hospital or like a surgicenter. You guys can talk about it offline if there are other questions, and then it would be helpful to us in your follow up report to—because small to large is a pretty large *[Laughter]* thing.

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

Yeah.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, so let's go back to med adherence, and actually—

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

So, for med adherence, Paul, this is one that was suggested that we bring back in, so this wasn't in the original set that was shared in August.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Oh, okay,

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

I don't think EHRA would have done an assessment of this one.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Is that true, Sasha, then?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

That is true, and I think it's one that folks would like to assess. I suspect there might be groups saying that it's a big one, so we can take that back, but it wasn't part of the draft that we were working off from your earlier copy.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I think that would be helpful, and that would help answer this question of stage three or future. If you wouldn't mind taking that on, that would be helpful to us.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

I'll take it back to the group.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Great. Thank you. Okay, let's move on, please.

Okay, so now we're going—oh wait, we wanted to skip this category, so can we skip forward to, well, we're actually trying to skip forward to population and public health. That's in the four series.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

I think slide 46.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, immunization history. Here, it looks like the only thing we changed—so, we were moving into numbers, trying to say that's a way of exercising the functionality without making the numerator or denominator calculations. One of our approaches was to try to get away from percentages where reasonable, because numerators and denominators create a lot of the work. This basically is taking out that threshold, right Michelle? Anything else to the—

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Exactly.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. I think *[Laughter]* actually what it does is it just moves the buck over to Rob Anthony. *[Laughter]*

All right, next one? Rob, do you want to say—any feedback on, as you know, we received guidance to sort of remove our thresholds. Any further feedback you have on that guidance?

**Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid**

It wasn't really our guidance.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. *[Laughter]*

**Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid**

We, I think we had a little bit of a discussion of this in the last workgroup meeting. It always gives us something of a platform to be able to think about. I think it's helpful to have an idea of what that threshold is to get a sense of where the ranking of importance is, as you might think about it, in the totality of Meaningful Use. It is obviously something that we take into consideration and look at a variety of other factors, how well people are performing overall, where we want to put emphasis when we pull the stages together. Personally, I do think that it's helpful for us as a consideration.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Well, that's helpful, too. I think where we left off, and this is probably—I mean, this at least is an indication—is, we were struck by how hard it is to figure out what the appropriate numerator and denominator are. Part of the reason is, they can get their shots elsewhere, nowadays; maybe the pharmacy could be a standalone clinic, et cetera. That's a problem in terms of getting both numerator and denominator. That's part of why we moved over to the 10, so that may be a pretty good indication of what we were—we feel this is an important functionality, but that it became problematic and costly to document.

Okay. Skip a couple, please. Here, I don't think there's any change—wait a minute, are we on the same, I'm on the electronic lab reporting.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Yeah, because we're on 50, so yeah.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, there we go. So this, I think this is no change.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah. This is no change from stage two, even.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Move on then, please. Okay, so this is case reports. As you know, case reports has a very low compliance, mainly because people either don't recognize this is reportable, and two, don't have the forms and an efficient way of reporting it. So this is a way to help improve at least the efficiency and awareness of reportable events. This is a certification criteria only.

The functionality goal we're trying to address is efficient and timely means of reporting on patient populations and sharing with public health agencies. Any issues with this, and should this be stage three or future?

Are the standards already in existence for these kinds of case reports? I guess it probably depends on what, and then the other question would be, for which case reports; just those supported by CCDA?

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

This is Mike, it would also—

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

Yeah, I think that is a good assumption.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Mike?

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

Yeah, I was just gonna say it would also be helpful for me to hear from Sasha where EHRA estimates this as jumbo?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. Is it jumbo?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

This is on page 18. We had, on page 15, you see actually submission of case reports, and then this is prompting when case reporting criteria are met, which is on page 18. Both of those are jumbo.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Because? Can you sort of give us an idea?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Sure, and I think we outlined a lot of the questions that are there, but there was a lot of uncertainty for us on how it would work, what is the external data that's being loaded, is it loaded in real time or in sort of a periodic import? Then you'd need, of course, the methods to show the prompts to the user that the case criteria are met, the generation of the standard reports, which it sounds like the CCDA is there, though there was a lot of questions amongst EHR developers about which agencies it is that accept non-customized CCDA submissions, and then there's no transport standard given here, but that would of course be part of the development effort.

