

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

Presentation

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

Good morning everyone, this is a meeting of the Health IT Policy Committees 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, this meeting is being transcribed and recorded, so please state your name before speaking. I'll now take roll. Paul Tang?

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

Here.

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

George Hripcsak? David Bates? Christine Bechtel?

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

Good morning.

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

Good morning. Neil Calman? Art Davidson? I know Art was on the –

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Here.

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

– oh hi Art. Paul Egerman? Marty Fattig? Leslie Kelly Hall? David Lansky?

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Here.

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

Deven McGraw? Marc Overhage? Charlene Underwood?

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

Here.

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

Mike Zaroukian?

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

Here.

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

Amy Zimmerman? Tim Cromwell? Joe Francis? Greg Pace? 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

And Rob Tagalico? Are there any ONC staff members on the line? Okay, I'll turn it over to you Paul.

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

Right, thank you Michelle. And welcome everybody back to government in action. As you know, we've missed a couple – well, we missed a monthly HIT – sorry, just got back from Spain, HIT Policy Committee meeting and a workgroup call, so we're going to have to try to schedule – reschedule the workgroup call at least, and that does push our calendar out a month. So, we might as well go to the next slide please, where we take a look at our overall work plan. Next slide please – one more – back, yeah. So today's call is an hour and a half and our objective was to finish up with subgroup 3 and then move on to subgroup 2 and hope that we could get through at least part of subgroup 4. That seems like it's cutting it a bit short in terms of the work needed, so that's one of the reasons we're going to try to schedule another call before our December – and so we were originally going to present our final recommendations in November, now it's going to be December, but that's still a pretty compressed timeline.

There was a Care Planning, otherwise previously known as Advanced Directive Hearing that happened in late September. So we'll go over the results of that at our next call on the 28th, which is Monday. And also talk some, and here again it's going to be – I don't know how much we're going to get to, timing of Stage 3. Then we'll be looking at the results to see Quality Measure Workgroup and the special ACO Quality Measure Tiger Team is going to be presenting some of their recommendations at the November HIT Policy Committee meeting, so we'll take that in consideration and start looking at how that would affect deeming for the functional requirements for Stage 3.

Consumer Workgroup will also have had a hearing in the middle of November, and so we'll be receiving their recommendations, as well as information from the HIT Standards Committee on imaging and sort of hopefully get to final recommendations – start the final review of our recommendations by the end of the call on the 21st. We'll then have one more call, and we're trying to schedule another call on top of that, is that correct Michelle?

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

Yeah, we're working to schedule another meeting.

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

Correct, because I think, as you can tell, we have a full agenda, we have two hearing input coming in, we have input from the Standards Committee, we still have to finish up our revisions based on the feedback we got and we have to discuss timing. So a lot to cover between now and approximately 5 weeks from now, so that's why we're trying to add another call. Once we get the final recommendations from the Quality Measures Workgroup about the measures that could potentially be used for deeming, we would begin in December to look at how that would affect our functional objectives, what would get deemed given the new recommended deeming quality measures. And then produce those final recommendations for the deeming program in January. Let me just pause to entertain any questions about that, that draft timeline between now and January essentially. Okay –

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

So Paul, this is Christine.

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

Yes.

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

Sorry, it's Christine. I was wondering, in terms of the timeline for receiving the Quality Measures Workgroup, does that mean that you would expect that our recommendations would include the way to structure the quality measures piece of Meaningful Use and not just functional recommendations?

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

Let me see if I understand your question. So, Quality Measures Workgroup would be talking about quality measures for the Stage 3 program, which hopefully some include some in the pipeline and then some new concepts. And in addition, they're to give us recommendations on what would be the most suitable for deeming. And then the things that would be left for us to do after they come through with their recommendations is then, what are the – what's the subset of functional objectives in our MU Stage 3 functional objectives that would be covered by deeming, in our opinion.

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

So I guess the question I'm asking relates to the fact that I feel like some – we need to make sure – we have a lot of functional requirements or things around things like health disparities for example, where we want to have input into the structure of the program with respect to quality measurement. Deeming is a piece of that, but even things like, well, should you have to report a core set or regardless of what you report, should you have to stratify by disparity variable, things like that. And I want to make sure that I understand who makes the recommendations for how that should be implemented to CMS and if it's the Quality Measures Workgroup, that we have a chance to weigh in on those recommendations before they go.

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

Okay. Well there's a couple of ways to weigh in, one is a lot of people on this call are members of the Policy Committee, so that's one way. The other is, as you recall, when we talked about the deeming program, one of the ways to address disparities was a requirement for –

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

Yes...

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

– stratifying by – and that – we still have an opportunity when they come back to us, to – that's part of what we can weigh in on.

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

Okay, so is it that group that makes the recommendation and not the Policy Committee or, what's – that's where I'm confused.

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

So they would try to get us quality measure recommendations, even if they don't currently exist, upon which to base our deeming program. We would receive those recommendations and then try to see how to – what functional objectives could be deemed if you were to perform well on some of these quality measures that they're proposing. In addition, as we did before, we may have that extra kicker of saying, you have to report on four – pick four quality measures to do for your deeming program, and then what we did before was said, and one of those four, please stratify by the disparity variables. That's still something we can recommend as part of the – between December and January.

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

Right. I don't know if I'm not being clear or what. There are two types of quality measure proposals, one is deeming, but the other is how the rest of the program, for the not-deemed people, is going to work. So, like under Stage 1 –

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

Yeah.

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

– everybody had like a core thing and then Stage 2, it changed to either one of the NQS domains or PQRS alignment. That piece of it, I'm wondering who's working on that, whether that's changing or not and is that – and who is making those recommendations directly to ONC and CMS, is it, well, I assume it's the Policy Committee, but I want to understand is there a workgroup that's looking at the overall structure for the not-deemed measures?

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

Uh, that would be the Quality Measures Workgroup.

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

So those would be coming back in addition to deeming on 11/6?

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

Have I got that right Michelle?

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

Yeah, I mean, but in a – right now, they're really focused on deeming, at least for November and through December.

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

So that means we can't really present a full set of recommendations unless they start to look at that in their workload as well, because we can't just recommend a quality measures approach for deeming, we have to do it for the other meaningful use regular, or whatever we call it –

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

Well, right. As you know, in Stages 1 and 2, it was the Quality Measures Workgroup that provided input that was actually passed on through Policy Committee to CMS.

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

Right.

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

So the Meaningful Use Workgroup didn't specifically say, oh, here's our set of quality measures.

