

**HIT Policy Committee  
Meaningful Use Workgroup  
Transcript  
January 28, 2014**

**Presentation**

**Operator**

All lines are bridged with the public.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. 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 for Health Information Technology**

Hi Paul. George Hripcsak?

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

Here.

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

Hi George. David Bates? Christine Bechtel?

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

I'm here.

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

Hi Christine. Neil Calman? Art Davidson? Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

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

Hi Paul. Marty Fattig? Leslie Kelly Hall?

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

Here.

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

Hi Leslie. David Lansky? Deven McGraw? Marc Overhage? Patty Sengstack?

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

I'm here.

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

Hi Patty. Charlene Underwood?

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

I'm here.

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

Hi Charlene. Mike Zaroukian? Amy Zimmerman?

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

I'm here, sorry.

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

Oh hi Mike.

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

I was on mute.

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

Amy Zimmerman? 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 for Health Information Technology**

Hi Marty.

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

Hi, how are you?

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

Rob Tagalicod? And are there any ONC staff members on the line?

**Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Office of the National Coordinator for Health Information Technology**

Ellen Makar's here.

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

Hi Ellen.

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

Elise Anthony, here. Hey Michelle.

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

Hi Elise. And with that, I'll turn it back to you Paul.

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

Great, thank you very much Michelle. So we have a full agenda today and we have three major objectives. One it to pick up where we left off, and thank John Halamka for joining us again, representing the HIT Standards Committee and their feedback on patient-generated health data. And the other things we need to do are go over the care coordination and public/population health categories. This is our last call before presenting it to the HIT Policy Committee next week, for hopefully final approval. So we really do need to get this in shape. So why don't we, because John's time is limited until 2:30, let's begin with his presentation on the feedback on patient-generated health data. Thank you John.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Great Paul, thank you so much. And I do want to just shout out Leslie Kelly Hall for presenting what was a magnum opus to the Standards Committee in a joint workgroup of her consumer-focused folks with the clinical operations focused folks. Reviewing both the charge that you had given us from the Meaningful Use Workgroup and an overview of all the standards and standards maturity for all the possible standards we could select to meet your needs. So thanks Leslie and I know you're on the phone, so please feel free to chime in as I go through some of these recommendations.

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

Thanks John.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So Michelle, if we could just advance to slide 5 or what is my slide 5 labeled Overarching Recommendations. So I will give you just a flavor of what the Committee said and then we'll go through some very specific standards recommendations. What the Committee noted was we had to be exceedingly careful about imposing certification criteria because the market for patient-generated healthcare data is still evolving and there are multiple architectures innovations still in process.

An example that was highlighted was Kaiser has what it calls today a "shared medical record," where in fact there really is no difference between a provider view of the record and a patient and family view of the record. And when patients and families do a medication reconciliation or a problem list reconciliation, they're actually contributing directly to the same database that is used and viewed by the provider. There is no CCDA or modular separation between the patient facing function and the provider facing function. And so as I go through these standards, you'll see that there are absolutely standards that we should enumerate, and there are constraints and optionality, which we should impose, but we just have to recognize that the attestation criteria may provide, you must do these same things with patients then families. And the certification criteria may have options that enable the product to do what the physician needs, without necessarily implying the standards be used, based on variations in architecture. So let's go to slide 6, which has some detail.

So the entire committee agreed that the CCDA as a transition of care format, with multiple templates is suitable for purpose and mature enough to use not only in provider-provider type communications, but also for patient-to-provider communications. So that in a case where there is an architecture of a modular or an external application needing to stand something that can be templated, such as a problem list, a medication list, an allergy list or such things as a care team, that is totally appropriate for CCDA to be the mandated standard in that circumstance. But what I was saying in that first slide is also enumerated here that there may be applications that offer such full integrated functionality that imposing a CCDA intermediary would actually not be logical, given the nature of how the application functions. So just as we – this may be an ONC-related task as regulatory language is written, we just need to offer that flexibility. But you see our full and overwhelming support for the use of CCDA, where templates exist, for the transmission of data from patient-to-providers.

Now in addition to looking at the CCDA and its templates for such things as problems, meds, allergies and care team, we were also asked to examine devices. And Leslie did again a fabulous job in bringing in the Continua people, and if we go on to the next slide, slide 7, and showing us the underlying IEEE 1173 standards that are used for the collection of data, by devices, and their transmission to other applications. The Continua Alliance, not really a standards development organization, but more of a profile writer, has listed those standards which are mature and suitable for purpose, and created implementation guides, which we think are directionally correct.

The challenge is that again, maybe Michelle, this is again – an ONC harmonization issue, that FDA at the same time has issued its own guidance and has issued a regulatory and sub-regulatory advice that actually enumerates slightly different standards and approaches. And so, I mean, Paul, maybe this isn't the exact answer that you want, but that is, we believe the Continua Alliance work is directionally correct, but it does need to be reconciled with FDA guidance, because the last thing we want is ONC regulatory guidance to be at odds with FDA regulatory guidance in the same domain. So hopefully in giving you the go ahead with CCDA and giving you at least a set of what we believe are next steps on the device interfacing using Continua with an FDA reconciliation, that will help you in making recommendations to the whole Policy Committee. Happy to answer any questions.

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

Great, thank you John. Questions before we sort of try to apply that to our PGHD objective?

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Hey John, this is Patty Sengstack; could you do me a favor and just give me a little more information about Continua?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Sure. So Continua is a consortia – well in fact, Leslie, you met Chuck and the gang, but my understanding it's about 60 different companies that have come together as a membership-based organization in an attempt to harmonize the standards used for capturing data for a variety of home care type devices which might gather telemetry. It may include blood pressure, pulse oximetry, glucometers, weight, these kinds of things, so that products and services can be offered in the marketplace that have some hope of communicating through a variety of architectures, to PHRs and EHRs.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Oh, okay.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

But Leslie, please add your comments.

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

Well John, I think you nailed it. They've also been doing work significantly internationally so have also had their Alliance endorsed I think, in several different countries as well. So it's more like IHE than it is HL7, if that helps.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Okay, yeah, that's really helpful. Thank you. Are they the only ones doing this?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

I mean, they do represent a certainly the widest swath of device manufacturers that I have seen in the industry. I mean there are – I guess one other caveat to add, if any of you has a Withings scale, Withings is a French company that offers a variety of home care based devices that today work with Twitter and work with HealthVault and other providers of services. They do not, at Withings, use any what I'll call healthcare specific standards, they happen to use JSON a JavaScript construct, and their own proprietary approach. I mean, fine devices doing a very useful thing with some social media type applications interfaced, but they are not a part of the Continua effort and have chosen a proprietary approach. So I think we do have to be just slightly careful in recognizing the marketplace is still offering solutions of value that aren't totally unified on one standards approach.

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

So John, that actually brings up a question. So the comment is that Continua does offer these profiles –

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right.

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

– yet they haven't been adopted almost by anyone. Is that – did I say that accurately and then what are the implications of that statement?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well, so let's – I mean challenge that a little bit. Again, Leslie, you talked to them, but my understanding is that there are dozens of products in the marketplace today that are employing the Continua standards, and I don't think in non-consumer industries, that there's a lot of argument about the suitability for purpose of IEEE 11073 type standards. I just think that the market is early and there are existent incumbents before Continua offered its implementation guides that have chosen to do their own thing. And Leslie, any comments you would make on the number of products available today?

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

There are about 12 different implementation guides and templates that have been completed. I think what interested us was we looked for some sort of an alliance that would attack all the device as well an interest in mobile. And so Continua has a considerable amount of membership from the Qualcomms, the Verizons of the world as well as the devices, so that presented some interest to us as well. We're also reminded that with an FDA approach, you have 2-3 years first for FDA certification before a product can go to market, and then to adopt standards would be on top of that, so this is a slower to market process than we're typically used to. So I think that's why the group felt that this was directionally appropriate, given all of those considerations.

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

That brings up another que – so, and I don't know whether you can answer this question, but maybe you can give an opinion. Given the – well, the timeline that Leslie just presented, the need to reconcile FDA guidance with the Continua guidance or profiles and immaturity, I think some of the market now is a mandate. I mean, the certification criteria becomes essentially a mandate for the market, is that helpful, harmful or early and could be helpful later. So is there an opinion you can render on that kind of question?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right, so as we put on our slide, our challenge is, if you said, the only thing that you can use is Continua Alliance and all existent products in the marketplace that are using proprietary approaches and still provide useful telemetry cannot be used. That would probably quash innovation in an early market that is just trying to develop new products and services. So I don't know working with our friends at ONC who write regulatory language, if there's language to the effect of this is a signal to the marketplace that we believe that there is going to be convergence around this series of standards as opposed to a mandate to only implement those at this very early market stage.

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

This is Marty Rice from HRSA. I totally agree there needs to be some sort of standard, but one of the concerns that I have is it looks like they have this certification process and what is the total cost to certify something? What would the cost – what would the added cost be to these products?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And I'm not familiar with their pricing model, but Leslie, are you?