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

I think we would assume direct.

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

Yeah. The other—this is Charlene—the other aspect here is, again, there's a lot of variability in terms of reporting, there's some standard case reporting that you do, but also then each of the local, there can be variability in terms of the kind of case reporting that you need to do, too.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Development experience has been that each specific acceptor of case reporting has specific requirements that require significant development. There's not a method so far that we've experienced to develop sort of one standard report and use it for multiple registries.

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

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Did we receive any—did we ask the Standards Committee about this at all?

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

I don't recall that we did, Paul, that we reviewed that specifically, but I think there is a lack of standards, and so you see a lack of continuity. If you were to name a standard, you could potentially develop a pamphlet under the consolidated CDA. That may be addressed, could meet the needs.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Is this something we could—it seems like, for us, we need to table this and provisionally mark it as future and we can have this discussion with the Standards Committee about what it takes to make this implementable. I mean, we can't just throw it out there and then have the vendors one by one try to work with all these recipients or sources and iron out the standards—it seems like it has to be more standards ready.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

This is Amy, and I would add on that end that a lot of the case reports that come into the public health and have to go into a specific system at the public health end, so I think it is important to think about the standards so that they can be imported, and that might be some conversation with CDC, too for their meds based systems and other systems that states are using related to CDC, so some of this data comes into the state, but it has to go on to CDC, and I would hate to have it automatically generate from the EHR and then get to public health and have to be a manual process to get it into their system, or to get it to CDC.

I just think that, when we think about the Standards Committee and discussing standards, I think we have to look at it from both ascending out of the EHR, but think about where states and CDC is on an acceptance point for you to really streamline it and make it most effective.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. Okay, so let's move this to the future and then start this discussion. Our hope is that we start moving things in that direction, but it'll take time.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Paul, could I also ask for clarification—when it says, “Uses external data,” is this implying external patient data, or an external knowledge resource that has the criteria for case reporting? That part wasn't clear to me.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

It's the latter.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Okay, that's what I thought.

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

Paul, this is Marc. I'm sorry, I was having trouble getting it before, but one of the things I continue to have trouble with this one on is that the literature on this says it doesn't work, at least as recently as six or eight months ago. People studied this, and it does not improve reporting. Intuitively, you would think it would, but we haven't seen that yet. It really continues to feel premature, if the question is stage three or future.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That seems—in a sense, well, one of the ways you can imagine, certainly for lab reporting, that can be an automated process, right?

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

You can, and obviously that's a different thing than sort of triggering in the EHR to prompt the end user into different things.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right, right. Correct. It sounds like this whole area, while important, needs a lot more work *[Laughter]* before we put it into the Meaningful Use.

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

Agree.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, so let's move this off of stage three and open up discussions on these various topics.

Okay, moving on, then. I think this is unchanged, correct, Michelle?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Correct.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, and it does fall into the support of public health.

Okay, moving on, please. Registries. Let's see where we stand, here. The consolidated—

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

This is a little confusing.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. *[Laughter]*

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

So there were three different objectives, essentially, that were merged into one, and instead of saying that you had to report on specific registries, it's giving you the option for both the EPs and EHs to report on registries that are relevant to practice, and so there's examples given. In the former slides, there were two different objectives, essentially, for the EPs and EHs, but the difference was really only in the examples and registries. I tried to reflect that here, but I'm not sure how well I did.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, so the point is, whether it's for disease management or quality improvement, registries are an important tool. It is being used by some specialty societies in driving this. The goal is to be able to populate these things efficiently where it is appropriate to your specialty and you get the right feedback. This is trying to make that possible.