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

Right, right. And I totally get that. All I'm saying is, it doesn't sound like that's on their plate, based on what Michelle just said, and I want to flag that because it needs to be on their plate or somebody's plate, if we're going to really have a full set of recommendations ready to go, after December.

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

Yeah so – Christine, this is Michelle, I'll follow up with the Quality Measures Workgroup and make sure that in addition to their deeming work, that this is also part of their work, but it definitely will fall under that group.

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

Great. Thank you very much.

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

Okay, any other questions? All right, let's go to the next slide please. So we're going to pick up from where we left off in terms of category 3, in care coordination, and as you recall, we had a set of – we were sort of working backwards from the outcomes to achieve. Now these are not outcomes that represent the total health outcome, but these are outcomes that are in theory HIT sensitive. So the goal for Meaningful Use Program would be to have outcomes such that all members of the patient's care team, that's the professional side, the patient and the caregivers, have the information they need to participate in implementing a coordinated care plan. Now these are aspirational goals, but this is sort of the eye on the prize part of it. Next slide please.

So if you decompose that, then...you went one – yeah, there we go. Okay, so for those outcome goals, you can say, these functionality goals would be HIT sensitive ways of achieving the outcome. That is, all the relevant information shared amongst the healthcare team, the broad team, and especially during transitions, transition of site to transition of providers, because that's where you will – that's where information falls through the cracks. And that in addition to information about an individual, we also understand, this is somewhat aspirational, we have to take it in stages, the goals, the care plans and the interventions going on for a particular individual, and those are both shared and tracked. You see where we came from in Stages 1 and 2 is, we were trying to get some of the components there, we got the summary of care, we have medication reconciliation, now we're trying to build more towards the complete picture. And again, Stage 3 is not our last effort, it's one of the first really important efforts going towards this bigger picture. Next slide please.

All right, so a couple of things have been added here. One is you still see the functionality goals that are motivated by the outcome goals for meaningful use. We see in gray, did I get this right Michelle? This is what we said before we took this –

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

That was from the August recommendations, I think it was, I might have my month wrong.

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

So it's still for Stage 3.

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

Yes.

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

So this is where we left off before we took a step back and said, oh, let's go top down and say, here's where we're ultimately headed with these outcomes and then work backwards, and hopefully they will align pretty well with some tweaks. Another thing that's been added to this slide is the fourth column, you'll recall that we asked EHRA, which is the Vendor Association of EHR or HIT vendors, to give us their best estimate in a qualitative way, on the level of effort. Because clearly if there's something that is really important functionality, and it's really a small piece or people already have it, that's sort of a no-brainer. On the other hand if there's something that's going to take major effort, as you all know, these do take resources that could go – be spent in other places, and we wouldn't want to spend them here if it's not super, super important, especially if it's a huge effort. So that's one way of sort of calibrating what's the level of effort required from the vendor perspective.

Okay, so going back to the goal, this is to get relevant information to the whole healthcare team and keep us all aligned on the goals, care plans and interventions for an individual. And we are saying that we – this particular functional requirement is to be able to transmit electronic notifications of significant events such as, being seen in the ER, being admitted, and those would go to people on the professional health team as consented by the patient. So, this is quite a new functionality. Not only is it new functionality, it requires a lot of things to be in place, and we've struggled with this in a number of areas, let's say, public health reporting, but it's one thing for a piece of software to be able to do it, it's another for the workflow to support capturing and transmitting that information. And it's yet another to say, and there's a way to transmit it in a standards-based way, and finally there are people out there who could receive it in this electronic, standards-based way. So that we can't load everything on, let's say one of those four components, if the other three aren't in place, and that's the dilemma we've struggled with.

One approach to that is, we've used in the past, start with a menu and go towards core, and that's a very strong signal, of course. Another one I want to introduce for our discussion, and we have used this before, is to, one of the four components – make sure the functional piece is in place in the software. And that could be done through certification criteria and that could also – so the certification criteria, the testing could be done with a test system, much the way CMS is standing up one for the summary of care document. So, I just want to introduce these different levers we have, and there may be others, so one is you outright force everybody to do it, which means all four components, all four major components have to be in place, at the same time, in your – area. Second is to make it menu, and give a bit of flexibility. A third is to require that one of the components, and this is the component we have the most control over here, is the certification requirements. And the fourth is to postpone it for a future stage, using that as a signal.

So let me open it for discussion on where the group feels – and that's partly taking into account what the EHRA says is a jumbo-sized kind of requirement. And I don't know whether, for the reasons that I described, how many other things have to be in place or what it takes specifically on their part.

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

Paul, this is Char – this is Charlene. Just to comment a little bit on this one, just as another nuance in thinking this through, typically this is done by registration systems, because that's who knows about these different conditions.

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

Uh huh.

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

So the thing I wouldn't want to necessarily have to bring to the table is all these registration systems now have to be certified. So I don't know what we do with that, but, the people that testified a little bit, I think talked a little bit about their use – because when a patient – when – it's often these functions happen within those systems.

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

Uh huh.

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

I think we've dealt with that issue before, but I wouldn't want to imply that we necessarily have to rebuild the functionality in electronic health record if we can do it within registration processes.

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

That's a good point. Other comments.

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

So hi, this is Mike. So this kind of functionality is something that we consider in general to be a high priority and are struggling with in our own systems, so I certainly resonate with the value of being able to notify particularly PCPs for the various things that are described here. Quite possibly prioritizing the most the admission and discharge, but I also resonate with the reality that this looks like a jumbo estimate and it would be interesting to see if we could start through the process of certification and an EHRA estimate of something less than jumbo, and take the kind of chunk we can out of it. I think most folks who had EHRs certified to do this would probably use it, without it even needing to be a menu or core item, if we could do it, we would be doing it now, because it has advantages to everyone. We just struggle to do it.

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

That's certainly true and I think all of us are resonating with this on the clinical side. What's your response to what Charlene says, which is, a lot of the notification, including getting the consent, would probably happen up at the registration stage.

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

Yeah, it could. So I do resonate with that Charlene's saying. Some of the clinicians I talk to would also, however, say, if we could do it without making it a free-for-all, the ability for me, if I'm with the patient and I see that the PCP designation is wrong, to be able to have control over that within the EHR. Because we are appropriately kept out of the registration system so we don't mess it up, but that we have the capability to do certain aspects of it that are core to meaningful use and some of these goals, is probably a reasonable set of functionalities to allow clinicians to be able to update.

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

So let me combine both of those ideas as saying one, we recognize the clinical importance of this. And two, I think one of Charlene's points was, I don't remember whether it was Charlene or Mike, saying is there some intermediary stage of certification requirement that can go to some "EHR module" that can help us do this, and make this available. And then it's up to the provider to take advantage of it. Other comments?

