HIT Policy Committee
Meaningful Use Workgroup
Transcript
April 10, 2014

Presentation

Operator
All lines bridged with the public.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thank you, good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the HIT 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 & Technology Officer – Palo Alto Medical Foundation
Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Good morning Paul. George Hripcsak?

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi George. Amy Zimmerman?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Art Davidson?

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Art. Charlene Underwood?

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Charlene. Christine Bechtel?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
I'm here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Christine. David Lansky? David Bates? Deven McGraw? Greg Pace? Marc Overhage?

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Marc. Joe Francis? Leslie Kelly Hall? Marty Rice?

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Marty. Marty Fattig?

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Good morning. Matthew Greene? Mike Zaroukian? Neil Calman? Patty Sengstack? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur
Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Paul. Rob Taglicod? And Stephanie Klepacki?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Are there any other ONC staff members on the line? Okay, with that I'll turn it back to you Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Great, thank you very much Michelle. We're going to quickly get to our first agenda item we really have only two, one is to go over the feedback from the HIT Standards Committee on MU 3 recommendations, as you know our recommendations have already been transmitted and what we're doing is we're gathering more information both from conversations like this as well as our hearings, listening sessions because we'll still have another chance to react to the NPRM when it comes out presumably in the fall.

The second agenda item is to plan our listening sessions, speaking of that, but let's get right away to John Halamka who is Co-Chair of the HIT Standards Committee for a summary of their feedback on our Meaningful Use 3 recommendations, because he can only be here until 10:00. So, thank you very much for joining us John and let me turn it over to you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Great, well, thanks so much and Michelle if you could go ahead and forward to your slide 4 membership of our Task Force. So, the Standards Committee was asked to review the standards maturity of the standards involved in the 19 Meaningful Use Stage 3 recommendations.

We wanted to do this in a very quantitative way and so I forwarded to Paul actually a paper that a number of us have written for JAMIA that codifies that quantitative analysis of standards maturity and actually sets specific thresholds for every aspect of standards maturity.

You know, I would say that we can't publically circulate this manuscript because it is in flight in publication, but obviously, Paul, to the extent that you want to take a look at some of those tables and share them with members as appropriate that's completely fine.

The membership of this Task Force included those who were experts in standards of content, vocabulary and transport but also those with a particular analytic capability to look at implementation difficulty and the workflow involved in actually bringing those standards into production.

So, let's go forward to slide 5, clinical decision support, and we looked at using this quantitative approach and provider use efforts, standards maturity and development effort which includes elements of implementation, and on the CDS criteria of specifically tracking actionable decision support responses we surveyed all the standards that are available and there is no specific standard for the recording of those actionable events and responses to them.

And the question that was raised at the implementation level is trying to track every intervention made at every point where decision support could conceivably, offered in an EHR, would be quite a substantial development effort and we wonder if there is a way to recast this one measuring an outcome as opposed to trying to create a standard for the recording of every actionable event as it is presented to a decision maker.

I recognize that this is above our pay grade it sort of in some ways goes into the policy implications of this one, but if I just report to you objectively there is no standard for the recording of actionable events and that it would be a substantial development effort to implement such function across most EHRs that exist today.

If we go to the next slide, the order tracking, and the interesting aspect of this one is that there are some aspects of the policy which are quite mature and others that are not and so let me just reflect on that. If, to the discussion we had as we gather this morning, laboratory standards in this country are quite mature, results very mature, orders becoming mature, LOINC becoming more adopted and so the notion of proposing closed loop laboratory results with sign off ensuring the delivery and action taking place on a laboratory order that results to an EHR is very reasonable.

Whereas closed loop consultation workflow both lacks standards as we go across multiple EHRs, across multiple vendors to create closed loop action tracking of what was done and do you really order a consult and how do you tell if it's completed or not completed.

Harvard recently, through its risk management foundation, convened a number of providers in the Harvard community to take a look at the workflow and found that there were 11 discrete steps with 11 discrete hand-offs in the workflow of what we'll call closed loop referral processing and that really no EHR could currently support that though a number of us are trying to build the componentry that would bring that to reality because we think it's high value, it just at the moment, again standards are immature and development effort is high. But if you focused on lab you could have a win/win.

Next is demographics and patient information, probably the same story here is that there are some aspects of this one that have quite mature standards so occupation and industry codes are quite well known and at the moment there isn't a controlled vocabulary for preferred method of communication.

And, as I think you'll hear in further testimony from experts, the current SNOMED CT codes for sexual orientation and gender identity are probably not complete enough to be considered a best practice. I did circulate to the Standards Committee, and Michelle you have a copy of, a paper by Harvey Makadon of the Fenway Community Health Center which recently did a meta-analysis of all the use of sexual orientation and gender identity designations in healthcare and actually found that the best way to approach this is asking the patient a series of questions, small number, rather than try to come up with a categorical pick list that specifically states gender identity and sexual orientation in a very concrete way, because there's kind of a spectrum for which questions are actually a better indicator of those terms.

And then the question on workflow and development effort is you can imagine there is gender assignment at birth, there could be genomic or phenotypic gender but if you have a series of questions which gender identity can be a spectrum, what is the implication for decision support, what is the implication for patient education materials.

And so as we actually talked to a number of vendors and looked at all the places where administrative gender is used today to trigger other functions there conceivably could be a significant development effort if one started using sexual orientation and gender identity instead of administrative gender in places in the EHR to trigger other functions, so, just some food for thought there. So, yes some standards are mature, but others definitely are immature and there are implications.

Next slide, care planning advance directive, well here's some good news for you, if the intent of the policy is a pointer to a document, it could be structured or unstructured and the presence of whether such a document exists, well of course a URL or a pointer that would go to a place where a document or a webpage or other indication of preference could be retrieved well that's a mature standard.

Probably the only thing that we would have to think about is are there digital signatures for authenticity so that we can ensure that the document or preferences are not modified and have associated signature authorship. But, again, there are certainly standards for digital certificates that are mature in that regard, so that one certainly looks very doable.

Electronic notes, so questions about this one really fall into two categories. As we think about what it is that it means to send narrative the concept of a discharge summary, hospital course, discharge instructions, etcetera probably need to be further specified.

A number of EHRs have two functions one which would be considered sort of at the point of transition a series of caregivers providing information to the patient which is not the hospital course or the final medical record discharge summary because that make take a couple of weeks to get dictated and processed through the system.

And so as we think about recording such notes and ensuring those notes are transmitted what is it that we must include the, what I'll call "cliff notes" version that is prepared by the team at discharge or is it the final narrative that could be weeks away so some workflow implications there.

And the CDA document structure or C-CDA templates probably are sufficient to accommodate the nature of narrative it's just not something that has been done a lot in the field yet to date and so as we think about what we want to include whether it's structured, semi-structured or unstructured we would just need to ensure we choose the template and likely to work just again not widely deployed yet.

Next, hospital labs, so to the comment I made to Marc Overhage before the call began, we actually asked a number of experts about the adoption of LOINC codes in community hospital laboratories that serve as reference labs for community physician EHRs and although Quest and LabCorp, and, you know, certainly our commercial colleagues have embraced LOINC very significantly.

And we all believe LOINC is absolutely the right vocabulary and its standards maturity is high, the analysis at the moment showed that small community hospitals only use LOINC codes in reference lab transactions about 25% of the time. So, the development could be substantial on our community hospitals which serve as reference labs and of course very significant numbers of community hospitals provide that function.

Unique device identifier, we love the FDA's work on this so much energy, such good work, the standard exists, the implementation guide is written it's just not yet deployed in the production EHRs or in production systems significantly in the United States. So the question really for you is not that, well the standards maturity is low, even though the implementation guide exists, still go forward with it that's certainly fine we've done that with things like CCD and CDA in the past.

But we wondered, if the intent of the policy is to simply capture the UDI for each patient as a free text field but then have no workflow associated with it like search ability, ability to notify patient in recall, you know, education or whatever, we wondered, I mean, again it's policy so it really did stray a bit into your area, but do we need to recast the scope of this one to be a little bit more impactful because we think that recording the data in unstructured text just may in itself not be suitable there could be mistyping and search ability could be lacking, so something to think about.