I'm imagining the pushback is, well, you've seen one registry, you've seen one registry. *[Laughter]* What does EHRA say about this? What page would we look for, here?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

This is Sasha. It's on page 15, and you pinned it exactly. Our past registry work has been highly variable per registry, so the estimate became very large.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. I guess the question is, what can we do to make that better over time? What policy recommendations can we do to encourage this to improve over time?

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

Paul, this is Marc. I'll share one thought, which is, I think one of the challenges that makes it so difficult is that, as you say, if you've seen one registry, you've seen one registry, and so the interaction interface with the registry has become this big foofaraw because everyone wants their format in their way. I think if you go back to basics in some ways and say, look, what you really want a registry to be able to do—and we obviously can't fixate this—but it's sort of the, if you want to get there, here's what needs to happen is, registries need to become more able to accept data in standardized formats, not as a case record if you will, but as a, "Okay, here's a serum glycosylated hemoglobin for this patient that belongs in the registry, and here's a patient preference that belongs in this registry." As long as they continue down the road of, "We want a record without 800 variables in it," we're never gonna meet all the registry demands. I think the policy action there would be to say something around, "Here's what you can encourage EHRs to be able to do to support registries," and that would make it useful so that the registry would say, "Golly gee, if we did that, then we can interact a lot with EHRs."

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right. Is there any minimal data set that we can describe—although that, I mean, it would only, the population—

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

It's pretty minimal. Yeah, it's like demographics. *[Laughter]*

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah, yeah. That is the challenge. It almost argues for—and you would know something about this, Marc—data intermediaries, trying to broker, come up with a superset. Now, that's tough, too, but at least if you did the superset just to one data intermediary that deals with these registries. I don't know how—I mean, the only thing we can, in the past, is to pick some federal registry like immunizations done at the state level, but some kind of small number that's important to a lot of people.

Other ideas on how we can advance this agenda?

In stage two, I think we had—what do we have in stage two?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

You get to choose one registry, right?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah, but it was named, like, cancer or something.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

There were two objectives in stage two—one for cancer registry reporting, and a separate one for specialty registry reporting besides cancer and immunization.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

How did the vendors deal with that one?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Well, there was no standard for specialty reporting. For cancer reporting, there is a cancer specific standard which came up in our estimates discussion, because now cancer is blended in with other registry reporting in this objective, which surprised us, because there's a specific cancer standard.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

What are you doing with stage two? What's the certification testing script for stage two for quote, other?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

There is none.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So it's just not ready yet?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

I'm not sure that there's even one in progress. There's no standard, so there's nothing to certify on.

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

For the specific registries, right? This is Charlene, and I know Art sat on our call, and I know he's not on today, that they were trying to see if they could generalize the reporting. I don't know, Amy, if you recall that conversation.

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

Did we—this is Leslie. Did we hear something from CDISC on this as well, about what they were doing to normalize and standardize common registries?

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

That's another one we want to take back the standards, Paul, because—

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I think so, yeah. So—

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

I'm sorry, Charlene; what was your question? I had someone pop in my office and I had, I got distracted for a minute.

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

No, it's that—Paul, Art had said that there was some work standardized on a common format for registry reporting, I just don't recall, I know the current state is not a positive one, so I thought we should take back the standards again.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah, the original feedback from standards was that it's not mature.

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

My general sense is that's true and it's very variable based on the registry, so I concur.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So, does anybody know how the certification bodies are gonna deal with the stage two under other?

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

It's not certified to other, it's only certified to where the standards are named.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Why don't we get Art involved in saying where are we in the current—and maybe we need to have this with standards as well, although Michelle just reminded us that Standards said this is not mature. *[Laughter]* Let's see where Art's thinking was in terms of how do we advance registries, per se, potentially with the exception of cancer. It's not clear that we can, it's not clear how you would implement this multiple registry without specifying them and without having one way to cover the ground. Anyway, we need to follow up with Art. Maybe this is something we hold out and get Art to weigh in on.