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

There's membership pricing to join the Alliance. Part of the Alliance is adhering to existing standards underneath it, so you see those standards then constrained to the particular device type. So I'm not familiar with the pricing structure at a device level, but to join the Alliance, I believe there is pricing just like HL7 or HIMSS or any of those affiliated organizations. I don't think it's out of whack.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, this is Paul – this Paul Egerman –

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

Hey Paul.

**Paul Egerman – Businessman/Software Entrepreneur**

I just wanted to respond to the question about the cost. Another way to look at the cost is what is the cost from the vendor standpoint and that's hard to evaluate in terms of the total amount of work, although there is significant work to do something like this. But there's also an opportunity cost to the vendor, which means – which is because while they're working on something like this, they can't be working on something else and so there are a number of aspects of implementing something like this, if it's something that is unlikely to be used or unlikely to be used with any frequency. These are exactly the kind of things that drive vendors nuts, when they have to do work on something that the vast majority of users will never use.

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

This is Leslie. I think that the language that John talked about earlier, if you are taking a proprietary approach and you have no need for interoperability, continue that. However, what we also heard loud and clear over the last year is that consumer organizations or organizations who want to participate and interoperate are kept out when it's too proprietary and there is no directional focus or an opportunity to say, hey, I can spend only so much of my R&D dollars on interoperability, give me which interoperability to use because that's where I want to go. So there's opportunity as well. So we felt that these caveats helped to address all of those concerns, while still providing a bellwether for people.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And Michelle, what I've sent you just for interest of the group, is the Continua certified product list, which include things from Roche and Sharp and Fujitsu and LG and a lot of what you consider mainstream consumer technology companies. And it delineates everything from blood pressure monitors to bathroom scales to pulse oximeters, etcetera, so at least the Committee can have a sense that directionally it does seem like there are a number of consumer companies headed toward this direction. It just is, as Paul has said, probably too early to declare that they must, because this is the only approach.

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

Paul, its Christine if I can get in the queue.

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

Yes and then I want move towards our objectives. Go ahead.

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

Yeah and I have – this is Charlene, I have one, too.

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

Okay, both of you. Christine?

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

Sure, so thanks John and Leslie. I think it makes sense, what you're saying, and it would be great if ONC could sort of advise us on whether there's some direction signaling that could happen, as opposed to standards mandating, I understand that. I think the stepping back a level, part of what we wanted to achieve here was we did – we wanted to be careful that if a provider has an existing connection to a device that is bringing them patient-generated health data, that they get credit for that, so – under this policy criteria. So from a policy viewpoint we're looking for both sort of creating the capacity to the extent we can, and I think we can in areas like secure messaging, which is already there, and structured surveys and perhaps signaling direction on devices. But we want to also make sure that if you're already doing these things, you should get credit for that. So is – do we have to have a certification criteria that names a set of standards or even signals a direction or John, I think you've kind of briefed us before on the certification process, that they show that they're capable. But how can we give providers credit without stifling innovation? I think that's my question.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right, and a very good point and one of the things that I've written about in my blog is to be so very careful of having certification only criteria without attestation as opposed to what you just said which is, if you can attest that you can do it –

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

Right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

– then in some ways that achieves the policy goal at a time when the standards are still evolving. And so maybe again the way to handle this, but above my pay grade, is to say, a physician must, either through menu set or core, demonstrate the capacity to receive such telemetry, and here's guidance as to where we think the standards may be going industry, but there is no certification criteria specifically on incorporation of that exact standard.

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

So the attestation you're referring to is an attestation the provider is attesting to the fact that they have an established device feed and are doing it, and whether it's using Continua standards or whatever at this point, it's too early to dictate. Did I get that right?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

That is my opinion, yes.

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

Okay, great, that's very helpful.

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

Charlene and then we're going to move to the objectives.

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

Yeah and John, in your role on standards, that directional point, I wanted to speak to that one. One of the challenges I think everyone will face is how we harmonize on the data that's captured. So there are scenarios where a patient is wearing three different devices that collect for instance vital signs in three different ways, and because that data isn't harmonized and collected in a standard way, the patient has to reconcile that data before they can even send it in. So, if we want to talk about a directional statement, I think starting to suss out the harmonization around the data element focus and starting to look at the data elements that are captured. How we can start to harmonize those and standardize those would be the things that take these devices off the fringes and get them in the mainstream.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well absolutely. And what Leslie presented to us was a series of IEEE 1173 profiles that actually enumerated such things as, I am a blood pressure device and I am capturing systolic and diastolic information and units of measure and so it was specific to the level of the data elements captured by the device.

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

Yup, and again, that's across the continuum, so whether it's captured in home care or the hospital or the – that's the value proposition.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

This is why we think that Continua is in the right direction with the right approach, it's just extremely early, to the comments of Paul Egerman that the industry is still figuring out use cases and workflows.

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

This is Leslie and I'd just add to that comment is a great example, Charlene. We talked about the Consolidated CDA and the question in response in the questionnaires, which was the task that we were looking at. Well under the Continua standard, they have constrained the Consolidated CDA even further for –

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

Um hmm.

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

– specific device types, so we have that harmonization and the data element level and the questionnaire structure, whether it's structured or semi-structured, whether it's multiple choice or yes or no and so forth. So there is a lot of harmonization that's happening, that's why we think this is an important directional step.

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

Okay and I think the –

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

Okay, let me move to –

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

– but the data elements are important to assure the communication of.

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

Let me move to the objective. If you could move the slides up to probably about the – there, and then fill it out please. No, no, go backward please, keep going backwards until we get the –

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

The first slide in – yeah.

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

There be go. Okay, so this is the objective. It's a little wordy, but each word has – is a reflection of a concept we discussed before. So let me try to parse this out for you and I'll try to interject this last comment about the non-mandatory certification. Okay, so that EPs and EHs be able to accept – actually, it's not accept, there was another verb that was better because accept really means incorporate into the chart, but at any rate, there's a verb like accept, if provider requested, which deals with the versus spontaneously entered question,. If electronically submitted patient-generated health information through, you have a choice, structured or semi-structured questionnaires, for example, screening, med adherence surveys, etcetera or secure messaging. Those are two choices and in a sense, become vendor mandates to be able to accommodate these kinds of ways of a patient submitting provider requested PGHD. To clarify the point that Christine made, if you are already, you provider are already incorporating some patient-generated information, for example, from remote devices, however that's done, then that would also count as patient-generated health information. We're just making an explicit statement so people realize that you're doing this, you got it done, and that counts.

And then the thing that we would add, based on the discussion we just had was that – but we're making a statement, or a signal, that the Continua direction is an appropriate one, but we're not recommending that that become incorporated in the mandatory certification criteria, at this time. Are people – how are people with that objective, with that amendment?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
Paul, can you say the amendment again?

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

The amendment was to discuss the – to try to give the signal that we support the direction that the Continua Alliance is going in, we recognize that it is early in the market and for that reason, we're not recommending that ONC create a mandatory certification criteria for vendors, at this time.

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

**Paul Egerman – Businessman/Software Entrepreneur**

And Paul, this is the other Paul. I have a question about the secure messaging.

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

If I send my physician a message saying, I need to have an appointment because I have a fever, and then somebody manually enters fever into my record, as a symptom, does that count?

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

No, I don't think that was the intent. Let's say you asked, hey look, I'd like to get some of your home blood pressure readings, and the way you send it to me is through secure messaging, it's obviously free text, that would count. That was the intent we meant. If you already connect to home blood pressure devices through proprietary or Continua profiles, that would also count, that's bullet point two. And if you filled out a form, a questionnaire, that would count.

**Paul Egerman – Businessman/Software Entrepreneur**

That's helpful; it's just somehow when you said or secure messaging at the end.

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

Okay, we can probably clarify that a little bit.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, well I'm going to wordsmith that a little bit because it wasn't clear to me –

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

Got it.

**Paul Egerman – Businessman/Software Entrepreneur**

– indicate that secure messaging was electronically submitting information, which it sort of is –

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– but it's not really what you intended.

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

Okay. Well, so I think we got the intent we discussed last time in these two bullets.

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

So Paul, this is Mike Zaroukian. For the device, do we intend that the data coming across the interface be structured or is unstructured okay?

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

Well, since we accepted structured or unstructured questionnaires and secure messaging, the answer would have to be yes. The thing that – the patient-generated data that's coming from outside of the organization is acceptable is sort of what this is saying.

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

Okay.

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

Sorry, we're getting a lot of feedback. If you aren't speaking, if you could please mute your lines, we'd appreciate it.

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

So, have we gotten this one now from an objective point of view with the amendment?

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

Paul, did you make a wording change to the word accept? It's Christine.

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

Yes, and I'm trying to remember where – what the wording change was –

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

Was it received?

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

It may be something like that, that's the spirit of it Christine, it was not to say that you're forced to accept it, because there is a staging –

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

Yeah, right.

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

That's all –

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

It was receive, review, respond –

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

Ingest.

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

Uhh –

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

No, not – I think that's what Paul's saying, is it's not ingest because you may not want to take all the data into –

**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**

– your EHR, you may want to take a summary or the bottom line or the PHQ-9 score or whatever. So –

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

Okay, let me work on that and the placeholder I'll use is "receive" for the moment, and then I'll also make some mods to the – to address what Paul raised – Paul Egerman raised. All right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well Paul, certainly you have my blessing on your amendment, not that I am a member of your workgroup, but it sounds good.