Next slide, view, download and transmit, only comment is that we love view, download and transmit, of course it's a Meaningful Use Stage 2 criteria, certified software has to do it. The addenda that you made to this one about family history available through VDT, the family history standards themselves, SNOMED CT, HL7 pedigree are themselves immature and at the moment not very widely deployed.

So, the question is, if family history is to be a structured package of data delivered via VDT the standards maturity is low. And then the only other comment about this one was looking at the time course of this making data available through VDT within 24 hours may have significant workflow implications to the point that I made earlier about, well discharge summaries are actually not available for a couple of weeks after the discharge so do you actually find to meet certain hour deadlines that you actually create workflows where cliff notes versions are inserted to make them available and that's all fine it's just novel development and novel workflow.

Next slide, patient generated healthcare data, we love the idea of patient generated healthcare data and assume that in an accountable care world will get much more telemetry with teleservices, telemedicine and patient generated preferences, functional status and other things over time.

One caveat is any time either the Policy Committee or Standards Committee creates an "or" you could do it this way or you could do it that way. What it forces in certification is "and." And so you would then find that every EHR in America would have to support structured or semi-structured questionnaires and secure messaging and then that gets into all kinds of workflow complexity.

And so I guess our hope with this one is the standards to do it really are low, I mean, Leslie Kelly Hall has had many discussions about the current use of C-CDA for certain things like transmitting data to and from patients, just the standard exists it just hasn't been used for that particular purpose.

But we wonder if this one could be recast either to be an outcome or to be prescriptive as a one way to do it because at the moment multiple ways to do it creates quite a lot of development complexity and impedance mismatch if one system expects it one way another system expects it another way.

And then 14, engaging patients and families in their care, secure messaging, so a comment was made as follows; there are many mature secure messaging systems that exist today products and services widely used, you know, maybe implemented in such things as MyChart or RelayHealth, they are actually well understood and well known by patients and providers.

They may not have the prescriptive workflow that's been indicated here of capability to indicate whether patient is expecting a response, capability to track a response, no response, secure message reply, telephone reply, etcetera.

So, the concern would be you could take an extraordinarily high functioning system that's highly mature widely adopted and actually require it to be retired because these couple of workflow elements are so prescriptive. And so one wonders is there a way to encourage the concept measure and outcome but allow latitude in implementation so that existent high functioning systems can continue to be used.

Visit summary and clinical summary, the challenge we had from a purely technological stand-point is defining relevant actionable information, in effect, you know, how do you technologically have a standard that ensures relevant and actionable data is transmitted and we weren't quite sure how any certification mechanism would measure that.

And so, hence, we were concerned that the implementation difficulty on trying to get through certification of being able to create a user interface that somehow on a disease specific basis limits data transmissions to relevant inactionable could be quite difficult. So, this one maybe just a wordsmithing issue to make it a bit more technologically feasible and measurable.

Patient education, a comment here, the InfoButton standard, which is what we have recommended in the past for linking to external educational resources does have a language field and so that technologically is fine, you know, it's just not that widely deployed, but it's fine.

The question is, if you only require one Non-English language use of such a standard you sort of wonder is there a way to wordsmith this so that it is actually going to meet a clinical need or outcome given that Beth Israel Deaconess has 37 different languages it needs to use, having just one language in itself wouldn't meet a clinical objective. So, that was just a comment on that one. The standard is fine.

Seventeen, summary of care, same sort of issue on narrative that I described earlier which is C-CDA does have capacity but not widely used in production today to send narrative and some uncertainty as to the nature of the narrative you'd want to capture and it's timeliness is it a document that is used as part of the medical record, is it a document that is created based on timeliness or workflow that would be different than the standard document in the medical record and that might imply some development.

Notifications, the standard HL7 2.5.1 messages for admit, discharge, transfer these sorts of things, those standards are very mature and very well understood, however, the thing about this particular policy recommendation that is very low maturity is the idea of capturing a list of care team members and their Direct addresses or technological end points to transmit such data to them.

So, typically ADT transactions are used within an institution to send information across different vendor systems of record or they might be used with public health or an HIE but it's very uncommon to send ADT messages to an external EHR or to a person based on a Direct address and gather their Direct address of all care team members at a registration step. So, in effect this is a new concept that employs standards that do exist in mature fashion for content but not for transmission.

Nineteen, medical reconciliation, no issue with this one at all, high maturity and already part of Meaningful Use Stage 2.

Immunization history, we have to be very careful with this one because the public health colleagues are very, very passionate about their use of the SOAP format that the CDC has published as of 2011 for query response of immunizations.

We've had experience where if an EHR uses the Direct standard for things like transmit of transition of care summaries then it's very easy for an HIE or an EHR to package up immunization, reportable labs, syndromic surveillance and also send it via Direct, but I think you'll find the public health colleagues don't really want to shift from their SOAP approach to Direct and rightly say that Direct is for sending data one way not for query response and the immunization history is a query response transaction.

So, standards exist, implementation guide is written, implemented in about 18 pilots across the country not widely implemented in EHRs today to do query response using the SOAP approach, so it is a bit of a novel workflow to consider.

On registries the challenge here is, as we examine the multiple registries that exist every registry has a totally unique set of data requirements and so we're concerned that trying to decide how to send arbitrary data elements from an EHR using an arbitrary vocabulary to a registry where every single data requirement of every single registry is different could be a nearly impossible development task because there is no common, what I'll call "registry submission data form" and so hence, you know, maybe C-CDA is a good container maybe it's not, it really depends on the nature of the data and every registry is different.

Electronic lab reporting already exists in Stage 2. We did not feel like this one was any barrier.

Syndromic surveillance also exists in Stage 2, didn't feel like this was any barrier.

So, I know I only have a couple of minutes left, but let me turn it back to you Paul, those were our initial reactions, I apologize for my verbosity.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
No apologies, John, I think they were extraordinarily on target and helpful. The limitation here is your limitation in time. A little hard to – you know, what we might do is try to summarize this and maybe formulate while you're gone, formulate some questions, we'll have some discussion and have some questions back to you and possibly you could either come back and talk about it, I'm not sure when though, but before the fall or give us written material if that's easier, whichever is easier for you. But I think this has been very helpful.

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

Paul Egerman – Businessman/Software Entrepreneur
This is Paul Egerman –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Hang on one second let me get John's response to that.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Yes of course and the answer is, I will do what – Michelle and I work very closely together and I'm happy to join an in person phone meeting or do written response, whatever gets you the data you need in a timely fashion.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
All right, thank you. So, maybe we have a couple of questions before John leaves.

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

Paul Egerman – Businessman/Software Entrepreneur
Yeah, it's Paul Egerman.

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

Paul Egerman – Businessman/Software Entrepreneur
First, John, thank you so much it's very helpful. My observation is about half of the material we just ran through is already in the 2015 version NPRM for certification, it seems like the train has left the station and so I'm confused as to what we're supposed to be doing with this since so much of this material like the coding of family history is already in the NRPM.

And I'm wondering if we should be organizing ourselves around if we want to make responses, you know, the response to the NPRM is due April 28th if we should be organizing ourselves around responding to the NPRM because like I said ONC is already moving ahead on much of this stuff.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
And Michelle, I believe the Implementation Workgroup of the Standards Committee is doing that thorough review of the NPRM and will be providing feedback to ONC in that regard?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Exactly, yes, three Workgroup on the standards side are responding and they're going to report back through the Standards Committee to have additional comments if necessary at the April 24th meeting and then we'll send those comments to ONC and then on the Policy side the Certification and Adoption Workgroup is also looking at the 2015 NPRM.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Right.

Paul Egerman – Businessman/Software Entrepreneur
Although the Certification Adoption is not looking at for the most part this type of content they're looking a little bit at demographics but are not looking at any other kinds of issues that John is raising, that's what the Meaningful Use Workgroup should be doing.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I think it's more related to standards –

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Which is why the Standards Committee Workgroups are looking at it.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I think it is more standards but we do want to use this as we think about our feedback at the NPRM from the Policy point-of-view. I think there was one more – somebody else was trying to speak?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
I was just going to ask John if there is one high priority one that he thinks of that "wow" this is the only you really have a problem with.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Probably not that easy to state. I think the overwhelming question that sometimes I raise in the Standards Committee is that if you look at any one policy or any one effort actually on their own even if they're challenging, you know, the burden, you know, is not that bad but you take it collectively and you can see that the burden of doing all of this stuff would in fact prevent the entire vendor community from doing anything else for the next 2 years.