Okay. Why don't we go ahead and move on? Let's see, now let's go to, I think—okay, we'll just review this next one. It's stage three priorities—so, one more, please.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Can you go to slide 58? So we can do this one and then move back.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right. Okay, so this is just pointing out, and actually we, although we sort of brought it out as a visible category, it's always been under category one, which included efficiency, and we're just highlighting the fact that one of the things we had put in was appropriateness of lab and radiology orders. That, ironically, was one of the things in our original proposal for stage one, it just never has made it into the reg. We're reinforcing that, I think.

Okay. Are we ready to go back to category three?

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Slide 39.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Charlene, you're gonna help us walk through this one. *[Laughter]* This is medication reconciliation, and I think it is no change, it's just removing the threshold.

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

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Fortunately, Rob—

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

It's a small language change, sorry, that Mike Zaroukian had requested.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Yes, that's right, to make the objective as well. Yes. Yeah, but we don't have the measure of that change

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right, so at least, Rob Anthony, you have our previous draft, *[Laughter]* so you do know what we were thinking.

**Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid**

Yes, that helps.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

*[Laughter]* Because that was our best thinking at the time. Okay, any other comments about this, then?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Can you just—this is Amy. The “or believes an encounter is relevant—or believes an encounter is relevant”—can you explain what that means?

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

Would you like me to, Paul? *[Laughter]*

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yes, since Mike is the one that—*[Laughter]*.

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

Yes, I'm—

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Was that the language change you were talking about? I'm sorry I missed that.

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

Indeed. This is Mike. Yeah, I was championing this one. There's a whole slew of us who believe that every encounter is relevant for medication reconciliation. We resonated very strongly with the original objective that said “During a transition, or believes an encounter is relevant.” We frankly are currently required to do one of two things—either somehow indicate in a structured way that this encounter is a transition of care and exclude those where it isn't a transition of care, because that's the current measure, or we have to sort of turn a blind eye and sort of say, “Our vendor considers all of these to be transitions of care, and it doesn't have a mechanism to track, only those that are transitions of care, so it counts everything.”

What this does is, it allows those people who only want to do med reconciliation if they believe an encounter is a transition, to therefore market, and for the rest of us who do this as part and parcel of our everyday work, for every patient, number one, we can do that excellent work, and number two, not have to do extra work to document whether it was or wasn't a transition. It's easy for us to say, "We used our denominator to be all patients seen." That's a higher bar to cross, but so be it, we're volunteering to do it, we just don't want to do the extra work to say whether it was or wasn't a transitional of care.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

I get it when you explain it, I'm just not sure if it's [Laughter] understandable from a self-sufficient wording point of view.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow**  
Yeah, that's true.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

I mean, it's just sort of a hanging sentence. With the explanation, I get it, but if I were just reading it, I don't think I would—I didn't get it.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Actually, so what people, I think, could—well, probably the first interpretation is, now I need a coded box to say this is relevant when ironically, you're saying, "Oh, if you define relevant as all," then it gives you an out, as far as not having to count.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

I just don't know if there's an easier, a more clear way to explain what you're trying to achieve. I don't have a problem with what you're trying to achieve, but I think clarity would be important.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Maybe what you're actually saying, Mike, is, either for indicated transitions—that's a check box—or for all encounters, because that's actually what you're saying.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow**  
That is actually what I'm saying.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That might be easier.

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

I have no objection to that. I'm sure somebody will find something wrong with that wording, but yeah, that's the intent is to not have to count is as a transition because you always do it.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, Michelle, that might be a wording that at least expresses the intent, whether people agree with that or not.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah. I think emphasizing it's an or, not an and.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Mm-hmm.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. Okay, moving onto the next one. This is probably gonna occupy the rest of our time. *[Laughter]*

Summary of Care. Here's the challenge. We certainly want to have coded information to flow from—we want information to flow from one party to another for all transitions. We want as much coded as possible, and we want to have some minimum set. Now, one of the realities is, people created one report and we had a lot of possible fields, and they just put it all to cover all the bases, and then on top of that, they made it the after visit summary. The way this was implemented turned out to be a voluminous document or report that both obscured information that was useful in the Summary of Care and obscured it for the patients in the After Visit Summary.