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

My – the counter-argument on not making it menu, I actually kind of like the menu situation, is because a lot of the work is process work and we're finding that with Stage 2, they're working really hard to get their governance set up and those kinds of things. So, so much of it is that kind of work and where we might just put it in our system, it could be one of those situations that after doing all the work, it's not used. Now Mike can counter me on that one, but it's like – I think there's both sides to that argument.

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

Yeah so Charlene, I'm actually, I think, in agreement with you. I think the key issue though is as we think about menu items and the number of menu items you have to choose and what you do if you're not capable of doing it. I just hesitate about making it a menu if it isn't already a clearly established thing you can do in certification and the issue of the devil being in the details about if this is one of the menu measures, how many do we end up with an what are the –

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

Yeah.

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

– logistics about fulfilling that. But otherwise, I completely agree, if it's an opportunity as a menu and it doesn't create those kinds of complications, I'd love the opportunity to be able to fulfill that as a menu item.

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

And this is Marty Rice from HRSA, and from a rural perspective, the more menu items, the more choice that some of our provi – rural providers have, because a lot of the quality measures aren't going to apply to them. So the more menu items that you have on a narcissistic view that it would be more helpful to the rural providers and hospitals.

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

All right. So let's see if we can't get towards some kind of closure. One, do we want to prioritize – so, there's – we have a list; significant events include, and there are four of these included. I think Mike suggested a couple of priorities, one is arrival to ED, you can do something about that, two is admission, and you can also do something about that. Three is discharge and death, the fourth you can't do a whole lot about, but these are important things. Is there a way that we can help limit the scope of the effort by pointing out two that are actionable, like ED visit and admission?

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

Yeah, and I would – this is Mike, I would just look to Charlene or others who are on the vendor side to try to get an estimate of what it would take to move this from jumbo to more manageable, so it didn't eat up so many resources.

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

Yeah, I'd – Paul, I would have to go back on that one.

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

Okay.

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

Because it could be, to what extent the standards are available and that type of stuff that could affect that.

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

Okay. So, so far I've heard – I haven't heard any support of suggestion for making it core, and I've heard a bit of wavering between menu and certification requirement and probably that's dependent on the level of effort. So perhaps we could have as a follow up, either from Charlene or EHRA –

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

Yeah.

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

– if made it to the ED – notification of ED arrival or – and admission, does that help with the size of the effort and if it does lower it, then maybe we can move it towards menu, which still allows people the flexibility, but does include a strong signal –

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

Okay.

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

– and starts the behavioral thing going.

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

Right. This is Mike, I agree with those two as the best – the highest priorities.

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

Okay.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

This is Art, I agree with those two. I'm not sure I'm entirely in agreement about this shouldn't be core. I think this is pretty fundamental. Maybe I'm not understanding exactly, and Charlene made some comments about the registration systems. Don't all EHRs have to operate in the context of a registration system and are they not talking with that system? And the registration system already is preparing the – well, at least in my environment, ADT messages related to these types of events.

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

Yeah.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

So, I just wonder if that's really as difficult as – I get it about death, it's totally a different sphere. And the discharge from the ED, I wonder about that as well, but it seems like just the fact that someone's admitted to an ED or a hospital is pretty important and we should make that available.

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

Yeah, I – I don't know why it's jumbo either, and again, I think it's – I would have to go back and see how they thought it through relative to, is it a new module they have to add to the – hopefully not, because it's the registration systems that know this and they've been doing this stuff for years. So – and I just don't want to bring the whole plethora of registration systems into the certification process, that's what I worry about. But, I know there's a strategy to not make that happen, I just forget what it is.

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

And this is Mike, I'm just saying, it's important enough to be core someday, I just would say that the approach that ACP and a lot of other organizations and I resonate with is it's way too early to call something core when it's currently estimated as a jumbo effort that people can't do today. And we're basically betting on the ability not only to be able to do it, but that it's so doable that we can predict that it's okay to make it core and have people fail to be meaningful users if they don't achieve it. And to me that's far too big of a stretch on even this important issue from this current horizon.

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

Okay, I think we have a game plan for this. Okay, if we move on –

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

Paul, this is Michelle. I just wanted to mention that I've been in touch with Sasha from EHRA and they were trying to figure out what the best way to do their work is, because they know that we are kind of – in their process and tweaking things.

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

Yeah.

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

So I'm going to follow up with her after today's meeting, because hopefully after today we'll at least have gotten through all of the recommendations, or all of the objectives, and then they are going to try and figure out when – what's appropriate for them. So I will share this discussion as well with Sasha and follow up with the group.

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

That's a good idea and the more detailed they can be – and I know, yes, it all depends, but the more detailed they can be as far as where is the level of effort or the uncertainty, the better – the more informed our recommendation will be.

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

Ask what assumptions they're making, right?

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

Right.

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

Well, yeah, so I kind of – I wanted to wait until the end of people talking about the details on this slide, but I have a couple of threshold kind of questions here and one relates to the jumbo vendor burden thing. And so my first question on that is, it's just a very basic question, I don't see that tag anywhere else in these slides, is this the only area where it's a jumbo effort?

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

You're correct, that's the only one I caught. I think there was a large to jumbo estimate. And I – as I say, I'm sort of reading between the lines, I'm seeing a lot of – remember, I sort of decomposed it into four major components, I'm just seeing a lot of each of those components and the in-betweens, would have to be in-line for this to work. And then especially to work..

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

Right. But what I'm saying is, like if you step back, there's a ton that aren't tagged as anything. So if I assume those are easy, and there's one or two that are large or jumbo, I'm not as worried about that. So I want to say, number one, I'm not sure how helpful this tag is, because it doesn't give me – it tells me on that one particular item, but there – not every item is tagged and a lot of them are repeats anyway of earlier stages, so I'm assuming they're not heavy lifts at all. So if we only have two jumbos, then I don't think I'm really worried about that. But the other thing is, I just sort of want to raise people's awareness to the fact that we've spent an enormous amount of time talking about the burden on providers. We've now come up with a classification system for the burden on vendors. And I want – if we're going to do that, then it would seem to me to be fair and comprehensive to think about the burden on patients and on purchasers in that context so that we have a way that balances out, well is this criterion really worth it. Yes it's a heavy lift for the vendors, but it's going to be a big benefit for providers, it's going to be a big benefit for patients, so I just feel like it's sort of one dimensional and it needs to be more comprehensive.

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

I think we're asking for them to decompose this. I'm reading into this with the broader eyes. I don't see this as small to any of the stakeholders involved –

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

Right, I don't either.