So, I guess that would be my overwhelming concern is we have to look at the collective burden of what we are doing as we move these things forward.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
So, John, it's Christine, my question is actually, and I think it's a brief one, is sort of similar to Paul's, but I noted as I listened to you that a lot of the pieces that you've pulled out were also in Stage 2 not just in the 2015 cert rule like preferred communication, discharge instruction content, which is what you were talking about, hospital labs, you know, family health history, secure messaging things like that. So, I'm confused if they're not ready for primetime but they're already in Stage 2 and presumably in certified products.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Well, so what we were asked to do is look at the standards maturity of specific aspects of what was suggested for Stage 3 and so there is no standard for example for preferred communication. So, if the policy intent is that there needs to be a standard for that there is no such thing.

And so where we, potentially Michelle, could use clarity is that if the scope of the things that Christine just enumerated is not to be changed there is no further specificity on what is a discharge communication, there is no further specificity or requirement for a standard or a particular vocabulary than of course, you know, the Standards Committee would say, okay our job was to tell you whether there were standards –

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, I get you, John, yeah, I get that, but discharge summary is a great example, we did an enormous amount of work to specify the content in Stage 2 and we did the same thing with the care summary as well. So, that's why I'm confused on a number of these, because we did the work on it but it was Stage 2.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Right, so what we tried to take into account is what we had understood to be the scope of Stage 2 and where that scope had not changed such as some of the public health transactions, medication reconciliation we said "good to go" and if it was our misunderstanding that the, as we read, the Meaningful Use Stage 3 recommendations that appeared to change scope that may be the source of confusion.

Again, we're happy to go through those as Paul suggested you guys come up with questions and we can come back to you and say, here's where we thought the scope was changed.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Great, thanks, John.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Well, I unfortunately have to go run and now to a State Healthcare Information Exchange demonstration, you know, it's all ONC all the time.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Thanks, John that was very helpful.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Have a good day.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
We'll be in touch with you about a future meeting.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Thank you.

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

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center
Bye.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Bye. Okay, I think maybe we do exactly what I was suggesting to John is we go through some of these and then make some questions either discuss this internally and some of it maybe – I think actually I heard some of the things were just a misinterpretation of some of our intent and we can work on clarifying that as part of our response I know there might be further questions. So, I –

Paul Egerman – Businessman/Software Entrepreneur
Paul, sorry to interrupt, I don't quite understand where we're going. We're going to give a response to John and then what, I'm just a little confused, is this a response to Stage 3 or is it going to relate in some sense to the NPRM? I mean –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Our ultimate goal is to be even more informed as we prepare a response back to the NPRM which doesn't come until the fall so we're gathering information such as this, you know, some of the – we had the pressure of time in terms of getting out our recommendations as you know there is a step process recommendations, then it goes to the standards and it would be nice if all that could happen before, but we didn't have ours finalized, you know, until later and so they're now coming back with their response, we'd like to use that information in making our response to the NPRM in the fall that's the –

Paul Egerman – Businessman/Software Entrepreneur
But is this – when I referred to the NPRM I was referring to the 2015 NPRM because a lot of these issues are in the 2015 version it's already out and so perhaps if we're commenting on it shouldn't we be somehow segregating those and give a response consistent with the timing for the 2015, because otherwise we miss our chance, right?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
No, I think, as Michelle just explained there are a total of four working groups that are working on a response to ONC for the 2015, so that's in the process you're involved in at least one of those. We're doing an independent thing in terms of looking at the policy and so I would like to sort of constrain our discussion on the policy aspects of the recommendations and yes if something changes in terms of 2015 that can update our feedback on the NPRM.

So, we're gathering – we're just making sure that we have discussed some of the – some of our reactions to more information about, in this case the standards maturity and the implementation effort of our recommendations and we'll keep that around as we go forward collecting more information from the hearings and just be much better informed as we prepare our response back to the NPRM.

Obviously, at the same time both CMS and ONC are listening to the same conversation as they even write the NPRM. So, how does that sound in terms of us asking sort of reconciling John's comments with our policy intent for the recommendations and going through and maybe generating some more questions if we have that of John? Does that make sense?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Paul, it's Christine, I think it makes sense to the extent that we need to clarify, you know, policy intent like we didn't change the content of the discharge summary or we didn't mean for people to have to use the certification, I mean, the – what's it called, secure messaging certification only criteria in the same way as they would use secure messaging for the 5% threshold.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
I think we could clarify some of those things but I'm worried, because John – it did not seem to me that group really stuck to the scope of standards they got into the workflow issues as well that standards might be mature but there are workflow implications and we know that, and we've debated that stuff like a long time.

So, I'm a little bit worried about our own ability to constrain to just reacting to what he presented and then I'm also concerned that we're not standards experts either and so, yeah, we're going to have a discussion again about standards. So, I think answering the questions is good, but I'm concerned about it.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, well, so, we're not the standards experts but we just heard from the standards experts and that should – we had our estimate and we certainly did have input from members of the Standards Committee as we went along and that was our way of trying to get as much information up front but if there is a more informed summary as John just presented than that certainly may impact, because we use that as one of our criteria, as you know, workflow, standards maturity, development effort, provider effort those are all things that we considered and we're just getting more refined information at this point. So, it certainly could affect our policy recommendations.

All right, let's go – if we could roll back the slides to the beginning we'll just sort of go through and some of it, you know, maybe a quarter or a third of it was I would say a misinterpretation of our intent and all that is good feedback that people who are immersed in this stuff didn't fully appreciate our intent than we need to do a better job of wording and if that doesn't become clear in the NPRM then we can probably help clarify. Next slide, please.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Paul, I just want to say one last thing too, which is maybe we can really focus on doing some off line questions and clarifications, and the reason I say that is because we're supposed to be gathering information about reacting to the NPRM but we don't know what's in the NPRM and ONC and CMS are hearing all the same information so we may spend a lot of time debating and refining things that they never include in the first place.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
So, we can just be more efficient.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I understand. So, let's see what you see in front of you is the CDS what struck out in my mind is what John was describing as that tracking response is still not what we intended and yes we're looking for the outcome, our intent and it's certification only is really to be able to say, hey, is there a reason why you didn't follow this for the purpose of improving the CDS itself.

So, I think we could probably – we've said that many times in words it doesn't appear in this writing and even John and the Standards Committee didn't get our intent. So, I think that would completely change the level of effort for example and understanding the intent.

So, that's an example where I think it's fairly clear so maybe the NPRM will be completely clear and if that's true then fine, if not I'm just trying to keep a track on our parking lot of things to work on and here we would just be just more explicit.

Paul Egerman – Businessman/Software Entrepreneur
And so Paul on this issue when I had asked about it I was informed a lot of systems already do this.

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

Paul Egerman – Businessman/Software Entrepreneur
And if that's the case maybe if we were more explicit and said, well, computer systems that are already doing it that would make it clear what it is we're asking for.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Well, I don't think we're the – see we're not the certifiers so that's the implicit – what's implicit in your statement. So, rather than that I think we just need to make it more clear what our intent was and it will be clear to people and the certification would reflect what it is that we were trying to get out of this –

Paul Egerman – Businessman/Software Entrepreneur
Yeah, my point is – my point is John is saying that it's unclear what it means to track actionable.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, I understand.

Paul Egerman – Businessman/Software Entrepreneur
That there is no specification for that and if there are systems that already do it then that is a specification so you can say, for example, here are the systems that currently do this and that makes it very real, the certification people can still certify it however they want. So, that answers the question as to whether or not it exists.

I mean, his feedback is different than what I was told. His feedback is there are no standards, nobody knows how to do this, but what people are saying is that a lot of systems already do it. So, if a lot of systems already do it there is an implicit standard.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
There's a difference between –

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
This is Marc, I strongly disagree with that statement that because somebody does it it's an implicit standard.

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
That's a very different thing. There are ways to do things they may work in particular environments or particular systems does not make it doable across the board.