One approach is to one, first clearly indicate what do we mean by transition, and two, really focus in on things that may not be there that everybody wanted anyway, whether—and particularly the recipient, like the specialist or the long term care—places where the patient is going want to know, “Why are they here, and what would you like me to do for them, and who's involved?” That's, in a sense, this current statement, and we worked through this, as you recall, to say, “Let's make sure people know why are they making this transition, what are the goals for the transition, what does the patient have to do, and who would I contact when I need to reach somebody?” It does not preclude anything else in your best interests, in your patient's best interests, that needs to be transmitted, but just not inadvertently make a floor out of a whole list of requirements.

Have I stated the problem *[Laughter]* and the objectives clearly?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Paul, the only clarifying point I might make is, again, this is—it's exactly where you started where it kind of overlaps with the documents that the patient gets and in order to try and tailor that one. This one, which is really being the source of data for the Continuity of Care document and its increasing number of forms, so that would be the only comment I would make. We didn't so much think about—but I think it's still pertinent in terms of what data actually gets extracted to send, in some cases. I think sending everything is overkill in some cases, too.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

This is Amy, and I have a question—where you've got “Summary of Care may include,” are we saying it may, or it must include those four bullets?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's a good point.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Yeah, recall we went through the exercise that looked at these by type of, by case—by use case, effectively, whether it would be required or not. That chart that we put in was what was taken out in this version. Again, in all cases, we felt that just that quick synopsis of the purpose of the transition was, I think, required. I think—but then, again, if you're sending back a consult note, it's more important to get the note back, we were much more rigorous, in that case. We were just trying to get the note back, right? Again, it varied depending on which use case you were doing the transition for.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

I guess what I'm—and I know that there's been a lot of discussion and I know I haven't been in all of them, so you can just tell me to be quiet and back off here, but you've got “Summary of Care may include,” and then you've got those four bullets. We're basically saying we're not gonna standardize what's in the Summary of Care. Is that what we're—and we're saying it can include these, but it depends on the use case with no guidance for anything of what minimally must be there?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

*[Laughter]* Yeah, Paul.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

If this discussion has been had and it's closed, that's okay, but I'm just trying to clarify, is that our position? I just am asking.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yeah. I mean, when we took out the table, and that certainly doesn't necessarily, isn't the right, potentially the thing to *[Laughter]*—the one thing it is doing is, there needs to be fields in the EHR to cover these things, and that's definitely making, this makes that happen.

Now, I actually got the table that Charlene had, it was an easy way to understand this, but it also then makes it a behavioral requirement, a functional objective that has numerator and denominator measures. The question is, is that appropriate? Maybe it is, but what do people think?

I think if you go to—yeah, if you go one more—yeah, there we go. That's the table. The implication, then, is that you would have to measure the provider behavior to cover those required fields and then the auditor would look for that as well.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

So the table that's in slide 42 would be part of the measure?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's the question. It was before and now we're, in this straw man, it's become more flexible and it's not a behavioral measure.

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

My one—I mean, I need to look at the table a little bit more, but my one concern is, well, I don't know. The flexibility appeals in some ways, especially like in states where there are already requirements legislatively, like for Continuity of Care form like in Rhode Island where there's a certain amount of information that has to be transferred. On the other hand, I think if we leave it too open, there's no consistency for our minimum standard of what should be communicated. I'm sort of, by having the conversation everyone's had on the meetings I couldn't make.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Right, and then I'll insert that EHRA said this was large to jumbo.

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

Isn't that because of the vagueness, though, and not the specificity?

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

Our estimate—this is Sasha—didn't include this slide. I don't know if we missed it, but the slide 42, we didn't have that. The estimate just covered consult, result, workflows, the auto-consult request forms, a narrative section in the CCA and then new reporting for the measure being revised. We can add this to the list of "to estimate," but it wasn't part of what we had.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Would it make it better or worse? *[Laughter]*

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

How far along is the Standards work to support this?