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

So it's not – we're not doing this based on it's just a matter of software code, no that's not what – that's not what I'm reading into it. It's a little –

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

Well yeah, but I think it's pretty easy to – I'm sorry?

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

It's a lot – I think Mike put it well in the sense of, you can be totally up and ready as one organization and then you play with a number of other organizations who aren't, the penalty is that you can't be a meaningful user, that's the whole core argument for example. I think a lot of us are sympathetic with the menu.

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

Yeah and I'm not speaking to core versus menu on this, I'm just saying as a general comment, we need to be very careful because if we're going to only suddenly have a slide deck that has one stakeholder's estimate of burden, there's at least two or three others that should be factored in. So I just want to have a note of caution about that. And then the second thing is a bigger picture piece, which is, and I know that I raised this a couple of calls ago, and I thought that folks were going to revisit the fundamental approach. But I'm worried that we're not getting enough detail, enough to – that every other one. Because as I mentioned before, and as Rob Anthony confirmed, the first time that people will see any kind of – any information on threshold, for example, even a general estimate, small, medium, large, doesn't even have to be a number, is going to be in a 60 day comment period.

And I think that's not – I think that is a huge disservice to particularly providers, in this case. Because they won't know when they get this – as we go through our comment process with the public, they won't know if this is a menu item that is, they're going to have to do for 80% of their discharges or for 25 people, without any characterization of scope of applicability, I think we lose a lot. Because people won't have the ability to really comment and be helpful to CMS in getting the scope right. And I wanted to suggest that maybe we think about using some characterizations like a small number or a significant number or a large number, kind of a small, medium and large, so that it gives people a better sense, even though it's not a specific number or percent.

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

Okay. I don't have any – you can see in the left column, we originally said 25 patients, and we've had the discussion on different – and if this qualifies as a small absolute number, I'm happy to include that as part of our draft that we present, if others agree.

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

Well Paul, when we present these, are we going to be including the gray box or deleting it, when they go to CMS, for example?

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

The new one would be the first green one, so the second column, that's our new approach. But so if your proposal is that we include either 25 or low absolute number, we can – let's talk about it as a group and see if other people are willing to accept that as included in that second column.

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

Great, that is my proposal.

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

Okay, others?

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

So this is Mike. I thought we had gotten feedback from a previous meeting that HIT Policy Committee is discouraging us from doing that, did I hear that wrong?

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

And that's the counter.

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

Yeah, okay.

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

Well right, but we got feedback from CMS that said, yeah, we don't anticipate changing the overall structure of the program and the more detailed work you do for us, the better in writing the rule. And he also said, if you take out all the numbers, then people won't have the ability through the Policy Committee to really weigh in on the subject.

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

So, and then that's all –

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

And I'm not sure that people – Paul, I mean correct me if I'm wrong, but I'm not sure that the feedback from the Policy Committee was get rid of the numbers. I think the feedback was from – it was Steve Posnack, I think, at ONC saying, yes, generally people do get hung up on the percent and the numbers and the thresholds. And that early in the process we needed to kind of get the concept right first and then address more of the details that we didn't need to be fighting so much about the weeds. But I didn't hear anybody say, get rid of the weeds and go to concepts. I then heard Farzad saying, we need to help people rise out of a kind of compliance mindset and into a more operational mindset. So I heard that feedback, but to me there's a balance.

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

So let me –

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

Christine, sorry, go ahead.

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

I think –

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

I'll just say, there have been conflicting messages. At the meeting when the Meaningful Use Workgroup presented their last recommendations, Farzad did specifically ask to not include thresholds. So that was feedback received. But to your point Christine, Rob on one of the calls also did say that it was fine to keep going with thresholds. So I think it's really a matter of how the Meaningful Use Workgroup wants to proceed.

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

So I would say we have gotten conflicting advice. Now CMS is the one that makes this particular part of the rule, they do appreciate some indication. I would say the most specific request of us, and it turns out that this is what we're not following at this point, is not to spend a whole lot of time discussing the number itself. And if we could leave it, if there's a compromise do none or precise, if we go to low absolute or low percent, we just stay there, then maybe that's a nice compromise, I can certainly see the value of having some kind of indication. So let me just put the proposal on the floor which is, Christine is saying, to add back into column two, which is our latest version, a low absolute threshold for this menu item.

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

This is Mike, I support.

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

Okay. Others agree?

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

Marty agrees.

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

Okay, so can we move on? We're just going to have to move on.

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

Do we have to revisit them if that's going to be – this is Charlene, the number then?

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

We'll have to revisit all the ones we've already gone through.

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

Yeah, I think we did the work, it's just a matter of transferring it over in more general terms.

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

And this is Mike, maybe we could say indeed the low absolute threshold and then in parenthesis, for example, 25, that way it's just an example of what we mean by low and they can decide what they want to do with it.

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

Yeah, or we'll have some kind of preamble that just covers it all. So we'll have to go through this Michelle, when we go through our final review, and see where we've already made a statement and if we can translate it into this low, medium, high, we can do that. If we run into problems, we'll discuss it at the time. But it may be fairly straightforward coming from our old work.

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology

Hi guys, this is Elise, I'm from ONC. I just wanted to add, on the point about Rob Anthony, I definitely don't want to speak for him, but I think on the call that he was on, the impression I got is that where the workgroup sees it as extremely necessary or extremely important, that that's where kind of the low, medium, high would be useful. I'm not sure that fully got the impression that it would be for all of the kind of components or the factors. But, I'd just add that into the conversation in case it's helpful. That's just my recollection.

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

And just the only other factor to consider in this, I mean, you guys know where I stand is; if you are the American Medical Association or the Hospital Association and the first thing you see is healthcare event notification. And you have no sense of if it's going to be a threshold that is 80% of discharges or 8% or 25 as a number, it is not helpful to go through this whole rigmarole process and there's only a 60-day window and you have one shot to give them feedback. So, I just don't think that's helpful as a policymaking process at all, and it's not transparent. So, that's my vote.

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

Okay, so let's – I appreciate what Elise just said. I think what we can do is instead of having to make sure it's in every one, I think for a new thing like this, it's very helpful. So when we have this new – we've talked about the level of effort, etcetera, it's helpful to give an indication. So we've done that, we'll see if we need to add that to any of the previously discussed items. But, I think we need to move on.

This one I think is the same thing, if we – next slide please. Okay, now we're moving into category two, the outcome goal is we want patients to be able to have the information so they can understand their disease and understand the treatment and to fully participate, to the extent they want to, in shared decision-making. And to do that, we'd have to understand and honor their preferences. Functional goals that would support that aspirational outcome goals would be that we give them the information they need online, we've done a lot of work as viewed in Stages 1 and 2 to do this. We give them the ability to contribute information, which includes PROs, and the ability to record and make use of their preferences. So that's the goals – those are the goals we have for functionality in Stage 3. Next slide please.