Paul Egerman – Businessman/Software Entrepreneur
That's fair.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, I think this is – I think this is an area, a comment that shows that we were not explicit, we were not clear in articulating both our intent and what would qualify as "track" and we have had that concern raised before. We attempted to clarify it but we didn't succeed.

So, that's something I would suggest that we spend some time wordsmithing if the NPRM is similarly not clear. Is that fair? Because I didn't hear him talking about this concept wasn't good, it's a misinterpretation of what we mean by tracking.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So, this is Charlene, the one comment from the vendors on this one is where there is experience in this space from the vendor community is in tracking, you know, the actionable, you know, drug-drug, drug-allergy types of alerts, you know, in the medication cycle.

So, I don't know if there is a way to use that as an example, because, you know, we talked about, you know, you can certainly – an order set can be a, you know, clinical decision support there are a lot of things – do they choose that order set.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
We weren't intending that.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So, you know, but where the experience is and where they've done it is in – again, not to say there is a standard for it, but clearly that's where people have been doing the work.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Good point, I think, both of those were good points Charlene. One is we can give that as an example, see that's not saying, Paul "oh, Meditech they do it right" I mean, we're basically talking about an example of what we mean by tracking and, you know, the whole, you're right CDS can include even having an order set. So, we just have to be far more explicit I think. Because our intent was actually much lower effort.

All right, so that – I mean, Michelle, you're keeping track of these I'm sure, right? You might be on mute. But at any rate so we're basically tracking where we want to do some work with this thing and around what area. Okay, can we go to the next slide, please?

Here I think he was – it's approximately the same thing. Oh, here is where he said lab that's fine, but what happens with the specialty request is hard and I think again it's our use of the word sort of tracking the result, we really – it's as simple as acknowledge but we don't want to check the box. We need to be more specific on what it means to disclose.

We basically want the specialist to get what they need and the primary care provider to get back the results but not really track, well what did they do with the results, it's almost an acknowledge really. Do people agree with that interpretation what I said?

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, so that's another, again, this is one of these clarification things. And that's good, because we can reduce a whole lot of burden and angst if we're just more clear on our intent. Next slide, please.

Here what he pointed out was although the standards for the results for sexual orientation, gender identity were not there HHS does have standard questions and what I heard is that's what he was recommending there. Did other people appreciate the same thing?

Paul Egerman – Businessman/Software Entrepreneur
This is Paul; I think that's what he said.

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

Paul Egerman – Businessman/Software Entrepreneur
But there was a whole discussion yesterday in the Certification Workgroup about really what should be certified is it the questions or is the data because there are a lot of situations where there are survey forms and things and it seems to me you want to certify the data and the data collection I would think and those were the comments that were made by the Certification Workgroup.

And around this issue also another comment that is made by the Certification Workgroup was that it's overly prescriptive to say that these have to be demographic data and the comment that was made was as it related to for example SOGI that depending on how the EHR's security system works all these systems have like role-based security and demographic data is available to certain groups of people, and something like sexual orientation you might want to put it in a different section of the record so it's not visible say to business office staff and all you need to do though is define the data it's not important whether or not it's in demographic data as that is perhaps unnecessarily prescriptive.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So that's –

Paul Egerman – Businessman/Software Entrepreneur
The same is true of communication preferences not necessarily demographic data, you know, you could put it in – there are a lot of different places where you could put that in the record and some records may have that stored already some other place and so there was a concern about why it's important to make that demographic data. Now the issue is this is in the 2015 NPRM as demographic data though.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay so that feedback can come back from multiple Workgroups it is a fair point and it is another one of these unintended – you know that wasn't – this was just done for categorization methods not a prescription for that it be called demographics and you had a couple of good reasons.

So, this is another one of these clarifications that can really basically eliminate the unintended issues. Any other comment about either capturing John's comments or what Paul just said, Paul Egerman just said?

Okay, next slide please. Is this useful? I think what this does is try to reconcile and bring closure to some things. Is this process working for people?

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
This is Marty I think it's a step in the right direction.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, thanks. Care planning I think, again we can clarify because he said, if what you mean is that there is a URL then yes those things are standard and that's exactly what we meant. So, I think we just need to make some of these things clearer.

I mean, it's good feedback for people who know this stuff and are immersed in it if they have some questions based on reading just our text then we can go far in just making that clearer.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
Just Paul on that, this is Marc, you know, I think when we say just a URL there are security implications that you can't ignore there.

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
In other words my personal documents are available by URL you're probably not going to just have them accessible and so there is another layer of security and authentication that goes with that and it's not just a pointer in the record.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
That's certainly a good point.

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

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
Maybe yours is posted I don't know. John Halamka's I'm sure is.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
That's right. No but it was not meant to say there is either one place or one way to structure the pointer it's really a pointer and we actually – it doesn't even have to be a "standard" it's just a way that the medical record can understand where to go and to your point with what security and protection. Anything further you heard on this one? Okay, next slide please.

I think our initial – we didn't change it we just changed the threshold he did go into the hospital discharge. Let's see is there – I think there is a future place where we can address that issue.

Paul Egerman – Businessman/Software Entrepreneur
Yeah, and Paul, this all is in the 2015 NPRM.

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

Paul Egerman – Businessman/Software Entrepreneur
So, it seems like it's not worth us talking about.

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

Paul Egerman – Businessman/Software Entrepreneur
It's there and it's going to go on its path.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, next slide please. The lab he did raise the concern about only 25% of community hospitals today use LOINC that maybe our intent and if I recall I think that sort of was our intent is to change that number. Is that people's understanding?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
This is Michelle, we originally added LOINC in based upon the comments that we received from the RFC and actually feedback from the Standards Committee but I think that makes sense too Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, which way Michelle was that, their comment was the same before?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
From the RFC they recommended that we specify LOINC.

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
At least the group who had looked at it at the time.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
And I can imagine the community of providers want this to be true. So, I think, in other words that was our intent –

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
Paul?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
To change that percent.

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
Yeah, Paul, this Marty, this is being adopted as we move forward with Stage 2.

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

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
By community hospitals so I think we're going to be all right by the time Stage 3 goes into effect.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Great, we'll push on. Next slide, please. The UDI, this is interesting, yeah, the number exists or is going to exist and then but he says the – it doesn't currently exist and I guess we're saying in 2017 we'd like it to exist in a structured way. So, is this what we designed this to do?

Paul Egerman – Businessman/Software Entrepreneur
Well, this is Paul, I mean, I actually did a write up on this that I sent out to ONC and to the FDA and had a lot of good communication on it and certainly from the FDA and I spoke to one of the two pilot sites, I spoke to the cardiologist who was actually was using it to understand the workflow and the basic issue here is John Halamka is right in that if all you do is have a text field you accomplish nothing.

Furthermore, this is in the 2015 certification edition NPRM and it asks the question should there be scanners but if a scanner is required the code itself is at least 20 characters long and could be as many as 80 characters long and these are just letters and numbers in sequence from a bar code.

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

Paul Egerman – Businessman/Software Entrepreneur
And there is just no way a human being can enter that many letters and numbers –

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

Paul Egerman – Businessman/Software Entrepreneur
And get it right and then you also have issues that people have multiple things implanted. The thing either has to be done right or it's just a waste of time.

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

Paul Egerman – Businessman/Software Entrepreneur
And so this is – what's written here is like scratching the surface.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right, okay, so this is one where we're going to be very interested in the 2015 edition and how HHS words the NPRM.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
This is Marc, just to underscore the complexity of this that we're just learning because these devices don't remain implanted.

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
And you don't need to be – you know, if you need to update – I mean, it's actually a – there is a lot to making that work and also even the definition of implanted gets a little bit funky.

So, you know, is a catheter and these aren't included in the FDA's, you know, first steps but in second steps, you know, is that "permanent catheter" implanted, you know, an implanted device, you know, and at what point does the line become an implanted device.

Paul Egerman – Businessman/Software Entrepreneur
Well, yeah, and this is Paul, that part is actually easy, the FDA has a rollout process –

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

Paul Egerman – Businessman/Software Entrepreneur
It includes all implantable devices but –

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
But all devices but are those implantable.