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

Actually, Sasha—this is Charlene—there's been a pretty extensive, we built this together with the Standards work that's being done on these particular standards. The standard that's a little further out is the Care Plan Standard, and we didn't take that one on, so these are going in the ballot, or—

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

Yeah, I think—this is Leslie—the one portion of the Care Plan is the Care Team roster that we would use is also pretty far along. That's also in ballot right now.

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

I guess we're—extensive work, and that was kind of why we followed, as we did these, that those use cases, because we were tracking pretty closely with the Standards work in these use cases.

**Sasha TerMaat – Epic Systems Corporation – Legislative Analyst**

That's helpful. This will be a net add to what we already estimated.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Now, also, most of these things are free text permissible, so it literally could be simpler.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Just simply based on the hearing yesterday, I was trying to drill, but it seemed like that's an appropriate approach in the midterm.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

What, free text?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

It's still a hybrid. It's in a construct that allows the free text, but there's still a standard that frames it.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Sasha, we appreciate the additional input on this matrix. The question before this group is, do we include behavioral objectives or not?

**Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

I would hope to.

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

This is Mike. I have to comment, because this gives me lots of heartburn as a primary care physician, having probably done six or eight consult request referrals yesterday in my clinic, if I were to—and I don't want to get too far into the weeds, but I'll just be really fast, I hope. That is, when I send patients to these various consultants, I'm almost always sending a Clinical Summary, so problems, meds, allergies, immunizations perhaps, et cetera, is going for their background reference.

The reason for the consult, which is number one, a few words on what is it I'm asking for them to do, and not much of anything else. The notion of trying to keep track of the various members of the care team, assuming I can get that right in the first place, the relevance that'll have to the consultant is variable on what they would need to do with it when they have it. Generally, there's not gonna be another designated family member playing a role unless I indicate that, but if it is, I guess I will. Overarching goals—you know, I want the fracture to heal and I want them to be able to walk, but do I really have to specify that every time in order to be a meaningful user?

The suggestion, instructions, whatever, et cetera are probably gonna be in my notes from the last note that I'm sending just before I have the patient see the consultant. If I have to back up again and put all that into some kind of a structured data field, even if it's free text, to meet this would be very burdensome and not helpful to quality.

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

This is Leslie, and this is a—let's think about how it's possible and helpful. This is one area that the consumer groups felt that having their goals of what they wanted was important to their care, the team members that were involved in their care. It was a way for them to become more involved and inclusive in care planning and care coordination.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I wonder if this—

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

This is Marc. I would second Mike's kind of concern about how much do we want—who do we want to have recording that, and how much time is it worth from different members, specific members of the care team to get that done? Because it is a big time consumer.

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

Yeah. I have no problem with the patient entering some of these data and, through a portal and letting that flow, et cetera, et cetera, if that's what they want to do, but to burden me with this for every consult, I probably would've skipped a number of the consults I did yesterday. Maybe that's good or maybe that's bad, but it's too burdensome.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

That's the point.

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

This is Leslie, and to have this patient very healthy is absolutely an opportunity, because it is important to the patient, it is a way to engage, so I think that's something that could be looked at. In fact, we heard in many of the discussions that gathering more information could create more of a burden, but when the patient was participating in patient generated data, like in care planning or in the results that they generate or how they're handling specific requirements, that that could be very meaningful and important.

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

Right, and I'll just carry it one more step, though. So I had a patient with a renal cell carcinoma yesterday that I have to send to two or three different areas, because he also has a pleural effusion and this and that, and the goals for that patient are very differentiates now and will become more crystal as they interact with the various specialists that need their care. Again, the key question of how much time and effort and energy I need to put in to sort of best represent that with incomplete information where their answer is, "I'm not sure what my goals are yet, but I'd like to be cured if I can be, and I'd like to be made comfortable if I can't be, and I'd like to not have too much time, effort, energy spent, and resources if it's not gonna help." All of those are general and true and real, but I'm not sure it helps at the other end yet. It certainly doesn't help necessarily for me to summarize that every time.