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

Actually Paul, I have a comment on that. In the Stage 3 functionality goals in the middle piece, the first bullet, I think it – I would prefer to change it to something that says something more like enabling active participation by patients to improve health and care. Because online access provision doesn't reflect at all, all of the things that patients can do other than just go online and view it, right? We have download, we have transmit, it doesn't reflect sort of patient education, language and literacy, so I think if we do something with more focus there on enabling active participation by patients and families to improve health and care, it's a little bit more accurate.

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

Okay.

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

Is that the outcome goal Christine?

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

That's the middle functionality goal or whatever, I don't know. But it's at least this online access construct doesn't sit well because you can do so much more than that.

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

Yeah, because it seems like you could enhance both of those a little bit with what you said.

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

Yeah, I agree. That's a good point. We can work on it later Paul, we don't need to spend time here.

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

Yeah, let's work on that later.

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

Okay.

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

Okay, next slide please. Okay, so now we have the comparison of our former draft in the gray and the addition of the EHRA estimate of effort. I actually didn't – couldn't understand it, they said large and then they have all these small things, but maybe it's the combination. So it's not terribly clear. I think more details and breaking it out would be helpful to us. So this is – it's actually not that much change from our last objective. What we want to do is get them the information they need to make decisions. So the stuff that's already available when they have a visit, we're asking for them to have that in their "available to them," VDT, within 24-hours of the visit. If there are results that are returned later, then make that available within four business days of that becoming available. And have the certification requirements for patients to be able to designate to whom they want this information to go.

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

So, Paul, it's Christine. I think one thing that didn't get transferred over is the family health history.

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

Okay, I think we're still stuck on, and we've been told in no unclear – no uncertain terms by the Standards Committee that unfortunately right now the family history isn't something that is stand – which there are comprehensive standards and the way we'd opt out of that – we dealt with that before is to try to pick some high value ones and hope that those –

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

No but Paul, can I interrupt for one second. It was already – it's on the left, I'm not adding anything new. It's already in Stage 2, we were just adding a view into it where it exists, or where the provider has it, for VDT that was something we already agreed to a long time ago. It just didn't make it in the translation to the green column.

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

So do you have any history on that Michelle. Another thing I can think of is they tried to take out the optional items.

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

Who's they?

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

I honestly don't remember Paul. Sorry.

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

Okay. So I think the proposal's just to put that back in.

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

Yeah, so I mean, I know where it came from from before, for VDT there's a list of items that should be included and the suggestion was that that be added as one of the items.

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

Um hmm.

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

Okay.

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

Right, it's just a data element, it's not a new collection requirement, and it's been there for a long time. I think the thing – the two things that we talked about previously that were new to make this more meaningful for reducing health disparities were one, getting feedback from the Standards Committee about what we need to do to facilitate mobile access to VDT. And two was, like more of a certification criteria around translating medical jargon into plain language, which you can already do I guess today through Medline Plus. So we had talked before about getting feedback – quick feedback from the Standards Committee on the best approach for facilitating those things, but I don't think we settled on anything and I don't know what the feedback – if we reached out to them or not.

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

I would think –

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

We haven't reached out to them.

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

I would think that's covered under educational resources, right, that's where we want to apply patient contact specific use for –

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

No this is – well, what we – before is so if I'm looking at my portal or if I'm looking at Health – or whatever, and I see the word lipid and I don't understand it, it gets hyperlinked to MedlinePlus Connect so I can translate – I can understand what the word means. And that context was specific to like view, download, transmit, for that reason, as opposed to patient education materials, which typically are already written in appropriate literacy level. So the context really was VDT.

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

Yeah, we may be –

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

Would it be possible to ask those two questions of the Standards Committee and get some quick feedback?

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

We can try and reach out to them, I'm just worried about process-wise, the best way to do that. But, I can follow up with you Christine, figure that out.

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

Okay, sounds good, thank you. And maybe we can do it through Leslie or something at our joint session or whatever. That sounds good, thank you.

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

Okay. Thanks.

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

I think there's also a different way of looking at it. I think VDT is, what we see in front of us, the hyperlink you mentioned, that would be my – my interpretation of that, that is applying an educational resource to a specific question for a specific patient. That's where I would – that's the bucket I'd place it and I think functionality wise, it's easier to do that way.

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

But that wouldn't – but Paul that would – the way I am interpreting your comment is that would only apply to the specific patient education materials that you give on a particular condition. So – as opposed to anyone who goes into let's say their portal or whatever, if they don't understand the terminology, they can link through, which is totally different. Am I misunderstanding you? It's not –

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

No, we're talking about the same functionality, it's just a way of parsing where you put the function and in the view, download transmit, it seems like a clean thing. You get access to your record basically and as another feature, you can get access to things about information in your record and I would put that in the latter bucket, because that's – it's easier to think about it.

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

Okay, okay, I think I was misunderstanding you, I thought you were talking about the separate criterion on patient education materials.

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

Well, there's one – yeah, I'm broadening that concept.

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

Okay.

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

You want to have patient educational materials, but not just another encyclopedia, that's an old framework. You want it to apply to new things, so I'm just saying, it's in that bucket and there's a lot of innovation that can occur in that bucket.

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

Great. I like that.

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

Okay. So I think we're done with this. Next slide please. And this is just a repeat of that. Next slide. Okay, now we're talking about making amendments. So this is a – what we described as certification criteria only. It's an easy way for you to say, hey, that either I want to add to that or that actually didn't happen, some way, an easy way for the patient to make a very specific note back to the provider. So the question before us here is this a Stage 3 or future, and I think part of that relates to the – sometimes we use certification criteria only, at least in the past as saying, oh, you know, that's not quite ready for primetime but we'll stick it in for the vendor certification, for the vendor function. And should we keep that style or should we just target this for a future stage?

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

Paul, where is this question coming from because – we have – we've had a workgroup that's had this since the very – it's very inception and no one's questioned whether we're ready or not because it actually went from a menu item to a certification criterion for good reason. So why would we not – I don't understand where the question is coming from.

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

This is Michelle. I think this came from when, I think it was August when Paul and George presented to the Policy Committee and there was a question of whether we were trying to do too much. And so the thought was, if things are certification criteria only, should we perhaps be thinking about the effect it has on vendors and if it's too much, then perhaps it should be a future stage rather than just a certification only item.