Paul Egerman – Businessman/Software Entrepreneur
The package either had a UDI on it or it doesn't. In other words when you do –

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
– implantable isn't clear.

Paul Egerman – Businessman/Software Entrepreneur
When you do this you can tell when you are implanting whether or not you need this because the package will have a UDI on it.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, so, we'll note these things to reconsider as we deal with the NPRM and the 2015 edition what they do with it. Okay, next slide, please. So, this is family history again and I think we did talk about it, and we proceeded with even if it's text essentially.

Paul Egerman – Businessman/Software Entrepreneur
Well, except the NPRM has it coded.

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

Paul Egerman – Businessman/Software Entrepreneur
The 2015 has it coded.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Using what code though?

Paul Egerman – Businessman/Software Entrepreneur
It has an HL7 code that provides for pedigree and so this is the same thing, since it's in the 2015 NPRM I suspect we should just not talk about it now unless we want to respond to that section.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well, I think this is where I have a question because this was in Stage 2 and I'm not sure if they specified a limited number of standards or not but it has been being recorded and I think John's feedback was to figure out if this is unstructured, you know, or, you know, more based on standards and so I think we need to understand both what was the standards approach in Stage 2 as well as what's in the 2015 NPRM.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
But he needs to understand also we're not necessarily asking for it to be purely standards-based, we've had this discussion many, many times –

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
But, that it be available if it is recorded under VDT.

Paul Egerman – Businessman/Software Entrepreneur
And all I'm saying is –

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

Paul Egerman – Businessman/Software Entrepreneur
The way I understand the NPRM it's coded using an HL7 standard.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Right, but do you know what it was in Stage 2?

Paul Egerman – Businessman/Software Entrepreneur
My understanding is it was not coded in Stage 2.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
All right I think we have to just – you know, ask John to clarify those things and restate his question. I don't think it's a matter of inclusion or not inclusion I think it's sort of how do you want this included because we removed this as in independent objective for that reason but said that whatever form it takes if it's in there it should be able to show up in VDT.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, okay, so this sounds like a very factual question one is Paul is saying there is an HL7 standard, Paul Egerman is saying there is an HL7 standard for family history and then Christine's question is and what – well, we think it was – it was not coded in Stage 2 –

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
I'm not sure that that's true, because remember the surgeon general had some standards and I thought that the cert rule did propose at least some limited set of standards for them because I remember people saying, yeah there are standards but they're not really well known and tested in the field and so it's going to be a new deployment but that was again Stage 2.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, so these are factual questions we can ask either – look back at our Stage 2 or ask John.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah and just to, you know, remind folks as well, this is one area that we also thought that if there are a lack of standards that under the patient generated health data objective the providers might be willing and might want to actually have PGHD or family health history be a form of patient generated health data. So, I think it is good to get a sense of the lay of the land here on standards.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right. Okay, next slide, please. Speaking of PGHD, and –

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, this – Paul, I was really kind of confused by this. He was talking about, you know, if you say it could be this or this it turns into an "and" but and I can see that there – I don't know, I mean, I thought that they had told us before that a structured survey was a pretty normal thing but maybe I'm not remembering that correctly.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
But secure messaging has been in there a long time.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
So, I felt like – I didn't understand how he could say "you've got to do both" well, yeah, but you already did one.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, actually, Christine, I think this is again a clarification. So, he's – we still are not clear on what we're doing so like secure messaging are we asking for a new kind of secure message for PGHD, we need to just be more clear.

The words there, if you put the words with that heading you could read other things and that's not what we intended and so we just need to be more explicit about what we intended. I think that most of this is a misunderstanding where we need to clarify what we mean.

Most record systems have at least semi-structured questionnaires, so we just need to make that clear and if they don't then yes this is a new requirement, but as you know in Stage 1 they all have secure messaging. All right, I think this is literally –

Paul Egerman – Businessman/Software Entrepreneur
And not to interrupt, I have the answer to that factual question I pulled up the 2015 NPRM.

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

Paul Egerman – Businessman/Software Entrepreneur
And basically it states pretty clearly that family health history will be structured and there is a discussion about SNOMED versus HL7 and an explanation of why they chose SNOMED and it does say it was not structured in the 2014 edition.

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

Paul Egerman – Businessman/Software Entrepreneur
So, this is a change.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
It's a change and they did specify one SNOMED?

Paul Egerman – Businessman/Software Entrepreneur
Maybe –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, well we'll –

Paul Egerman – Businessman/Software Entrepreneur
The clinical term is SNOMED CT I'm not sure what that means though but then there is –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, we'll get that answer out but it sounds like they did one the change and two they did specify. Okay, next slide please.

Yeah, here they're – I mean, it's a fair point, we did discuss it, it's like are we getting into the prescription here and is that necessary? Well, let's see what the NPRM brings us and then we'll rediscuss that, they'll have what they say and they'll have a why, and we can respond to that.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, I was – so you're saying respond to just clarify we meant to start making the functionality available right?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
No, he's questioning whether saying you must have these functionalities is that too prescriptive and what I was going to say instead of – we did discuss that, rather that rediscussing that let's see what HHS says, because they say here's what we think and here's why and let's look at their why and respond to it.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
So, maybe I didn't understand John on this because when – I think it's fairly clear when you say certification only there, he talked mostly about workflow in this and whether that a new system or not and things, so we didn't intend to force a policy requirement around using it in these ways, in fact we originally did, but we found a middle ground of just saying let's start to make this available because it would be very helpful to the market. So maybe –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, that's true, but I also think he was saying just with these words, again you can have a lot of – you can have interpretation that creates a lot of work that was not necessary. For example, the second sub-bullet, what's the response, well that's pretty hard because you don't know – the response can be from anyway and how would you link that response so you generate a new telephone encounter for example that was a response to an on line request, how do you know that was actually a response without having somebody do an extra check box, it's things like that I think is what he was re-raising. We did discuss it.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well, but I think, we – that wasn't our intention, so I think rather than sort of wait and see I think we should clarify our intention was that if someone decides they want to track their response time than, yes, they would have to, you know, do some data entry but that's the case with any certification criteria that if you decided to use that function you do the workflow around it, but we're not saying you have to use the function we're saying we need to make this available in the market given that we see a proliferation of the use of secure messaging, we're starting to see reimbursement for it things like that, we want to give this provider capability for quality improvement and, you know, timeliness, but we're not saying that you have to use it. I think we should just clarify that and see if that helps.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
That's a good point we are requiring the vendors to with this requirement though.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, the vendors have to do it, definitely, but that's not the comments that I heard from John. What I heard from him was to say, does this mean I can still use my same secure messaging system and that's where I'm a little bit confused –

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Because I would say, well you can still use it in the same way and if you decide you want to use the additional function then sure.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
That is worth restating I think or stating in the first place in our words.

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay. Next slide, please. Altarum next slide please. So, here I think he misunderstood what our – in the red text we were actually responding to problems of – well, people just doing a data dump or a visit summary and we're trying to get around that but I think we could be more clear, it certainly didn't come across to John what we were trying to do.

For example, he asked how would the machine know that the text there is actionable, in other words we have to – I think, just being explicit about the problem we were trying to solve will put this in better context. We say it when I've presented it, I've said it all, but it's not here in the text and I think we're not giving people the intent clearly enough. Any other comments there? Okay, next slide, please. Altarum, next slide, please.

This interestingly, he just said, well, what if you need more than one, I think that's why we said at least one, but I think we covered it and I didn't understand what else we could do there. Next slide please.

Paul Egerman – Businessman/Software Entrepreneur
I would say again, 2015 has a bunch of material on patient education.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, thank you. Here I think his concern was the text narrative is that right?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Yeah, this is Charlene, yes it was.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
And what was the actual concern?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
I mean, the intent Paul has always been to give providers a means to provide a short explanation of the purpose of the transition of care, you know, a synopsis of whatever they wanted and they – and once you get the stuff to standards then they want to encode it, like if goes to home health it should have these goals.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
And that was never the intent.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
And the workflow that – in the workflow there is going to have to be a space when you're, you know, there is going to be development when you're doing a transition order whatever that you're going to have to be able to capture this and each vendor they could code it, they could do whatever they want to make it easy for the physician to get it. That was what the intent was.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, so, I think we just need to say, yes, this is text.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
This is text.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
And people want it, right?