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

We wanted to get that as well. So thank you John, thank you for taking the time.

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

Thanks John.

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

Thanks John, appreciate it.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

You have a great day. Thank you.

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

Bye.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Bye.

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

Okay, so if we can skip forward to the next set of – the four column colored – yeah. Okay. So this – we're getting into Category 3. Charlene, do you want to walk us through this?

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

Yeah and Paul, I'm not online on the monitor, so I'll – I've got the screen.

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

Okay, do you want me to –

**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**

I'll read it out – oh, okay.

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

I've got it. So I'm on slide 7.

**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**

Okay, so last time we discussed – let me just walk through the current status of care coordination, but I want to frame it in the context of what we saw Stage 3 being was the mechanisms to set the infrastructure for broader collaborative care models in future stages. So what we did is we tried to put in key processes that supported care coordination, but also set a framework for some of the key types of transitions that happen to do effective collaborative care. So when we did our vision and all that, so just – so, what we did is we looked at the issues around, again, med reconciliation as a key process that needs to be accomplished. And we'll walk through that, the summaries of care and what we did in that process was drill down and understand the current state of the work that's being done in the standard.

And similar to what John just said, again the work in the Standards Committee has broken out three types of transitions of care, and actually, there was a fourth, the actual one was the care plan, but the recommendation was to focus around the CCDA and the fact that it has infrastructure in place that supports three types of transition. And that's what we put in place support for. In getting the feedback from the community, and especially the vendors, there was a lot of pushback around how to manage the transitions around – and we talked about this with David Bates, around referrals or consults.

So what I did for this set of recommendations is I separated out and made menu the summary of care for consult requests and reports, and made that a separate objective. It again, parallels the summary of care for transfers of care, and again notifications also remain menu. And the reason these last two are menu is again, I think we've all seen them as high priority requirements, in terms of closing the gaps for care, but also recognizing there are going to be gaps in infrastructure to be able to support these. So some places will be further ahead and be able to do them, other places won't be. Okay, so with that, if we go to slide 8, this is the new and improved objective. Again, we kept it aligned, what was in Stage 2, because again, stepping up to med reconciliation is a difficult process, a key process, so we left the threshold the same. But what – the change that we made, and we didn't make it directly – we talked about this last time, in the measure but what we want to say for guidance is that if a physician wants to do reconciliation regardless of whether it's a transition of care or they want to do it at any point there's an appointment, that's fine, it should be able to be counted. So any questions on that?

Okay. The summary of care for transfers of care, again, these – this is, I'm using the CCDAs format, but it looks –

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

Charlene?

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

Yes.

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

I'm sorry, it's Christine, and I couldn't get my phone off mute.

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

Yup, sorry, sorry.

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

On med rec –

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

Yup.

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

The FAQ for reconciliation may also be performed for all encounters; I think it's not going to be clear what that means just standing along by itself.

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

Okay.

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

Like does that mean that you can get credit if you do med rec at any time outside receiving a patient from another setting of care, like I think people are going to struggle to interpret that without your explanation.

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

Yeah, that's fair and we can wordsmith that offline, but you got the concept correctly, Christine, it's just –

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

You got it, yeah.

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

So what I wonder whether or not you actually – it doesn't – that doesn't feel like an FAQ, that feels more like a change and a broadening of the objective. And you may want to revise the objective itself so it includes that, otherwise I think this is the opportunity to kind of clean up the language.

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

So Paul, do you want to put it back in, we had it in, so –

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

Well, no – okay, so the reason was because it was too easy to think this is yet another certification requirement and reporting accommodation, when actually it was to accommodate – so Mike Zaroukian suggested this. It's really to say, it's okay if you check it on everybody and don't go through the trouble of figuring out is it the transition or not. And so, we'll do a better job on the wording, but we're trying to avoid it looking like yet another certification requirement report.

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

Right. So you're just saying if you perform it on another encounter, it would also count.

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

Yeah.

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

Right, so this Mike. It goes back to the original objective that says, during transitions or when the eligible provider feels it's relevant –

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

Yeah.

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

– and to us it's always relevant, so that's all we're trying to accommodate. Yup.

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

Right, so there's not a checkmark for something, another step.

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

Okay, why don't you go on, we'll make those changes?

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

Okay. All right, so the next one, again this is the objective as it stands and again, the summary of care is used when there's a holistic transfer of a patient from one setting to another, so we included those examples. What we did was, we again, went through the process of saying in this particular case, to the current required – the current scales on the CDA, in addition they may include the following four types of fields. And the important one here, again was just a real easy way for them to put a synopsis, it's not standard, it's some narrative which allows them to support communication from one setting to the other that's important about the patient. And then we put in placeholders for patient goals, patient instructions as well as known care team members, including a designated caregiver.

In this space – oh, I don't know where we put that – we said that it could be free text, but we don't want to preclude coded, if that emerges from the industry, but I think we lost free text. Was that important?

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

For all of it Charlene?

**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**

Okay.

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

I think we were pretty clear just to get this moving we would support free text.

**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**

We didn't require – we would love there to be some standards on this, but then we weren't sure that could emerge in the timeframe.

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

Why don't we do the same FAQ approach, just so we – it's almost like providing some of the guidance or FAQs from CMS. But instead of mucking up the concept, we'll just make sure that it's clear what our intent was with respect to certification.

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

Yeah. And again, if there can be advancement on these elements, I think we'd like to signal that, but again, I don't think – the standards don't exist and we just – and it's important we move the needle on this one.

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

Hi, this is Marty. Quick question, when you look – since we work with the critical access hospitals, most of the transfers from critical access hospitals are to other hospitals and it's just because they don't provide those services –

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

Okay. Yeah, we'll get that in there, that's a great miss. Perfect.

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

Thank you.

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

So just hospital to hospital as one of the categories.

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

Right. Thank you.

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

Anything else?

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

Charlene, its Christine.

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

Yup.

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

I think where it says designated caregiver, I think you need to say family or informal caregiver, otherwise I think sometimes people think of professional caregiver and they're likely to say, well who's the PCP or whatever.

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

Yeah.

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

So I think that family or informal would work.

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

I think we had that in one and we – yup.

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

And that's the same on the next slide.

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

Michelle, did we have those words at one point, or we should be consistent with whatever Christine has, if there's – that language.

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

Okay.

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

Okay.

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

Yup.

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

All right. Okay, and so the one that I added, and this was again based on feedback and I was, Paul honestly, a little challenge of when I looked at the feedback to the original objective we had on referrals, it was really about capturing the fact that a report was sent back. And then we said it was acknowledged. And again the feedback we got from that was that while in most cases in a pretty robust infrastructure, the fact that it's sent, the infrastructure takes care of whether it's acknowledged and people didn't know what acknowledged meant and so it got pretty confusing. So, and what they said doesn't the evidence that the document got back be the evidence that it was closed as opposed to putting a whole process in place.

So, in light of looking at the feedback that we got from our request for comment, and then what I did was I just simply just took the step and the feedback that this is going to be a big step in some communities, I broke this one out. And this is again the case where if there's a request for a consult that can be communicated and typically there's data that goes along with that and then in addition, when a report's sent back there's a standard for that, the report comes back and there's additional data that comes back from the specialist. So, it's still in – broken into one objective, not two, but it's a menu objective so consult request can be sent out as well as consult reports can go back. Again, we are trying to track – we're using the standards of summary of care; our preference is that it's electronic –

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

Excuse me, Altarum, could you move the slide please?

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

Oh, I'm sorry, yes, this is slide 10, I'm sorry. Slide 10. And then in this same case we actually again at the discretion of the provider organization, ask for those same four data elements. And we would make the corrections to say they could be free text as well as we'll change caregiver.

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

Now Charlene, on the first – in our old table, we made a point of emphasizing that for one of them, the care transition, you really needed to focus on the all four but –

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

Yes.

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

– for the consult, we should just focus on – and I know it said discretionary and may, but did we want to reflect that some of these are more important than the others. I think patient instructions and goals were maybe left off the table in September, is that right?

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

Yeah, so how do you – yes, that's true, we took those – when, yeah, so I didn't know – because I said may, I didn't know how much to go back to those tables. So we could definitely, well, you definitely need information about the known care team members...I don't know, that's up to the call of the group of how discrete we want to get here. Because even if you think about a consult request, you could have patient goals, I mean it's possible you'd have content for some of these fields.

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

This is Leslie and we had patient goals also here and then I think the next slide, but that was something that we talked about as an important component, especially as we look at patient reported outcomes starting to happen more and more, to have the ability to compare to the goals is important.

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

It's Christine, I agree with Leslie and I think actually we had this exact same conversation and I recall that Neil Calman weighed in and said he definitely wanted to keep the goals in as well.

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

So I think the fact that we have this as a "may" at the discretion of the provider, we in theory have that covered.

**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**

So your main reason for separating this out is one, to become menu and two, that there is a tracking.