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

Well, okay, that's helpful Michelle, thank you. I guess in this case my reaction would be that we do need this now because we have now, in Stage 2 and then further in Stage 3, opened up a potential sort of Pandora's Box of health information and we know that there are a lot of issues around accuracy. So it makes sense to make it easy for both providers and patients to fix that, since they already have a right under HIPAA.

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

So, can I hear from other folks who want to keep this as certification criteria for Stage 3 or a different approach.

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

Yeah, so this is Mike. I think for me the devil's in the details, not so much from a provider, but maybe from the vendor side. So I would love it, for example, if my patients could look at their medication list and check a box on the portal that indicates they're no longer taking that one, so I can do something about it, or a problem list entry where they said that's now history, I can remove that. Or, have a more free-form way of messaging me to say, "I see my problem list, but I – or I see some other piece of a note that you've shared with me, because you're doing OpenNotes or whatever, and I'd like to correct this piece of information." We do that in a crude method in our own organizations, the two that I work with today, basically just as a sort of free form open message. So I think the devil would be in the details about what would be the mechanisms and the functionalities that the EHR vendors would have to support either directly in the EHR itself, or more likely in the patient portals.

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

Right, and this is Charlene. I don't know how specific you can get there, because I think this is where we were trying to give the vendor some flexibility, but I could – in reading it, the amendment would be less sophisticated than what you just spoke to, because –

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

Well do we have any sense of – sorry, just a quick question, do we have any sense of the burden level on vendors on this? I mean, if it's a small burden, then we're – because it's pretty important to patients, but –

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

Well my – it was certainly more sophisticated than certainly – I mean, sending – enabling sending a communication back, if we have secure messaging in place and that kind of thing, a message that, oh by the way, my med list is out of date or blah, blah, blah. That's a whole different kind of functionality than authenticating – putting the framework up so a patient can actually interact with the system and update fields and all that type of thing.

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

Right –

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

I think this is just – this is a request.

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

So just to be clear, for the simple version that we use today, we use basically simple secure messaging.

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

Right –

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

We let a patient say that the category of their message is request a correction to my record –

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

Yes.

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

– and then they just free text in whatever they want to –

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

Exactly.

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

– so that kind of functionality would be extremely low burden, I think, compared to current existing functionalities, and that part I think would be easy to resonate with, it's just the devils in the details like I said, about what it means to do this.

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

Yeah.

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

Exactly. The alternative is you by field, you can make edits, and then you have to understand well, what standards are you going to use and it would have to go through a staging and so on and so forth. So, if what we're saying is, let's make do with what people have already implemented, including ourselves, it's really somewhat of a structured or at least categorized secure patient message that goes to the right place, that may be very helpful and that's very doable in Stage 3. So if that's what we mean for this first incarnation, I think that would be – we just need to say it more plainly.

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

Yes.

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

Yeah, I think that will help move the needle on the goal and so I certainly support that.

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

Yup, yup. Good with that Christine?

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

Yeah, I think that's right, I mean, I think maybe to give a little more detail sounds good to me.

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

Yeah, I mean, I interpreted that way, but it was not – that won't be – like you said, everyone's interpretation varies with this stuff.

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

Paul, I'm sorry, can you just reiterate how you said to change it?

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

Okay, so the point is make an easy way to request an amendment to the record online and what we might do is add to that sentence, saying, e.g. a secure patient message – well, we'd do is like describe – in the right section. So let's say immunizations a common one, oh, I had this done somewhere else. So if you give people a hint that helps us triage where it goes to, saying this is – I would like to update my immunization record, that's helpful, versus I'm just sending a generic message and you have to figure it out. So we have a way –

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

So one way to put that might be, identify specific elements in the record and request an amendment.

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

Yeah.

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

Would that work?

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

So yeah, I think we can fine-tune that, but that's the point. So it's, one, it's a request and two it's really going to a human to interpret rather than being – those are the key parts, so we can fine-tune the wording.

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

Thank you.

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

Thank you. Okay, next slide please. And next slide. Okay, this, I guess we might as well wait for the results from your workgroups Christine?

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

Sure.

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

Okay. Next slide. And next slide. Here's clinical summary. I believe this is just a clarification, but then we'll have to read what EHRA said. So the desire is to say, what happen – what actual things happened with your current encounter, whether that's – in here – whether that's a visit or an admission. And one of the unintended consequences is some people stuck the ent – just a brain dump into this which made it much less useful to know – for the patient to say, what's actionable based on this most recent encounter. And so that's what we were trying to fix in the text. Now, what is large to jumbo?

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

Yeah, I don't understand that either.

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

I didn't understand what they meant here, so –

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

Oh, it's the including and excluding of data I guess, is the large.

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

Is to decide what to include or exclude, maybe that's it.

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

Yeah, which is – I could understand that, but that was the biggest pain point we've had since the beginning with this thing.

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

So, one way – let me test this out, is you have a set of defaults. So here's where I'm going to inclu – you know how you – I'm trying to think of an example. There are like websites where you say, I'm going to synchronize the following or send the following, you have this default, but you can check or uncheck things that are not relevant or that you don't want included. So, that's how I might imagine this being done. There are certain things that must be there, and we've spelled them out in the past, and they're a minimal set, and there are things that you may include, and images may be one of those things, and you click or not click.

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

This is Mike. That's exactly what I was envisioning and it helps customize to the patient's preferences about how dense –

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

Right.

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

– or extensive their summary is.

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

And from an innovation point of view, I said, there's a default. Well, the innovative company could decide, based on this visit of this specialist, you could almost tailor what the default is, I mean, so there are ways that you can make this system much more helpful document – so that's our response back and maybe we could get clarification from them on what's the large effort required there. But it sounds like we're all on the same page, yes?

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

Yeah, we'd need – the same page being that that ability does need to be in here?

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

Well, there are two – the major point is, we want it to be specific to this encounter, not just a brain dump.

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

Yes.

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

And the second is, we would like to have a default set, so there's not additional burden on what gets printed out – or what gets transmitted, made available, but that the human can decide to include or exclude certain things.

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

Right, yeah. Okay, great, on the same page.

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

Okay. All right, we can just check with them on – so that's our – that's what our recommendation is for this one. We might get additional feedback from EHRA.

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

Paul, the only small thing that I would request is that we change the title of the slide, because we've talked about agreeing that it needs to be called after-visit summary, because people confuse the clinical summary with the care summary –

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

Yes, I agree.

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

Yeah, the trouble is, we got a complaint from a vendor who says it's their term –

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

Oh, proprietary?

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

We can call it encounter-specific summary – no encounter –

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

– hospital.