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay. Any other comments there? Next slide, please.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
This is Michelle, before we go on there was the question about timing because there wasn't any specificity around timing and they had a lot of discussion around that.

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Because for most things it's like within 24 hours or something.

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
And I think the Meaningful Use Workgroup left it purposely based upon other feedback, but just something to think about.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Let's go back to that slide please. So, we might as well discuss this whole discharge summary. Christine, do you remember what was specified for, not discharge summary, but things available after discharge within 36 hours from Stage 2?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Off the top of my –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I thought at one time – yeah, I know at one time we had a long list, but I think we reduced it; go ahead what's your recollection?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well, it's in Stage 2, so I'll pull it up, but off the top of my head it was, you know, medication list, allergy list, you know, things like that are sort of standard, things that we did almost like under VDT. I'll pull it up it's on the CMS tipsheet.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right, but not for example discharge summary that's been always the key concern.

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I believe if that's true then we're okay, but yes, we probably should restate it.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Wait, I'm sorry, but you're talking about the summary of care document right now?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I know but he put that comment in here and I'm just taking advantage of, it's come up here, it's come up with VDT let's just try to deal with that issue because I don't know where – I don't know that we have a slide on it, but just to clarify.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well, can we come back to it in a few minutes, because I'm going to look up the tipsheet because I'm not sure –

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
I mean, I don't know what you mean by discharge summary but my recollection of Stage 2 was that we said, you know, if you – that it is things like mediation list and, you know, basically what happened in the hospital but not things like if you have outstanding labs or test results, although I think you were supposed to actually say you have outstanding labs, but they don't have to be in the record until they're back in. So, let me look right now and I'll see what I can find.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, you can look it up and then we'll get back to that.

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
Paul –

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

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
This is Marty I have the list in front of me.

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

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

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
Patient name, referring transitioning provider's name and office contact, procedures, encounter diagnosis, immunizations, laboratory test results, vital signs, height, weight, etcetera, smoking status, functional status including activities of daily living, cognitive and disability status, demographic information all of that, care plan field including goals and instructions, care team including primary care provider of record and any additional care team members beyond referring or transitioning provider and receiving provider, discharge instructions, current problem list, current medication list and current allergy list.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay so the important part –

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
But that's – not VDT hospital right?

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
No, no this is a summary of care record.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Right and I think Paul is asking about the VDT.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
For hospitals right.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
For hospitals so I'll look that up.

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I do have that too it's not that different. I don't know do you want me to read through it all?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
The key thing we're looking for is the phrase discharge summary.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
I thought we removed that from Stage 1 Paul because there was so much issue in that with Stage 1, so I thought we overtly removed it in Stage 2 was our intent.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I agree, but I'm just trying to make –

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well, so Michelle, can you read it, because maybe we're talking about two different things. When I think about a discharge summary I think the whole package of the data that is listed on the tipsheet to me is a discharge summary, but I guess I'm not understanding it.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
The difference here, there is a term of art Christine that a discharge summary is actually the dictated summary of the whole course and that's what everybody's referring to that takes a couple of weeks to get.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
So, they just refer to it as discharge information they don't say discharge summary and then they list the information in the tipsheet.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, yeah, okay, so I think it's worth giving people a pointer to that because, you know, even we can't remember that to say, here's what it was in Stage 2 and we mean the same thing. Because that, you know, that came up in the HIT Policy Committee as well. Okay, how about going to the next slide, please.

Notifications here, I think this is, the problem is – he did a nice job saying, you know, ADT is one thing and all these other things are difficult to get – I think it was referred to as it's fine to say somebody is here that's the "ADT" information it's like who do you send it to is where the problem was. I think –

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So, this is Charlene, the challenge here – we have – I've been talking to some customers about this and some of our customers like we've said do this today and they do send it to at least the – when you register in a hospital you have to designate the primary caregiver –

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
You know who the doctor is, so there's data in that system –

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
About who to send it to. I'd hate to not do this one because we can't get the care team straight and Christine I know you're an advocate on this, but, you know, I think that there are two messages I get, one the market is going to drive it by then it's just going to happen and/or, you know, this is a high value, that's the feedback I get.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, here's the – here's what I heard him say is even the name is fine how do you link it to a Direct address.

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

Paul Egerman – Businessman/Software Entrepreneur
Yeah.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I think it's going back to this whole provider directory and you have multiple Direct addresses and even when you have an address there is an inbox and who is watching the inbox, so there's a lot of things that need to sort out. We probably just need to keep track of those and HHS I'm sure is going through these same issues as they write the rule and we'll have to see what they say, but clearly a lot of things have to be in line for this high value thing to take place as we intend it.

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

Paul Egerman – Businessman/Software Entrepreneur
And this is Paul, the problem is that some of it is occurring now and it's occurring without the Direct protocol, so the concern is, does this like replace what already exists?

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

Paul Egerman – Businessman/Software Entrepreneur
Which would have very little value.

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

Paul Egerman – Businessman/Software Entrepreneur
And so that's a concern is how do you do this in a way that's additive.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, I think ONC is aware of all of these issues and will come up with some way of dealing with it and then we'll look at that and respond.

So, the good news is that even Charlene is saying the customers recognize this is high value and we're just hoping the combination of the market and standards sort itself out between now and 2017. And by –

Paul Egerman – Businessman/Software Entrepreneur
Well –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Sometimes what we do is signal this is where we need things to go and hopefully that ups the amp on the efforts to get it there.

Paul Egerman – Businessman/Software Entrepreneur
Yeah, but Paul, I mean, it's not like the market standards sort itself out, I mean, there will be a standard for this that will be published this year.

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

Paul Egerman – Businessman/Software Entrepreneur
And the issue is will there be flexibility, will you be required to use that and is that going to be a reasonable standard to use, because there won't be a chance for the industry to sort something out if, you know, we're just required to use Direct.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Well, what I mean by sort itself out is once you have a standard you still have to populate it, somebody still has to watch the in basket that's what I mean by sort itself out in terms of the market actually using the standard. All right so we'll wait for HHS to come up with their solution and we'll comment. Next slide, please. Medication reconciliation we passed over, next slide.

This one, I think ONC is aware of this too the whole Direct versus query response. What other points did he raise on this? Okay, let's move on, next slide, please.

Registry, he did bring up a good point we were aware of it but I'm not sure – we didn't have as forceful a statement as he just made. Really we want to support registries, people want to support registries how is it that you would certify an EHR to essentially comply with all registries and is there some sub-finite subset, he is basically saying "no" that's what I mean by, I don't know that we really had that definitive statement and that seems like a fair statement.

We can either – well, this might be another case where we understand the issues, we understand the goals and we understand the value, HHS will have to take the same input we have and come up with a proposed rule and then we'll respond to it. How does that – does that summarize where we are?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health
This is Art, I think so Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, thanks a lot Art. All right, next slide, please. He didn't say anything here. Next slide and next slide.

Paul Egerman – Businessman/Software Entrepreneur
Did we do this?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
He didn't comment on this. It is an interesting point. Did we consider hospitals, I don't know that we didn't consider them and I'm not sure what the issue is why they're different because they certainly have their measures. Maybe they're saying the relationship – they don't typically maybe now get the same kind of demographic or disparity variable with data that we do in ambulatory, maybe that's it data can be from multiple systems like the ambulatory side.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
What do you mean by that Paul?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health
I don't understand that Paul –

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

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health
Isn't there a demographic variable that the hospital has to collect?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, they have to collect all the – data.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, we're – I'm guessing, this could be a question, clarifying question from John what does he mean by some of this.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
This is Michelle –

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I was part of those discussions and I honestly can't remember where that came from.

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
This is Marc wasn't part of it the need – where he's talking about the need to separate between the clinical posts and the financial posts to protect the patient's privacy and –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
No that was back in the demographic section and those were good points and we recognize them so we're going to try to clarify –

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Classified there didn't mean it had to be there.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
I guess I was thinking this may be relevant here as well, because it's the same set of kind of issues of kind need to know data and so on –

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
But maybe I was just hearing it that way.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, this is a clarifying question back to John, what do these statements mean. So, actually, I'm feeling that we – you know, so at least half of this was on us or HHS to be more clear both about the intent, the context of the words that we wrote, so that seems fairly straightforward to deal with it.