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

Well this is – I wasn't quite sure, Paul, this is where I got stuck a little bit. Maybe we have to go back to the order tracking objectives, remember how we talked about when they – effectively when the report comes back, they would close the loop. And in the original objective we wrote a long time ago it said, give the acknowledgment and all, but from the industry we got a lot of pushback that said isn't the fact the report came back closing the loop? Most –

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

No because the –

**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**

– you can't figure out whether it's a report coming back in response to what.

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

Yeah, so the issue that we had then, the gap would be, is there an order number or some mechanism that ties it back to that ordering request? So – and I don't know, I guess that's an open, I don't know if that concept is included in the standard at this point. So that would be the –

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

Order – this is Leslie – orders and order acknowledgment or – without a result, is commonly used.

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

What about the – no, what about the order ID?

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

Yes.

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

When you send an order, transmit an order, is there space, I think there is, to submit the order ID? Yeah.

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

Yeah, there's an order ID and order IDs can actually spawn other orders inside a lab, so, the structure is there for us to follow and that's why we thought that this was quite doable.

**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**

So that would be kind of in terms of closing the loop, if the report had a reference number back to the order that would close the loop. The acknowledgment people – I – there was just a lot of pushback, Leslie, from the field on the acknowledgment capability.

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

Every – we've been doing that for 40 years on an order, because we've been sending medication orders one way, where devices they have the knowledge to receive it, but there's no closed loop. So we have the knowledge in today.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

So hey, this is Patty. So can I ask for a little clarification on this? So you're saying that in order to provide a summary of care that there is an order that's going to prove that they did this, help me understand the whole ordering piece. Because in my experience, I can see that with a consult, you do – most inpatients, you put in an order for a consult and then it's done and they put in their response and then it'll close it, and so that's – I think that's pretty clean.

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

Right.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

The, what is it, the third bullet or the fourth bullet, the summary of care. Help me understand how that's an order, or is that something different here?

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

Yeah so Patty, when that order would be placed, in addition there would be a synopsis of key elements of the patient's record that would be sent with that consult. So the medications, the allergies, these four data fields so that when the consult went across – request went across, there would be some relevant clinical data that would be communicated with the consult, that's all this means. And then –

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Oh, okay.

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

– so it's just in a transition of care, rather than going in to see your specialist, which meds you're on, that whole process, they've got them.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Um hmm. Okay.

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

And that's what this is about.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Okay, so these contextual items under the narrative and the overarching goals and the instructions, etcetera would be part of that consult –

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

Yeah.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

– that would be, okay.

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

In addition to what's currently on – that's required on the CCDA, they're in addition to those fields.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Okay.

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

It's just to provide that communication. And the same thing on the note being back –

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Um hmm.

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

– if, for instance, the specialist changed the med, in theory you could get it back, right?

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Um hmm.

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

That's gets complex, but it's the framework to do that.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Okay, gotcha. Thank you, that helps.

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

Okay, so I think – so for this your question is, is it okay to break this out as a menu and have this tracking, and that's actually what's making it menu as it stands here on the screen, right?

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

Yeah, I think what made it menu is we got a lot of feedback from the vendor community that this was one of those huge ones, because they didn't know – there wasn't infrastructure in place to do this. We felt as a committee that we needed – this is an important one to move on, so where there's infrastructure in place and people can do this, there was something – this is the case where you get a referral and you never show up at the doctor and who – there are communities that know that. You could send your request to a referral tracking mechanism, they would tap you on the shoulder and by the way, you need – they could do that, but – and we didn't want to make it such that it will drive the need for that kind of infrastructure was this requirement, we felt.

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

And actually, this'll be pulled from the ACO kind of payment models.

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

Um hmm.

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

So we're just basically introducing this into the products.

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

Um hmm.

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

Your comm – your asterisks about summary of care, electronic summary is preferred, what does that mean?

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

I think in our other, and I don't have the Stage 2, the threshold was at 50% and then 10% electronic. So I don't know if we need to say that, because I broke it out separate, just we put threshold low. But in our other objective, there was a certain number you had to be able to complete with a certain percentage electronic. So that was kind of what that meant. And we can either pull that out of here, because we prefer electronic in all the cases –

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

Yeah, that's what I'm saying; it seems to introduce another concept, so just like you said, even if it was identical to Stage 2 that would project your sense. And the only thing that keeps the threshold low is really what you raised, which is the infrastructure is not uniformly distributed throughout the country –

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

Um hmm.

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

– in all geographies.

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

Yes. Yeah, and I mean this is one that I think once it's started, it's one of those that will be used, right?

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

Okay. Do you want to move on to your notification then?

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

Yeah, and so Paul, the only gap I have is, and I don't know if you want me to follow that one up, I'm not sure how to track back to the original order, but I can check into that, okay? I'll follow up with that.

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

What do you mean, how to?

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

If, for instance, if the consult report contained an order number in it, right, or some referral number, which it might, then it should be able to map back, right?

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

Well I think what we're suggesting in this – well, in the menu requirement for providers and the certification criteria for vendors is that they do have the field that does comply with the HL7 message that identifies, that does transmit the order ID so that it can be matched when it comes back.

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

Yeah, okay, I'm good with that, or referral number, sometimes it's that case, a referral number, whatever –

**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**

Okay. Then the last one was again improving care coordination for notification. Again, this again is menu and this is the case where it's simply a communication of a significant event. And I think the – we had a couple of questions about this one. One, the feedback from the vendor community was, again, in some communities because there's no infrastructure in place, it's hard to send out notifications, plus you've got to go through the process in terms of the patient in terms of knowing if it's permissible to actually communicate. So there's some work in terms of doing this, and that's one of the reasons that we wanted to make it menu; however, there is pretty significant evidence that many systems are already doing this today, so it was a signal.

The feedback from the vendors indicated once that infrastructures in place, you can – the type of event, the trigger really isn't the issue, and it's just having that infrastructure in place. And so – and this was one where our last point was, if the notification of the admit was sent to an HIE, that could be the smart node that would know where to send it. As opposed to necessarily having each EHR having to be that smart, which is why there was an indication that modular certification was encouraged or is allowable or – I don't think we want to say infer – referred, but again, many HIEs see this as their value proposition today. So that was the rationale, and we've pretty much kept it the same after all the feedback that we received, and left it as menu.

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

Is that another FAQ then, that final explanation, the modular certification?

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

Oh maybe we want to make that an FAQ then, right? And just give guidance on that.

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

Yeah. What to people think about this?

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

So this is Mike, I think it's okay. I do want to just make sure we have enough flexibility, key members of the patient's care team. My recent example is one of a patient who died, whose cardiologist who might or might not be considered part of the key team, called to set up an appointment for the patient who had expired. So I guess the notion is making sure there's enough capability in there to designate whomever should be part of that with a tendency to be broader rather than narrow, based on difficulty anticipating the significance.

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

Should it be relevant, relevant members?

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

Or could you even say, patient designated? And the reason is, how are people going to decide who is key and who is not –

**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**

– and how would you report on the numerator, so is it just patient designated members? And then that's something you could capture.

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

Well that has its limitations, too, but I hear, I think it's probably more helpful than the current definition or the current term. But this patient would also not have been able to say, who do I want to know if I die, or if I'm admitted or whatever, so I think there may be some special conditions around death that are somewhat different. But certainly, a family's grief is different when they're not getting called to set up an appointment for a member who died.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

And this is Patty. I know there are challenges around getting patient's consents to – where, so as for NIH, prior to my current job now, we had to get permission from the patient and have them spell out which providers you wanted to have them send data to, and that was a huge challenge, I know that. And then they would change, and so maintaining that was difficult, so I understand, automatically to the provider of record makes perfect sense to me.

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

So Patty, what would you recommend?

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Well – so, maybe this is just the fact that I don't know, maybe there is some rule or policy out there that, do we not have to get permission from every patient to sending something somewhere?

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

Actually, no under HIPAA, you can send, in fact, the entire record if it's to someone with a treatment relationship.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Okay, so if it's deemed that it's to provide care to the patient, then we can send. Isn't that correct?

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

Correct.

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

Right, right, that's right.

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

Right and –

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

And that was why we said, do we even have to put patient – we just left patient consent if required. There was a question, do I need to include that, because of that caveat.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Um hmm.

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

So –

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

Well, I suppose it could be mental health or it could be a Title II thing, so –

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

Yeah, right.

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

– there are those cases. I can imagine the way this might be operationalized is how you, in a lot of cases you're expected to, when you register, put down an emergency contact. And that would be the implicit approval, consent that yes, and I would like you to use this number, if you do in a case of emergency, you could imagine them saying, who would you like us to send your records to that's in your registration form or something, and you put down –

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

Yeah so, this is Mike again. I think for the functionality purposes it's the notion of being able to select and or all members, how we do it, whether we – and how we involve patients in it is another thing, but – and we'll have different opinions on it. But I'm pretty sure that at least in my circumstance, if somebody is designated as part of the care team and somebody's gone to the work to make that obvious, then they probably want to – they probably need to be informed when the patient that they are part of a care team for dies, for example. But again, different people have different views, so I think the functionality is just simply to support the sharing of the notification with members of the patient's care team, and let it be that.

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

Right. But should I drop key then? Should I drop key?