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

This is Michelle. The only concern I have is every – the public now knows this as the clinical summary objective –

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

Yeah.

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

Yeah.

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

How about in parenthe –

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

I actually don't – I don't totally agree with that. I think it's after-visit summary is what we – if you look at the next slide I think it is, we already started calling it AVS a while back. I think we just need to make the switch, because I think its caused so much confusion that people – remember, even in the last hearing that we had panels, they were confusing the two. So I actually don't totally agree.

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

So is it after-visit or after-encounter because you want to encompass the hospital, too?

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

Right.

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

Well this is EP only though, isn't it?

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

No, I thought I saw it said hospital on here –

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

It does say –

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

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

This is Marc, I might think about – while you don't want to change it, do you amplify it and describe it as something like interval-clinical summary, because I worry a lot about over-emphasizing the episodic nature. So it's still a clinical summary, it's just an interval summary, it's at a point in time.

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

Yeah.

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

But it does have a trigger though, that's important – so, you communicate with your healthcare team and they gave you a certain plan and certain instructions, we sort of do want to tie it to that, rather than being free flowing. Does that make sense?

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

Yeah, but is that after – that could be after a phone consultation, that could be, the visit starts to conjure up a, I went and walked in the office and then they sent me this stuff and –

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

So first of all, Michelle, is this hospital or EP only.

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

It's EP only, I'm sorry, I think that was my mistake. So I've deleted the hospital from the green.

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

Okay.

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

Okay. So then, we still can use the term encounter, because as Marc pointed out, telephone or onli – it's related to some – it's very – could it be a paren encounter-rela – encounter-specific summary? I guess that would be not consistent with what you just said Marc.

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

Does this also have to – this is Mike. Does this also have to be understandable to the patient, because most of them won't understand encounter. We use the term visit summary or clinical visit summary or something like that, that helps them know, this really is –

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

Oh.

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

– the output of the visit you just had with your provider and this is what you're going to do based on that visit.

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

I'm okay with just –

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

What do people think of that?

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

I'm okay with visit summary because I think even if it's used to cover a telephone encounter or its used to cover an e-visit, I think patients will – they get it, they're like okay, that's a visit summary, no I just talked to them on the phone, but that's fine, I get the point.

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

Yeah. Yup.

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

Okay, visit summary going once, going twice, anybody opposed? Will that work Marc?

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

Oh absolutely.

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

Okay, visit summary. So if we can re-label things, Michelle, it'll – I think it'll be good. Clinical is just too generic and then we couldn't use after visit, so that's –

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

Okay, I'll go through and fix.

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

Oh my goodness, yes.

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

All right, next slide please. And the next one. Okay, patient education. So maybe here is a time we can broaden what we mean here to accommodate what Christine was just talking about, which I think is the more modern and innovative way anyway. We did not mean a Spanish-language encyclopedia versus an English-language encyclopedia, we meant things that were going to be useful to this specific patient, that's what we imagined back in Stage 1, it just takes a while to get to – get everybody on board. So does that help, if we made it a little bit more clear in the preamble Christine?

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

Umm, in the pre – which preamble.

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

Well, we're – so, my proposal's that, instead of people thinking of well, here's a document or here's something that just needs to be translated into one form or another, that's not what we really mean. We mean patient-specific educational help. It's almost context-specific, but that context includes the patient's context. And so, if it's a hyperlink –

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

– this is very specific – sorry.

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

If it's a hyperlink in your problem list, that qualifies. If it is, how do you do back exercises, that qualifies. Anything that is – can be tailored to your specific context and provides additional educational resources should qualify. And what I meant by preamble, just sort of explain that that's a broader way than we've been looking at it in the past.

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

Well I think we need to back up for a second because what we're looking at actually is only describing patient-specific education resources in a language other than English. It's not all of them, it's in other non-English languages, which I think is an important thing to maintain on its own. What I can't recall without digging is whether we maintained the objective. I don't think we meant to retire the objective around patient education generally, we did not. So – oh wait a minute, Stage 3 – okay. So we actually – I actually think we didn't – we never had that discussion, but we ended up, and I'm only realizing it now, ended up de facto retiring the objective to use certified EHR to identify patient-specific education resources and that has a – it was more than 10% of all unique patients for EP and EH. This is very specific to non-English, this meaning slide 14.

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

Uh, so is that true Michelle, we retired the other one?

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

Yeah, to Christine's point, I don't think we ever really talked about it formally, but that is essentially what happened.

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

Right.

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

Yeah, I don't think we meant to, we never talked about it explicitly, we just knew we needed to add in the language other than English, but I think we didn't realize we also should have a discussion on carrying over the patient-specific education resources. And I'm not –

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

But can I propose –

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

Sorry?

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

But can I propose that we instead of keep adding new objectives, one way to handle this is let's not implicitly retire patient-specific resources, let's just add other ways that you can be patient-specific.

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

Well, so, that's part of why I think we should add in view, download, transmit – and specific to view, download, transmit, the ability for the technology to connect patients to plain language and literacy appropriate information, basically MedlinePlus Connect. I think that would be –

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

So I guess I'm – what I'm saying is, those are two orthogonal kinds of functions, at least in my mind, and it's – it'll be hard to keep adding more and more things to VDT when the function really is to get access. The function here is to make what you have access to more useful to you, and you can see a number of attributes. They can be more useful to you because it pertains only to you, if it's your disease, if it's your disability, if it's your language, do you see what I'm saying? If it's easier to decompose this and allow innovation here, if we don't restrict it to like the encyclopedia, which is sort of what people –

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

Right, but that's what this – I mean, like I just – I think somehow I'm missing your point because I agree with you, or I think I agree with you. But then when we talk about kind of the encyclopedia approach or the brochure approach, that is this particular criterion that we're talking about now, or that's the foundation. Whereas view, download, transmit is very specific to the patient, it's something that if we support mobile access, that people from underserved communities could really link to and that you can put through MedlinePlus Connect, have a fifth to eighth grade reading level.

Now you can't do an alternative language, so I think we need to preserve this particular one we're looking at on the screen. But we didn't – I would be okay thinking about exploring the other patient – the broader patient education piece, once we look at the performance thresholds, because I think performance has been pretty good and we've been doing it now for several years, but only if we're doing the education as you're describing Paul, in other mechanisms like VDT, which it will be, I think, the predominant way that people interact with health information going forward.