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

Would it help the patient to know that their provider knew what their values and preferences were in care, and that those were being considered in the overall treatment decisions, being that if the clinical goals are still not quite formed?

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

Well, the question is whether it adds enough value to burden the provider with transmitting that information to the extent that it's been gathered and captured in the note and putting it into another space that then goes to the consultant. Again, I'm thinking about how many clicks, how many data boxes I have to fill out, how much or how extensive I need to be in sending what I think is helpful to the consultant. If somebody says, "We want to put a forcing function in here that says doctors too often don't include overarching patient goals, whatever, for the various problems that they have, then I think we can talk about how to do that." The question of how to get that into a summary and the mechanisms for that, I think we should discuss more before we get too prescriptive about it or even to make sure we're data based in terms of it's crucial for the provider to do that as opposed to the patient doing that.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Let me try to pull this together. I think we all agree on the intent, and a lot of times, of course, the intent is carried out and sometimes asking for things to be documented actually *[Laughter]* takes away, is the burden that interferes with some of the intent.

One possibility is, if we don't include—if we can go to the previous slide, please. If we leave out the behavioral matrix, but we make sure that the EHR systems have these buckets, have the fields to be able to put information in that's transmitted and consumed by the recipient, even if it's free text, that's sort of like making it, enabling it without forcing documentation of a specific behavior. I believe the market actually is driving this in the sense of moving towards accountability, moving towards shared decision making, because I do believe there's quite a bit of movement in that direction—if the tools are available, then people will use the tools. The cost of prescribing exactly what tools in exactly what fashion creates actually the barriers that impede actual use of this.

Could it be that this, what's in front of us, which has an implicit certification criteria, is the compromised middle that allows, that makes sure that this is enabled and yet has the market driving its use?

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

This is Mike. This is why I would say—I'm sorry, but this is why I would say that word “may” was the critical word. I actually think that's all fine if it is indeed “may.” Whenever I think including any of those things will be helpful to the consultant and to the patient, I'll be more than happy to put them in. If I must put them in for all of them, then that's burdensome, regardless of whether I think it adds value.

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

I think “may” is—this is Leslie—I think “may” is appropriate in this certification. It requires all the systems to support it, as necessary. That could be a very good compromise, knowing that the market is moving further in this direction.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Good. Okay. Let's declare victory. *[Laughter]* I've got to put it up to public comment.

I think we worked this through. We heard both sides, and I think that is a way of moving the ball forward, and I really do believe the market is driving this. We wanted to stay out of market driven things, because it's just so much more efficient. Okay.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Paul?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yes?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

And Michelle, remember we said e.g. hospital—don't forget to put home in that first line, transfers of care.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yep.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Big point. Okay, let's go ahead—

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Wait, actually—sorry. Where, \_\_\_\_\_? It's in the first part. Where else did you want it?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Under the first bullet, types of transition, one to another, e.g.—yeah, put home in there.

**Michelle Consolazio – Office of the National Coordinator for Health Information Technology**

Okay. Okay, thank you.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

It was written someplace else in the document, it just never got replicated, so.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

The first bullet has it included.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Do you still want it up there, though? Setting of care, including home?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator**

Yes.

**Public Comment**

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Okay. Operator, can you open the lines?

**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 have no public comments at this time.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. I want to thank the members for attending. I think this was a productive and constructive discussion. I really appreciate that. I think we are moving both with the spirit of the approach we have with the outcomes, the flexibility for innovation, and moving the ball forward, so thank you all for that.

Sasha, I want to thank you and the EHRA for doing this work and putting together—as you saw, this was helpful, and we look forward to some of these other questions and your final document, but this is useful information for us.

Thank you, everyone, and talk to you next call.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, Paul.

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

Good night, Paul.