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

I think so, just from my perspective, because I would not like to have it interpreted, as we only need to configure it for either the PCP, referring provider or care coordinator.

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

And leave it very flexible, right leave it flexible.

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

Yeah.

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

So one of the – you might say patient designated and the reason's because that sort of helps you with the whole consent, and then means you're asking the patient.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

I like that or – this is Patty, again. Perhaps use the word relevant, or actually, I like Paul what you said, I like patient designated.

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

Because that infer – that implies they're an opt-in. All these terms like relevant and key, somebody the machine is not capable of telling who is key and who is relevant, that's the problem.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

That's really –

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

So is it really important though? I mean part of what I'm trying to get at is burden for physicians, so I if I have to have yet another series of questions about stuff that wouldn't be HIPAA required, that probably the vast majority of patients would say, if there's something important and you're a member of my care team, go for it.

**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**

Well, you could write your NPP that way or your registration that way or, I mean it could be written as an opt-in or opt-out, however you construct your –

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

Should we leave the patient designated part out of it then and let the organizations decide how they want to do that, patient designated or otherwise? Or do we want to be that prescriptive about it?

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

Yes, I'm in favor of just taking key out and letting the teams decide. Because we've got –

**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**

– patient consent if required in there, which could imply they have to ask the patient, right. But then they'd have to operationalize this in terms of their context.

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

Yeah for us, regardless so you can bet the legal folks in our organization will weigh in and help determine whether, either based on our current documents or our future ones, we would have to as opposed to perhaps want to get patient specific requests.

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

Okay, is this good to go?

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

So we're going to drop key and leave –

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

I just want to confirm what Charlene said, Charlene where were you taking out from, to key members of the patient's designated care – all of that?

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

We're going to just say to members – just to members of the patient care team, but we're leaving in with patient consent, if required, so that they have to think through that process.

**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**

Exactly.

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

Thank you.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

This is Art; I have a question on the bullet below. It says notifications should be automatically sent to the provider of record –

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

Oh.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

– is that provider or providers?

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

Do we need that line, we said in a timely manner.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So that's taken care of above is what you're saying.

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

Yes.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Do we need the word automatically?

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

I think in a timely manner implies that.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Okay.

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

Plus it's electronic above.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Okay.

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

So we're saying delete bullet two or three, whatever –

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

Yeah, bullet three, yup, because provider of record will confuse things again, what's that mean, right?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

And all notifications should be capable of being sent automatically as well, I don't know that we'd ever want to say some must be otherwise.

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

Yeah. I mean if people are going to do this, they're not going to like wait days.

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

Okay, so just delete bullet three.

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

Delete bullet three.

**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**

Great get, great get. And then modular certification, we need an FAQ around that.

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

We're going to put an FAQ, right.

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

Yes.

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

All right. Anything else?

**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**

Thank you Charlene.

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

You're welcome Paul.

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

We're really cleaning this up and I can see how we're trying to preempt these questions, we're trying to address them, we're trying to write the objective – the language more clearly. I think this is all going to help. Can't guarantee the approval, but it's got to help. All right, let's move into category 4 please and Art, are you going to guide us through this?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well I don't know that there's that much to really –

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

Okay.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

– discuss, but, I will be happy to take you through this.

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

Okay.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

In Stage 1 and 2 you can see the patient – we're actually sharing immunization data, cancer and specialty registry, electronic lab reporting and syndromic surveillance data were listed. And in Stage 3 the functional objective is to allow case reports, that's newly introduced. Registries have been somewhat changed and several methods have been described. And then the rest of them all remain the same. And I don't know that I need to go through the meaningful use outcome goals or the functionality goals, I think we've all agreed to those previously.

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

Right.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So if you go to the next slide, which is focusing on case reports, which is, as I've described, new. The EHR is capable of using external knowledge, for instance the Reportable Conditions Knowledge Management System to prompt an end-user when criteria are met for case reporting. This is in certification criteria only. Then when case reporting criteria are met, the EHR is capable of recording and maintaining an audit for the date and prompt – a data and time of the prompt. And then lastly, the EHR is capable of using external knowledge to collect standardized case reports using the structured data capture component of the S&I Framework and preparing a standardized case report, that's similar to the Consolidated CDA that may be submitted to the local or state jurisdiction. And the date and time of submission is available to review by audit. That's a – these are all certification criteria. Any questions about what's been written there?

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

This is Mike, so thanks for this, but just to be clear, so this is something the systems have to be capable of, but it doesn't have to be turned on?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right and I thought that John, I think it was John who earlier in the discussion said something about having a certification criteria without attestation is a bit weak. But I think that's where we wound up with this Mike.

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

So I guess I would just make the plea for it to be on. I mean, we have this in one of my systems and it's easy to decide not to if it's not indicated, but it sure is helpful to be reminded that this is reportable and would you like to do it.

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

I think the challenge is this whole external knowledge, that might be – and you are presu – I'm guessing you wrote your own rule for that.

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

Right.

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

So I think where the challenge is going to be is the external knowledge.

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

Yeah.

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

I think John's point about the whole...his objection to certification only is that often times they're not potentially well writ – the testing script is not well written, partly because we don't have a use case motivating it, and that's what causes test scripts to be written in a way that may not actually make sense. I think, if anybody else understands his argument, I think that's what he's after. From our point of view, we believe it's too early to mandate a behavior, but we wanted this to be essentially more than a single step in the direction to having the capability and using the capability to do something. Now I suppose one of the ways we could try to address his concern, while still maintaining certification only criteria, is to spell out a use case, like in an FAQ, that would help give guidance to ONC and the people who write the test scripts. Is that fair?

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

So let me do one other just brief challenge, if I can. So to me this is somewhat reminiscent of, but probably even more helpful than turning on a formulary, whether you use it or not, given the amount of accuracy or inaccuracy issues there are in formularies.

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

Um hmm.

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

If you have to meet certification criteria that to me at least implies that it's going to be good enough to have it be on. And if you don't have to do anything other than have it on the entire period, you give the EPs and EHs some experience with it, and if they don't actually have to do anything other than get socialized with it, that's not such a bad thing. We do it – we use ours for occupational disease reporting in the main form, but obviously you could pick some other ones. So, I may be missing something, but that's kind of the way it feels to me.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So are you saying Mike that you're suggesting that we could attest that it's on?

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

Yeah, I would just say that if it's certified that it's happening and capable of doing it, you just have it on during the entire reporting period, then people would attest to that.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Uh huh.

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

Yeah, we're trying to go away from those check mark things. We played around with that in Stage 1 and it wasn't very popular.

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

The other question there, I think the challenge is, and I think that clearly this would be great if this could happen, is the current work with state health departments is so rough, and so – and when you have to...the certification testing that Paul alluded to, it's usually they test maximal case, right? And I'm not even sure how they would do that, unless it's – so either like Paul suggested there's a narrow use case that starts to move this down this path, but something that puts some guardrails around this, I think. So – because I think it's a great direction. It feels like a high bar for Stage 3, but, it's a way that'll at least will make this work, because of the variation that you get I mean across local health departments as well – we've got local ones that are using it differently than the state ones.

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

This is George. I think, I agree, I worry about feasibility of the consumption of external knowledge, which then, of course, corroborates our CDS objective mention. I mean I guess, this is the least we can do, but I can understand John's point earlier about the certification criteria. I guess what'll end up happening in reality is that CMS and ONC are going to look at all of our certification criteria and decide what to do, to drop them because there's no actual use of it because it's too much for the vendors to do or not. This is not the final rule, in other words, so if we want to keep this in, I guess I'm okay with keeping it in, but I am worried about it. And then we'll see, we'll have CMS look at it and then we'll have the NPRM to respond to it.

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

Okay, so is everyone in agreement with leaving it in then and does anybody favor writing a use case for it to help with the testing?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So, we don't need a use case right away, do we?

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

No.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I –

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

Well actually, we sort of need a use case – yeah, we do, because we're going to submit our final recom – the only other thing we could do is submit a use case after the NPRM, but that doesn't sort of quite make sense.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well, but I mean, when I said right away, I mean, we don't need it by next week, do we?

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

Well, if we want to get it approved, we sort of do.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

You mean to have the use case presented at the same time –

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

Yeah.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Did you say yes to that Paul?

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

I think so. I mean, even if it's really brief, you say it's a reportable –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I can do that.

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

Yeah, I don't know how to get it in there otherwise, sorry.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Okay. I'll do that for next week, but I think that I'd like to speak with my public health colleagues about maybe being a little more complete in some suggested use cases. But I will give you one to present for next week.

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

Okay, thank you.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Okay.

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

Okay, final one on registries please.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Okay, so the last one here is around registries and here it says that they will reuse – the eligible provider or hospital will reuse data to electronically submit standardized data elements, structure, transport mechanisms, reports to two registries at the state and local health level, professional society or some other aggregating resource like an ACA. The reports might use or should use one or more of these mechanisms, and there are three listed here, for uploading information on individual cases to registries such as a cancer registry or healthcare associated infection, that would use a standard or enhanced CCDA, the enhanced would be through a structured data capture. That's the first mechanism.