Very few in terms of, we had a couple, you know, one factual and then a couple for John, so I think we can almost handle this in e-mail and then distribute the results unless he has time to come back and spend a few minutes with us. But, I think we have an approach for all these is I guess where I'm feeling and how does the group feel?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Paul, can you repeat that, sorry, my phone cut off?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, I think the majority of these actually were wording things where we could clarify our intent and then that would resolve some of the questions that John raised. We have a factual question, we have a couple of clarifying questions to John, but I think we have an approach of how to deal with their questions, the Standards Committee's questions, and I think that's important to be at that stage because this is an important step of the process, you know, we have our policy recommendations, we need to incorporate the standards feedback on those and at this stage we're basically teeing this up for our response to HHS's NPRM. Do other people feel the same way that we have a way to reconcile this and even action some of these areas?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, I agree I think clarifying things is a lot of the battle as you said.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
So, I think that's right.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
I don't see anything, this is George, that changes our course drastically.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Good, okay, so we'll summarize all this and be prepared for the response. Okay, let's move forward, this is the second agenda item is to plan our listening session. Let's summarize right now they're scheduled for two of them, two 2 hour sessions May 20th and 27th and the goal is to identify the lessons, this is a forward looking goal, identify the lessons from Stage 2 so that we can inform Stage 3. Next slide, please.

The way it's currently thought of is having two panels in each of the two hours our traditional way 5 minutes plus the time for discussion. The first panel would be on providers trying to get a spectrum of providers including a provider association. The second panel would be for hospitals a spectrum of them including a hospital association. Next slide, please.

The second session – and the questions are how has it been going, you know, are you working towards Stage 2, where are you, what's been your experience to date, what are your barriers and what lessons can inform Stage 3 recommendations. And we're posing this kind of structure to both of these panels.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Paul is now the time for comment or do you want us to hold?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, go ahead, yes?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
So, on our last call we were really clear about wanting to include enablers and successes that, you know, providers who have actually successfully attested we want to know why what was the key. I think all the questions in both, you know, listening sessions are really negatively oriented and I think that's not of as good a value.

We also – and I assume that these are the questions that we're going to have them answer and brief in their application process right?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, you're right and you're right. So, I think, this should be – these questions should be – yes, they're all going to be given these questions to address and they should be written in the "what's been your experience and what would improve that and what should we take in account in looking to Stage 3." So, you're absolutely right.

Paul Egerman – Businessman/Software Entrepreneur
So, this is Paul, I would simply ask a question what has been the benefit to your organization of –

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

Paul Egerman – Businessman/Software Entrepreneur
You know, implementing Stage 2.

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

Paul Egerman – Businessman/Software Entrepreneur
What benefits have you achieved?

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

Paul Egerman – Businessman/Software Entrepreneur
Hopefully, benefits to the patients or the organization. What benefits have you achieved or do you expect to achieve from Stage 2?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, I agree with that, I also want to make sure we, you know, I mean, there are some people who have already attested or even for the provider side I think that's probably less likely because they started three months later, but, you know, what is it that is keeping you on track, you know, what did you have to do to get ready for this so that we understand why they succeeded on that timeline as well as the question that Paul Egerman just posed which I think is a great one.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
And what would magnify your benefit in Stage 3? No these are good suggestions. Other suggestions on these questions?

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
Paul, this is Marty, I still think it's important to ask about the challenges too because there are many.

Paul Egerman – Businessman/Software Entrepreneur
Yeah, this is Paul Egerman, when I said what benefits I meant that just as a balancing question. I mean, I thought that would be additive to the question for the barriers but lessons, what benefits.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah. Good. Other suggestions on the questions that are essentially posed to everybody? Okay, next slide please. The second day, the first panel will be, you know, as we've always talked about we're looking at the new models of care and so we're trying to get feedback from folks that are more immersed in that to find out what they are interested in.

For those of you who listened to the Policy Committee meeting I thought the ACO presentation was really well done and it does have that different perspective and we want to make sure that we are serving those needs so that's why we have a panel specifically from folks in that area. We called it arrangements just to make sure it's not just the federal program. And the second panel would be the vendors, you know, what's their feedback.

Do we have a set of questions for this, is there a set of questions on the next slide or is it the same questions? Okay, so this I guess would be for the vendors.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
But again, I would just raise where is the positive side of this. So, for those that have rolled them out, you know, how were they able to do it and what lesson can we take for our Stage 3 in terms of either timing or number, or whatever to help ensure their success.

Also, you know, I don't know if there are any other questions maybe Charlene and Marc could advise, you know, in terms of are there other resources that ONC might deploy to better support their work?

Paul Egerman – Businessman/Software Entrepreneur
This is Paul; actually, I have a problem with the very first question. It says, for a vendor, have you deployed your Stage 2 product to your customers? That sort of makes it sound like deployment is entirely in the hands of the vendor, you know, I mean, there is a –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, so, I think it's just –

Paul Egerman – Businessman/Software Entrepreneur
–

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Have any of your customers implemented your Stage 2 certified product?

Paul Egerman – Businessman/Software Entrepreneur
– to what extent have your customers, you know, to what extent have your customers deployed and implemented Stage 2 – have you done it and to what extent has this happened among your customer base. And the question is about, again, when do you plan to isn't quite right it's more like, you know, can you tell us about the process how long it takes, what the obstacles are and also to simply ask the vendors what are the benefits, what are the benefits that they've seen for their company from doing Stage 2 or what are the benefits that their customers are reporting to them for Stage 2.

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
This is Marty, that would be –

Paul Egerman – Businessman/Software Entrepreneur
I want – this whole thing is up to the vendors as to when the deployment occurs because that's just not really all of it.

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)
Well, this is Marty and if all vendors had a Stage 2 product out there that would be great, but we've got significant gaps in hospitals in Nebraska that where the vendor does not have a 2014 certified product at all.

Paul Egerman – Businessman/Software Entrepreneur
Yeah and that could be a separate panel though. I mean, in other words, there were 900 vendors for Stage 1 and there are 300 vendors in Stage 2. So, 2/3 of the vendors have disappeared and a separate panel might be to ask a vendor who decided not to do Stage 2 why not, but I'm assuming that these vendors have somehow been certified for Stage 2 and have some experience with it.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, let's –

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
This is Amy and I dropped off for a little bit I'm back so I'm sorry that's why I've been so quiet, but I think there are still vendors out there that are in the middle of doing it but haven't done it yet and I think that's important to hear from them. I mean, I think there are sort of three categories.

Paul Egerman – Businessman/Software Entrepreneur
Yes.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Those that already have the certified product, those that are working to try to get it certified and are having their own challenges in getting it certified and then there are those that have decided not to do it and I think we need to think about it in those three ways.

One other comment I have and I don't know where it would fit is, it might be helpful to hear from the vendor's perspective for those providers that have – where they do have a certified product and the provider has been able to implement it what were the success factors from the vendor's point-of-view in addition to the provider point-of-view, because I think we can learn from both perspectives on that.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right, that's a good point.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So, this is Charlene, I just want – there is a separate Workgroup working on the certification process. If we get deep into the issues around the certification process and some of the barriers software is immature, we won't get the content that we want out of this hearing.

So, I would rather, you know, focus the questions on, you know, what was it about, you know, two things, what was it about the process that in delivering this functionality to your customers that makes it work and what could we do to improve it?

So, you know, there were requirements in there and it could be the combination of the measures plus meeting the requirement that just made us have to deliver something that was less than optimal that's the kind of stuff, you know, I think that's really important, you know, that maybe we could learn from and, you know, they could also tell us where to improve.

I would rather keep it focused on the customers achieving Meaningful Use like have any of their customers attested, if so, you know, what made them successful and what would – did they learn from it that would make them easy, would make it more viable for them to accomplish the intent of, you know, what the Meaningful Use was for and if they say "well, we don't know what the intent is" that's one thing.