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

This is Mike, I'm going to have to jump off because of a patient issue, but I wanted to make one other comment about this if I could. So, I resonate with everything that's being said, I just want to go back to the issue of the EHR identifying the information. Our experience has been that it actually can be quite clunky, clunky and not very helpful and in fact, even contrary to the purpose to only count those things that the EHR identifies as something relevant to the patient. I would far rather reward the providers who are assiduously, if manually, deciding what is exactly the best patient education resource for the patient using the technology and giving it to them. But right now none of that is counted because it's only counted if the EHR has prompted them with that specific resource, and that resource may not be the best one. So I'd far rather see us counting every resource that's in – that's accessible as part of the technology and that the clinician uses, whether manually or identified by the technology itself.

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

Paul, I'm not sure how you want to proceed because we don't have a lot of time left. It feels like this one needs some thinking.

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

Well, let me ch – um, let me try one more time to try to express one suggestion and then hear from other folks on which way is going to be more extensible and more sustainable in the future. I think for me it's easier to talk about access to information and context-specific information that helps people make decisions or understand something, which is part of our goal. And if we try to untether the – what we used to call patient-specific education resources, untether it from a mental model of encyclopedia and make it basically patient-specific information – context-spec – it's almost like context-sensitive help. Only the context is not just what page are you on in a document in a manual, it's what's the context for this patient and then over time we'll have more and more things that can describe the context of this particular patient and that makes the educational resource richer and more relevant and – the information and the functionality allows. That to me allows you to build in this – we can start building and innovating in this functional group. Can other people lend their thoughts in terms of how to approach where we put this functionality, whether to put it in VDT or this group?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

This is Art. I thought Mike made a good point there. I don't know if there's some way that we could change this functional needed – functionality needed to achieve goals to say something more like, eligible providers use CEHRT to provide or track patient-specific education material, and allow what Mike was saying. And I think that's true that the search functionalities are not always fully understanding context –

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

Right.

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

Hmmm.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

– and it may be difficult to get that to match properly or effectively and that the clinician is, at times, best to figure out what's the right material to share.

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

Okay, all right. I follow you. And now what would happen is we'd allow innovation to take place so that obviously the smarter and the more efficient the provider can get the right information for this patient and the machine can help you make that available, that's a good thing. And that vendor would have a better product. But yours and Mike's point is, well if the machine can't do anything but male and female, then if you give me the library of things, in the context of the EHR, where I can just pick the better thinks, don't not make that available as part of fulfillment of this objective. That's your point, right?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Yah, right.

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

I think that's Mike's point. Okay, so we can clean up that language –

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

Paul, but remember – Paul, I just want to say remember though, this is not an absolute because we're talking about a low number of patients, so it's not like you have to do – you're forced into something on everybody either.

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

No, the point is right now, they are not actually getting credit in the numerator if the machine didn't actually prescribe – select that particular educational resource.

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

Yeah, no, I understand.

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

If the – and that doesn't seem right.

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

Right.

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

We can clean up the language, we need to clean up the language, it'll be in the measure section that does not – as long as the provider is doing this in the context of EHR, even if they are making their own selection, that should count. And that selection ends up being patient-specific, that should count.

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

Um hmm.

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

It was just an unintended side effect.

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

Okay, so is somebody going to revise and circulate some language on that and also on the connection to – I think the connection to MedlinePlus through view download is a completely different issue and resource.

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

Well, I'm looking for some people to help us adjudicate where – which bucket we should put it in, I think we're agreeing that this is a helpful function, and which bucket should be put it on?

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

And Paul, the more – because this is kind of in place, maybe we lighten it up a little, but as you talk it through, that whole category of clinical decision support that we've talked about, re – resonates here a little bit, too. So, I'm not suggesting we move it, but I think as we look back over everything, when we're done deeming, we can kind of maybe just keep our eyes open.

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

Yeah.

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

Yeah, but I think there are two issues here, one is alternative language, language support is different. And then the other is, what we do with what used to be provide patient education materials that isn't even in here anymore. Where else you build that in, in a way that is not jargony, but then there's this – the other piece of well I'm going to have access to health information and it's going to have big words in it that we know from lots of research patients want to understand more and how do we make that easy?

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

Okay, so we'll try to get some new language to go over to cover that, in the next iteration. Okay, so what is our next one, can we get through one more? Next slide please – uhh, secure messaging. Umm, I think this is –

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

Paul, this is Michelle. I might suggest that we not go into – so Altarum, they have an evacuation drill at 11:30, so, we'll probably start to hear fire drills or something. So, we can get through as much as possible, but we do have a hard stop at 11:30.

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

How many more after this one in category 2?

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

Umm, that's it for category 2, so let's try.

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

So it's fair to say that we are going to need more time, so please help us with scheduling the next call so that we can finish on time by the fourth of December. Okay –

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

Okay, well I'll just jump in – I have comments, so I'll flag that for you.

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

Say that again please.

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

I just wanted to get in the queue, I have comments on secure messaging if we're doing it.

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

No we're not doing it for today.

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

Oh, okay.

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

Okay, any other final comments before we open up to the public? Okay, and the other thing I might ask is for the folks who – so Christine, you're going to present on the Consumer Workgroup, let's see, how many hours we dedicated for that –

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

I think it's probably Leslie and I together, I think –

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

Yeah –

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

– she's got the standards –

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

That's in the context, wow, of the 21st, so there's a whole lot of stuff on the 21st. Okay.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Paul, this is Art. I just wanted to know, I have reviewed the slides for the population and public health stuff and have some edits. Should I wait to show you those in a public activity like now or should I just go ahead and send those to Michelle and we can decide whether we want to modify the slides based on that, before the next public presentation?

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

Yeah, why don't you go ahead and send those edits, Art. Thanks.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Okay.

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

The closer we can get it to where you think it's near final, the better, I think.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Okay, then I'll send those on to you Michelle today.

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

Okay, thank you.

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

Thank you.

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

So we do have a call on Monday, so, at least we'll all be fresh for that call, because this was a bit of a reprieve since the last one.

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

That's right. Okay, do you want to open for public comment please?

Public Comment

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

Sure. Operator, can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have no public comment at this time.

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

Okay. Well thank you everyone. Welcome back Michelle and welcome back to the group and we have our work cut out for us between now and December. So thanks for your help. Take care.

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

Thank you everyone.

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

Bye, bye.

Public Comment Received During the Meeting

1. Regarding the patient's consent, how is this tracked / managed? This seems like a pretty large effort to effectively manage.
2. VDT large estimate for vendors—lots of small projects within an objective will result in a large project to complete development for that objective.
3. What is PRO on patient's ability to contribute information to the record?
4. Patients have the right to review and comment on their medical record. The issue at hand on Amendments is requiring vendors to provide an electronic process for providing this information to the EHRs and clinicians.

5. The Amendment process from portal to EHR and any messaging and reconciliation will not be a small project. It would be a large project.