For a second type of registry, these large-scale population-wide registries, it would be for reporting common conditions of high priority. They would use a modified CCDA to limit exposure of protected health information when creating a community-based registry for obesity or hypertension. And then lastly, a third mechanism would be to use – leverage the national networks like the FDA Mini-Sentinel study, another study the DARTNet Institute or some local environments like New York City and there's another one up in Massachusetts where they've established federated query technologies.

So the key part here is that the electronic health record, the CEHRT's capable in achieving a certification criteria in that they allow the end-user to configure standard CCDA files to determine which data will be sent to the high priority condition registry, that's the second method. We want to restrict how much data would be sent to the registry so that names, which are not necessary for this type of registry, would not be shared. And in the end, to prove that you are participating, as in Stage 2, public health departments or others who maintain registries, like professional societies or other aggregating resources, would provide a proof of participation through either a letter or an email or something like that. So that's the modification to the registry which in Stage 2 just deals with cancer and specialty registries, now we're expanding to three different methods and you must do two registries and it does not say in which domain.

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

And if you continued doing what you did in Stage 2 that would also qualify?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yes. Yeah, you wouldn't have to do anything different if you picked that in Stage 2, correct.

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

We might put that in as an FAQ, too, I think. Do people understand what's presented here?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I should maybe state one thing, in response to the question there Paul, it's a menu item I believe in Stage 2 and I don't know that you have to do two of them in Stage 2. Michelle, do you know?

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

You do have to do – what they were calling the specialty registries and then cancer.

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

But do you have to –

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

But one is just for hospitals, I believe, let me just check. Sorry.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right.

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

Yeah I think there's this whole menu and how many of the menu you have to do and – but if you were doing two registries, a standard – a cancer and specialty, you would just continue to do that and you'd be in full compliance with what you described here.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right.

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

Okay.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I'm just not sure if you have to do two, I can't remember.

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

But if you were, you would be doing this.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yeah.

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

If you were doing one, then, and you're proposing this one as a menu or –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well I think our pattern has been to move from menu to core as we go through from one stage to the next and I'm proposing that this be moved to core.

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

It appears to me – this is Marty; it appears to me that it is menu for EPs, because it does not appear on the hospital list.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right, I think so. And many hospitals already are participating in the healthcare associated infections as required by JCAHO and participation in the National Healthcare Safety Network, so, I think that they would get credit for something they're already doing.

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

Yeah, the reportables to the public health departments, we all are participating in those; it's the registries that we're not.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right, but in this first – in the first bullet here, we're considering healthcare associated infections part of the registry component. It's not reportables like gonorrhea or salmonella.

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

Okay.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

This is what thousands of hospitals are already doing.

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

Okay.

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

So Michelle, did you verify, is that menu – were both of those registry things menu.

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

They're both menu for EPs.

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

And then how many menus do you have to have?

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

I should know off the top of my head, but I don't anymore, I haven't thought about it in a while. Umm, I think it's three.

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

So the question is will everybody have to have done one registry of those two by Stage 2. I'm trying to understand whether this is a heavy lift both for providers and for vendors to do all three, for example.

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

Well based upon the menu items for Stage 2, it might be difficult. Because syndromic surveillance is one, which many EPs can't do and then the others are electronic notes, imaging, family history and then the two – the cancer registry and the specialty registry, as they called it. So, some could have potentially not have done either the cancer registry or the specialty registry.

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

Because in Stage 1 I think we had that you had to do a menu in public health, right, category 4.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Correct.

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

For Stage 1.

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

So in Stage 2 that's no longer true?

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

I don't –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well the three items that were – the menu items in Stage 1, immunization registry, electronic lab reporting and syndromic surveillance have moved to core for the hospitals.

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

Syndromic surveillance stayed menu for EPs, though.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

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**

So chances are most EPs will not do either registry in Stage 2, I mean, you could see some specialists perhaps participating. So this would be – so taking that into account, do you want really to core it's really a zero to two jump.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well, this will be the last chance to get registries to work.

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

I don't think the world stops, but you're – see, well, just have – regarding menu or not, it already has to be done by vendors, that's a pretty heavy lift, I'm guessing.

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

Yeah, I mean, this is – I mean, Art you have two hugely directional things, which I think are very powerful, to get these things done. So –

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

And this is Mike. I think part of Paul's comment; part of what I would resonate with is one, for precisely for those reasons. But also because I think there's going to be an increasing movement by some professional societies, internal medicine being mine, where they're going to try to take a pretty comprehensive approach to supporting registry functionality or desires that their members may have. So it may well be that there'll be lots of good things that happen from connecting to one registry and I think beyond that, it's all based on our individual practices or organizations. If it's easy enough to connect to other registries once we've done one, we're likely to do more.

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

So I'm thinking about this as, thinking of like immunization, it's partly technical, and the vendors will have to do one of the lifts. But the other is that you have to find the registry, figure out whether you can supply all the data, so there's a lot of organizational, human labor involved in just figuring out what's one, important to this organization and two, you get all your ducks lined up, the data, etcetera. That seems like – if we put something that is burdensome and you make it twice, you decrease the chance that each one of those will be really fixated on as being of high value to the organization. Do you see what I'm saying?

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

I agree.

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

One is good, two does not mean its better, it may – you actually may be depreciating the willingness and the value that you get out of the first one. That's just my concern.

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

I agree.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So, would be still having this be core or are you suggesting it be menu?

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

Well okay, so one possibility is you do – you make one core, that's a big step versus having up to two – well, I mean, like I guess making one core is the counter-proposal.

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

Yup.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

That's what I'm asking.

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

Yeah.

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

So this is Mike, that's what I would support. I'd really like to be able to focus on one, but really have to do it for the good it will do.

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

Other comments?

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

This is Mike; I have one more comment, just in terms of parsimony of the functionality. The second bullet with the three sub-bullets with a lot of verbiage, do we really need those in order to achieve the goal? I think CDA is in all of them, Consolidated CDA. I see the word should as opposed to must and it's really one and as I look at them, I'm hard pressed not to imagine I wouldn't use at least one of them anyway. So –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

We were mostly trying to give ideas of how you might do this, and there are three –

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

Except – yeah, sorry, go ahead.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

– there are three different methods. I don't know if there's a better way to summarize it. It was to let people know that we were not dictating one particular method.

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

Okay, so that's helpful to me and it's the notion of helpful additional information, which is sometimes put in the final table of contents – documents that way. But –

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

From a presentation point of view, Art, I might suggest something consistent with what Mike's saying. So we could say, one of three mechanisms, uploading individual cases, reporting on population conditions and leveraging national networks. We could put all this stuff in the final recommendation, but from a presentation point of view, probably emphasize what you're – the message you're trying to get across, which are there's a flexible way of getting this...depending on what you choose, of getting this information transmitted.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

That's a fair point Paul and Mike. Thank you.

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

But it's really helpful the way you've done this, we just will include that in the – somehow in the transmittal letter, but not necessarily present that way.

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

So Art, so is the intention that the vendors have to support all three of these then, or –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

No, I think a vendor could do one and that's it. I don't think that they have to do all of these. I think that in the second one though, it says down below that we're asking for vendor capacity to certify, but not to say that the vendor's going to make that happen for the end-user. I think we're just saying that you should be able to establish the contents of a CCDA that's sent to a population-based registry for high priority conditions.

**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**

But is – so is that a generic – that is a little different from the other way we've treated objectives, but is that a generic thing? Literally, all I have to do as a vendor is have a configurable CCDA?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well, what else can we do with a certification –

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

Well, I'm just saying is that really – and then I don't know whether you do need these three options as part of the objective, it can all be illustrative, sort of back –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So I think that the standard CCDA would have all the identifying information for a patient, that use case is typically a transition of care. This is not about a transition of care; this is about aggregating data to identify pockets of morbidity or such, or behaviors.

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

So I wonder if you could just keep that first bullet, and then we have to re-talk and see if we all agree on the one, but keep the first bullet and then say, using a CEHRT that allows the end-user to configure the CCDA file consistent with the registry chosen.

**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**

It's a simpler concept and then we can include all of these other things in, as I said, in the transmittal letter and as FAQ to CMS and ONC, to explain what our intent was, and then of course they would have to write the language if they agree with it.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So I think that works for the first two, Mike earlier said that all these say CCDA, the third one I don't believe does say anything about CCDA, and in that instance, it's really not a CCDA, you create these virtual data warehouses that are shared across systems. And that's a different construct than the first two.

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

So that would require the vendor to do something different, then.

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

Right.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well actually it's not the vendor, it's not the vendor, it's the organization. So there are, as I've stated before, about 130 million Americans whose records are being reviewed by the FDA for post-marketing surveillance. And those institutions set up the data in a format that it could be queried by the FDA Mini-Sentinel Technology.

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

Well don't they need to have some tool provided by the EHR vendor?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

They do it out of their warehouse.

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

Okay. Now – okay, the implication of that statement Art then I think is that you'd have to have your – if you want it in this crit – in this objective, then that means the warehouse would have to be certifiable. Do you see what I'm saying?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

No, I think what we are saying here is that if you participate in the Mini-Sentinel study, Mini-Sentinel would write a letter for you saying you participated, and you'd get credit for that.

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

Even if really the EHR vendor doesn't really offer me anything in their product, I extracted this data and made it available to the FDA. Is that correct?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

That is what I'm assuming would qualify for meaningful use.

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

Then I don't know how that "demonstrates that you are meaningfully using a certified EHR."

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

You're participating in the post-market surveillance for the betterment of the drug.

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

Using clinical data that I can get however, I choose to get, that's sort of the implication.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well, it starts out at the beginning, its reuse CEHRT data to electronically submit standardized reports to registries. So it's starting with, you couldn't do that without using the certified electronic health record technology.

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

Yeah, you could, right, you could set up a separate database. I mean, this is just in the – so the statute says, they – it must come out of a CEHRT.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

That's what we're suggesting here, yes.

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

That is the same, okay.

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

So this is Mike. So Art thanks for that, but I would also then say to Paul's original question, do we all really understand that? I guess I would put myself now in the club of those who don't. So I would not have guessed that by making my data available for someone else to do a federated query, without my actually having to send them something of which I have some control, that that would qualify. So that will probably need more explanation, not that it's a bad idea, it may well be a great idea, but it's not as clear.

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

So I think this almost – let me see if I see an analogy here. I think you're saying you must use the CEHRT to make available some relevant data to one or two registries, using the specified standard CCDA. In addition, you're giving people credit if they participate in a national network, such as the FDA Mini-Sentinel, which happens to go query this database that you – this warehouse that you make available. Is that an accurate state – have I stated that accurately?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right, but in the first instance you said by CCDA, in the first bullet, we do not specify it has to be by a CCDA.

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

Uhhh, but in the two options, 2 (a) and (b), you do, right?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right, we do. Right, right.

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

So I'm just trying to figure out – what would I read from this and know, that was part of my question to you, hey, if I was already doing this in Stage 2, did I qualify, without reading these words? I'm trying to figure out what's different and what really is the requirement and how does it really fit in the certified EHR. And I think –

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

So Paul, for me this was a really good explanation that you had. To me it reads like it's an "or," you must have – whether we do –

**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**

– one of two registries using the CCDA or to Art's point, or use this other approach in which you have a federated one, and those would count. That's much clearer to me and gives a clear alternative path that people can pursue.

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

Okay, I'll try another way. So your objective Art is to get data, clinical data, from EHRs and it be used in registries. So, you have two options in this objective, one, you connect your EHR using standard CCDA to get it directly into a reg – interfaces directly to a registry. Or you participate in some other national network such as, blank, national or local network such as blank. Is that your intent?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yes. And in the first one, the EHR is actually sending data away.

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

Correct.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yeah, yeah. Right, that is the intent.

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

Okay, so what – so I'm going to now parse that and say what's there to be done and then you pick whether you want all three or are two enough. So one is, you have to participate in a registry, because we said it's going to be a core of some type. Two, another requirement is the direct transmission from the EHR using CCDA. And three, a third message in here – concept in here is the participation in an external database. Now do you – are you trying to push all three or is there a subset that's acceptable to you?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So I think what we're suggesting is that the first one is a requirement.

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

Okay, puts out data from your EHR through CCDA.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

No, that you have to participate in a registry that was your first bullet.

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

Got it, okay. Fine.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

And then just as Mike said, the second and third are –

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

Are “ors.”

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

– alternative methods of achieving this participation.

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

Okay.

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

So Art, this is great. So let me just ask then, let’s take a use case, let’s say that the American College of Physicians, just as my professional society example, let’s say that it wants to use federated query technology to take a registry it develops and then connect with my EHR. I don’t have to do anything, if you will, other than allow the American College of Physicians or cardiology, or whoever it is, to do that. Would that meet the expectation or the intent of this from your perspective?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So, in principle yes, but I think it would be dangerous for you to allow them to directly attach to your EHR because it’s transactional and the data aren’t stored in a way that are easily retrievable for the queries that ACP might want to do.

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

Right, probably wouldn’t be in the EHR, it would probably be in some data warehouse we’d produce –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right.

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

– and I mean, that’s part of the certified technology. But the idea is the same way the FDA or NYC would do this if ACP or any other professional society or other entity wanted to help eligible professionals and hospitals out in that process by offering this kind of service. That to me feels like it would be both the spirit and be helpful and maybe maintenance of certification, etcetera, etcetera are other benefits and if that fits with the goal, that would make sense to me.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

That is the goal. I – professional societies is listed above there, well actually, it just says professional aggregating source, so it meant professional society like ACP, yes.

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

So Paul, I really like the way you’ve worded it then and maybe if we could go down that path –

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

Okay.

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

– that would work really well.

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

Okay. So, and actually Art, is that third bullet, you called leverage national networks or local, is it also fair to call it participate in an external data, some word – recognized database?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Umm, participate –

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

In some extern –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I'm not sure –

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

I'm trying, because you essentially said national or local, so I don't know what that limited, because that didn't exclude anything, so what is the key word that gives you credit for being a good citizen here? Is it an external –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Networks.

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

Network –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

That are using federated query technologies.

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

Okay, okay.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

That's the federated query technology is the key word.

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

Opt-in. Okay, got it.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Or key words.

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

Okay, so we'll try – I think, it's very helpful. I think we have identified your key criteria and we'll try to write the words so that it's potentially simpler and as a byproduct, less scary, and pass that by you, how's that.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Sure.

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

Okay. Then let's settle the one versus two and core versus menu. So you had proposed core and then –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I would like to see one core, yes.

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

And then is one core okay?

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

This is Marty, are we talking about hospitals and eligible professionals or what?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

It's both.

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

Hospitals have no requirement to participate in a registry now, in Stage 2.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So this is where I tried to describe that the healthcare associated infections – does your hospital report to the NHSN?

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

No.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Not at all? Okay.

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

Ours does.

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

So we have done – advanced directives is one of those cases, one, we have kept many to menu and we also have split out EPs versus EHs, core and menu, too. So we've done both of those kinds of things. So it's within the realm of precedent. I think by Marty's rule, we would go EPs core and EH menu, for one registry, using one of these two methods.

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

I see lots of value in this; it's just a huge jump.

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

Yeah. What do you think Art?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Umm, well I think we could split it. I don't want to create too much of a burden on a hospital that may not be participating in a registry. And the hospitals already have to do ELR, syndromic surveillance and –

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

Right, that's right.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

– participate in immunization reporting, because they became core in Stage 2. So, I think it's reasonable for us to say that could be menu for them, but core for professionals – providers.

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

Okay. What does the rest of the group think?

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

Mike, I support that.

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

I'm sorry Paul, what are we voting on now?

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

Okay, so the current proposal is to make it core for EPs, one registry and menu EH for one registry.

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

Oh, but not – and not two anywhere?

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

Not two anywhere, no.

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

Oh, I'm sorry I misunderstood. Okay, if that's what we're okay. So one core EP – one registry core EP –

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

Menu EH.

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

– one menu EH and we keep the first bullet, the second bullet we clarify, it really just says here some examples and use CDA. Third bullet is to use the certification criteria and fourth bullet says about registry owners, I don't know if we need that in there. And the last bullet would be you can – like, just like what is it, patient-generated health information, we have a way of getting it without using the standard, so analogously, we can use national networks or federated query technology to get credit for that registry or no.

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

It didn't –

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

Or did we drop that?

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

It's more – no, it's stated as you must – core EP, menu EH, participate in one registry and the choice is between transmitting something directly out of your EHR using CCDA or participating in a national or local network using federated query technology.

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

Umm, okay. If Art's saying that then I'm good with it.

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

Art, you're saying that, right?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I am saying that. I realized we were compromising here a little bit and trying to figure out how to make it possible for the vendors and providers and hospitals to make this happen.

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

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

So this is Mike. One other question, if we go to the red text then, do we need to say anything different about whether and how the end-users can configure what might go across or be queried by the national networks federated technologies or can we let that be?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So I think that for the presentation next week, what I was understanding from Paul is we're going to make it simple and not necessarily get into that detail, but that would be something discussed in the more detailed letter to the Coordinator.

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

Yeah, so we are putting in terms of certification would include the ability for providers to be able to configure the – what goes in the CDA file.

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

Okay, but since you won't be using a CDA file though right, for this national network approach?

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

Correct.

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

So I just want to make sure again it's – to the notion that says, you have some control over what these external entities in the national networks using federated query technologies would be able to get.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Correct.

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

Pretty obvious, but I just want to be sure.

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

And registry owners, since we don't have any jurisdiction over that, is that even something we can – that's sort of what – that's something you're proposing as a way of attesting.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yeah because in Stage 2, for syndromic surveillance, hospitals are coming to my health department asking for a letter that states that they're participating. I don't know that there's anything – I don't know what they're going to use for specialty registries. I don't know that the law or the rule described the process for showing that you participate in a specialty registry. Maybe Michelle can correct me on that. I think that's something that needs to be addressed and I thought we would just include it here, because it felt like an omission in Stage 2.

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

Yeah, but I mean it's one of those things I'm sure the registry would be glad to send you a letter and you would want – the provider would want that in their file if the auditor comes. But I don't know – I mean, they're not part of the EHR Incentive Program, so I don't know – we don't have any weight.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Well, but for Stage 2, you do need a letter from your public health department stating that you participated in syndromic surveillance. Marty is going to have to do that for Stage 2, and he's going to need a letter stating that his jurisdiction is expecting him to participate and he did, or his jurisdiction does not do this and he didn't. That's part of the rule. But it doesn't describe it for a specialty registry.

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

I mean, I –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So I'm not sure whether I made it more confusing, but there – in the rule it does say that the health department needs to declare that you have been a good participant for ongoing submission.

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

So I get – my only question is, do we need to take up the space of a full bullet on a presentation? It's really an implementation detail, I think.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yeah, no, no, I agree with you about that Paul.

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

Okay. Okay, very good. Well thank you so much, I think we are finished – I'll ask Michelle whether she thinks we ought to go over CDS, what we've edited there.

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

Paul, if we have the time, I think it might be worth it to look at CDS. So Altarum, though, we'd have to go to the word document that was distributed.

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

Page 1. So what I was going to do is just walk you through because as you know, one, that's one of our emphasis areas and two, we made a fair amount of changes and I just want to walk you through the edits and how we reflected the discussion there, just for your checking.

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

So Paul, this is Charlene, I hate to – there was one more, because we made a change on the – one of the care coordination requirements, I just had one more piece of feedback. We changed and pulled out and made menu the consult request as well as the consult report back.

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

Right.

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

One of the recommendations, and again the people on the call might be able to respond to this, was that potentially should be EP only and not hospitals, because typically the consults come from the practices. Does that make any sense to people that we should exclude hospitals from the menu requirement?

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

Yeah, this is Marty that makes sense to me.

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

Okay. So, it would just be EPs and we'd given them a menu capability then, in this case. I mean, I think that's a big step.

**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**

I think that's a big step, so, okay. Just because otherwise we'll get that feedback again, so –

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

Okay, thank you.

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

All right, so Michelle, you got that one. We're just going to make it EP, menu –

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

Yup, thank you.

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

– for consult request – yes, closing the. Okay thanks, bye.

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

Okay, so –

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

But don't leave us Charlene.

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

Okay, no, I'm not leaving; I'm just going on mute.

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

So on your screen is the revised CDS wording, and let me just go through that with you. So our final decision was, instead of numbers, we say multiple CDS interventions that apply to at least 4 of the 6 National Quality Strategy priorities, there's a reference to the NQS. And that recommended intervention areas include, and what that is is a signal to vendors. They must be able to do each of these, address preventive care, address chronic disease management, address appropriateness of lab and radiology orders, address advanced medication related decision support, improving the accuracy and completeness of the lists, problems, meds and allergies and drug-drug drug allergy interaction checks.

That they would have to provide the tools to do that and be able to do the following functions, one, track actionable CDS interventions. We tried to clarify what David meant – David Bates meant, so one, not track down and say how would I know that that future action, one-second or one year from now, is related to that ECS, that's hard. So what we meant by actionable CDS intervention meant that in the cont – often you get an alert and you get an easy-to-do click response to that. If you – whether you do or do not take advantage of that embedded response is what David Bates' intent was, because that's almost the only surefire way to say, well what did they do at the time, and that's what he meant.

So, you will also be able to write reports on how often did the alert fire. How many times did they take advantage of that in context action? And did they provide a reason for overriding the alert? Because that's a very important learning, to write better guidelines. And two, that it should be able to – the system be able to perform age-appropriate maximum daily dose weight calculations. And be able to consume external CDS rules according to the Health eDecisions standards. Comments on how well that reflected our discussion, it was a complex discussion.

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

This is Mike –

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

This is Charlene – yeah, this is Charlene, just a couple of pieces of feedback for actionable, typically there's – I know a big debate, we had lots of conversations with the vendors on this one. So actionable could be something – so just say like you come in in the morning and you get a printout that says, oh by the way, this patient's due for this preventive health stuff. It's not on a work list on your screen that you – again the vendors do this a lot of different ways.

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

Right, right.

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

So even that's actionable. So is it – so they debated, should it be active or some word that, again, we all kind of know what it means, but – so use a clinical context I think, whatever this actionable is, it means that – and that was why I said could you use active, rather than passive or something like that.

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

Okay. So how about if I put in – ability to track actionable, open paren, action embedded in alert –

**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**

So just to try to clarify that, okay. Get the point. So –

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

Because there are a lot of different ways to do these interventions and blah, blah, blah.

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

Go ahead Mike.

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

The other one –

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

Wait, Mike's trying to say something.

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

I was just going to say, could I just add, does that also imply its workflow embedded, integrated? In other words, not a list that I get at the end of the day.

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

Yeah, that's what the vendors mostly – and actually the vendors recommended, just start with drug-drug drug allergy alerts, because that's where – when there's been focus on doing this, that's where people start. So even if you're starting there, it's really clear, it's valuable and just start there. If you have to choose an area to start and be prescriptive, just start there. So again, because –

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

So I, I would say that's inconsistent with what David – I'm almost positive that's inconsistent with what David would want. And I would also push back, 87% of drug alerts are false positives, nobody even wants to deal with that.

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

Yeah, I know, I know, I know, I know. But that's where we want to improve, right?

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

Okay. Mike, you were saying something. Did what I say capture our discussion?

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

No, I think it did, it captured it very well and I would just say again that the notion of actionable means that it functionally meets the, if I click the next button, it does it for me.

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

Correct.

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

Um hmm.

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

Yeah, and that it's embedded in the workflow rather than somebody prints out something from the EMR –

**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**

– and that counts, right?

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

Correct.

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

Thank you.

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

Okay, well I really appreciate the work of this workgroup in – we've gone through a lot over several months now. We developed very detailed recommendations, we got feedback from the Policy Committee, we've traced it back now, working backwards from really the outcomes we're solving for, the functionality that serves that and back to a much more simple, conceptual presentation of Stage 3. It's a different world, Stage 3 versus Stage 1, in many, many ways. And we have, I think, done a much better job using clear language that hopefully has your questions, has a better reflection of our intent and gives CMS and ONC a better chance to understand our intent. And you've put a lot, a lot of hours into this, so thank you everyone. Any final comments there, we're going to present this, as you know, next week, to the rest of the Policy Committee. Hopefully we'll get this approved that will go off to CMS and ONC. They had committed to having an NPRM this fall, with an expectation that they would have the final rule out the first half of next year. So that's sort of the timeline, as we understand it, from their communication at this point.

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

So this is Mike. I would just say thanks Paul and George for your leadership on this and for everyone who lead one of the subsections. It's been really great and I really appreciate the thought and effort that went into it.

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

Yes, thank you to the subgroup leads, that's been really helpful, thank you.

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

Michelle, any comments about dates coming up?

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

Thank you George. If anyone noticed, there was a work plan presented in one of the first few slides. I just wanted to note that one of the dates was wrong, I think I put March 3 and it should be March 4, so, please note that the wrong date was in the slide.

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

And then I want to conclude, before the public comments and thank Michelle, our –

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

Oh my goodness.

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

– who not only – I mean, she took on another, I couldn't believe she took on another job besides working on the Meaningful Use Workgroup. But – and has been doing such a stellar job, is really as our FACA coordinator, not just for us, but for Standards Committee, but has maintained her loyal and dedicated help of support of the Meaningful Use Workgroup. So thank you Michelle.

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

Thank you Michelle.

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

Thank you Paul.

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

Thank you <Michelle for keeping us straight, yes.

## Public Comment

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

Well thank you all and with that, we'll open for public comment.

### **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 one public comment. David, please go ahead.

### **David Tao – Technical Advisor - ICSA Labs**

Hi, it's David Tao from ICSA Labs. Thanks for the opportunity. I wanted to just make one comment regarding the summary of care recommendation. – talk about care planning and goals, instructions and so forth, there are standards for those goals, instructions, and interventions in a structured form that are in Consolidated CDA 2.0, but it's undergoing ballot reconciliation, and is about 90% complete through the comments. But my main point is that the structure is defined in a new document type called a "Care Plan," rather than in an existing summary document like a CCD. So I suggest that when the Meaningful Use Workgroup makes its recommendations that it try to avoid wording that suggests that everything has to be within a single document. I believe the providers should be allowed to send one or more documents, so long as they conform to the standards. So someone might send a CCD by itself, with some textual care plan information. But another provider should have the option, at their discretion, to send a CCD plus a separate care plan document, and that should also be okay. That's my recommendation. Thank you very much.

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

Great.

## Public Comment Received

1. Thanks for the opportunity to comment. Regarding the Summary of Care for Transfers of Care, I would like to add that standards for structured goals, instructions, and interventions are defined in Consolidated CDA version 2.0, which is currently undergoing HL7 ballot reconciliation, which is about 90% completed. However, the structure is defined within a new "Care Plan" document type, rather than within an existing summary document such as a CCD. So I suggest that the MU policy objective wording not be too prescriptive by forcing all information to be sent within in "A" single document. Rather, the provider should be allowed to send one or more documents, as long as they conform to the CCDA standards. So one provider might send a CCD or a Transfer Summary document with textual care plan information. But another provider at their discretion might send a CCD plus a structured Care Plan document, and that should be OK to fulfill the objective.