But I'd rather stay away from the questions around – you'll hear about the certification process, but I'd rather really get down to the – there were issues in the implementation where the regulation just made us do things that, you know, weren't really the best for the customers.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
That's a really helpful distinction. So, Michelle, I think we want to make sure that they understand there is a separate hearing –

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
– process looking at certification.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Certification process itself and that will be very vocal that one, but –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right. So, let's – Charlene – so let's focus their attention and our attention on what can we do with Meaningful Use objectives that both get higher value but less – and less of the unintended side-effects.

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, that's absolutely important, yeah. Can we step back a slide please and let's take a look – and actually go two slides back, one more. Could we get some – what do you think about the type of test, you know, panelists we've got here and if you have any suggestions?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Paul, it's Christine, my concern is that there are no consumer or purchaser voices on these and I think they are the benefactors of a lot of this work and could bring a different perspective that is maybe not so heavily focused on burden, you know, I keep raising this concern –

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
That all of our slides talk about burden on provider, burden on vendors, you know, and we're not engaging people who benefit as well, I mean, not to say that they don't, certainly they do, but I think we need to do a better job of integrating consumers and purchasers.

Paul Egerman – Businessman/Software Entrepreneur
But do consumers know that they've been treated with Stage 2 at this time?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
I'm sorry?

Paul Egerman – Businessman/Software Entrepreneur
Is it visible to a consumer when they've been treated with the Stage 2 EHR system?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
I don't think it's visible – I don't think they care about the technical details of the stage of the program, but I do think it's worth finding consumers who can speak to – or their representatives who can speak to the value, there is data out there around what consumers want from HIT and they can speak to that.

I think there are also obviously there are a number of hospitals who have attested, there are patients and families who have on line access, you know, for the first time and I think they can absolutely speak to that.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, Christine, I think that's a really excellent suggestion. What do you think about us putting that – adding them to the "ACO" let me call it the new model of care panel so we can get that perspective woven in there?

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
Paul, it's David, I wanted to add, supporting what Christine said, that from the purchaser's side as well, I think, purchasers would be eager to participate in that panel you just mentioned.

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

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
Because obviously that's something they're trying to support.

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

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
And they could talk about whether they're getting what they need out of Stage 2 or what they would see as changes in the requirements.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Yeah, I'm less sure, Paul, about putting them on the ACO panel, I think it makes – because sometimes they don't know, you know, that they're sort of part of this accountable care organization or maybe care, but I think it would be – I wonder if, you know, instead of having these, you know, four provider types if there are some ways that, you know, you might have a small practice who is also rural or whatever.

I mean, I guess I would question as well whether there is a need for small versus rural because the CMS data that we got in the Policy Committee this week tells us there isn't a difference in attestation rates anyway, there isn't a disparity, but I would tend to put them more on the first two panels, because it's much more contextual to how they experience Health IT.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
All right, we can do it either way.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
You know, this is Amy, one of the things as you're talking about purchasers and if it goes in the ACO panel that's fine, but one of the things to think about is also asking them whether they have any incentive programs for EHR adoption that align with Meaningful Use.

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

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Like the actual financing part of it, because that's really important and we've seen, you know, at least in our state when they do that, you know, when they can align it it's that much better for the provider and if there are incentives and the outcome either on the clinical quality measurement side or on the functionality side are the same then it's more, you know, more cohesive approach to trying to get to where we want to be.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
All right, so let me try to also while we're discussing it re-label that panel three instead of accountable care just talk about advance models of care so we're not boxed in. And the advance model of course include patients much more actively on the team.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well, even than I'm not sure contextually what an advanced model is, so, I would still say to put them on the provider panels because that's really how they experience HIT through their providers.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, I'm just trying to speak to the label of the third. Now, two hours is not magic, we could extend it, we could extend it to 2.5 or extend it to 3 if we wanted to increase either the size or the number of topics. Let me try it first with this on the slide on the screen so there are two panels one for EPs, one for hospitals and then we may include the consumers on one or both of these.

Somebody raised the question, Christine, whether there should be two different people for small and rural or we have other types of providers that we want to include.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well I think as long as we extend the panel time, I mean, that's really what I was reacting to, I'm not averse to having the largest possible array of provider experiences we can, I think that's great, I just want to make sure consumers are on those panels.

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

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
This is Amy and if we're going to pull consumers in I wonder if we need a panel three with consumers, because I think the issues are a little bit different about a provider working towards Stage 2 versus a consumer experience about the outcome and the benefit of the technology and what change it's making for them. To me they're very different kinds of issues operationally.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, let's see these are –

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
So that may allow, you know, you to get – I mean, even if it's a smaller panel to either get a, you know, a few consumers someone who has, you know, been hospitalized and discharged versus someone in a practice so like a primary care kind and/or a hospital, you know, if its – just a thought.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
All right, okay. So, what if we thought of – so first of all do you like the layout for the panel side, the provider side of these two panels or is there a different way to organize it maybe, and there is nothing wrong with having a twofer like a small rural.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
So, Paul, this is Amy again, would we try to do this with a different mix and blend of EHRs that are certified? I just think that if we're going to do a two – you don't want everyone –

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

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
I mean, obviously small practices are going to have likely a different EHR than a large practice.

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

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
But, I just want to make sure –

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

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
That when we figure out who is doing these we get different perspectives on the EHR vendor side as well that they're using.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right. If people want to either speak up or e-mail us some suggestions for panelists that would be appreciated.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So, Paul, the question I had is you're not going to go through process of soliciting written comment and then selecting the best one anymore? I thought – I'm not sure that was what the final decision was so –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Ah, yes, maybe there was a missing – so, ONC looked at that proposal we had and thought that it was probably – would create a lot more work for them than they have available.

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, it's gotten back – it's more our traditional.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
So, then, you know, the only thing that struck me in terms of panel one is, I mean, when you look at just having one there are a lot of large hospitals out there, you know, it just –

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
It just – it seems like you could have an academic, you could have –

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
You know more of an IDN oriented one, you know, you could have East Coast/West Coast, you could have, you know, so it's just – it seems like just select one is going to be a challenge would be my concern.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, so I think let's use this as –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
This is – sorry.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Go ahead Michelle.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I was just going to say that a lot of this was just for people to react to and as people have ideas of people and hospitals, and vendors I think that we'll be able to flush this out a lot here.

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

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

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
So and that's really me saying, please send me people that you would suggest so that we can start setting this a little bit further.

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

Paul Egerman – Businessman/Software Entrepreneur
And Paul, I'm looking at this my only concern is, is there going to be enough time for a discussion? You've got 20 minutes of presentation if everyone is really good about sticking to their 5 minutes.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Oh, they will be.

Paul Egerman – Businessman/Software Entrepreneur
And then you've got –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
No they are, the ones that we've – is they are.

Paul Egerman – Businessman/Software Entrepreneur
And then you've got 40 minutes of discussion.

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

Paul Egerman – Businessman/Software Entrepreneur
But my guess is we might have a lot of questions.

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

Paul Egerman – Businessman/Software Entrepreneur
So, I'm wondering if we want to give a little more time for discussion.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, let me throw out two suggestions, one is we move to three hours and we can either use that time by having a larger panel and/or a larger amount of discussion or creating the third panel that was suggested.

Paul Egerman – Businessman/Software Entrepreneur
My vote would be to go to three hours but to make sure we get more time for discussion for questions and answers.

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

Paul Egerman – Businessman/Software Entrepreneur
Because also I think – I have a feeling some of these providers and hospitals are going to have some comments that are heartfelt.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Yeah, I do too.

Paul Egerman – Businessman/Software Entrepreneur
We want to make sure that they are – you know, if they're making the effort to present to us you would like them to feel good that their comments were heard and they can participate in any discussion.

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Are we going to –

Paul Egerman – Businessman/Software Entrepreneur
And I understand where Christine is coming from in terms of getting consumers and patients, but, I mean, I'm still trying to understand the objective and we're really trying to understand how successful Stage 2 is and most of that information is going to be coming from, you know, either the users and the vendors. So, it's really going to be very hard to evaluate, you know, was a patient's health improved as a result of Stage 2.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
I think we're not just talking about health although that's, you know, possible but that's not typically, you know, patients don't think that IT is the sole factor in improving health but it is a huge influencer on their, certainly safety issues as well as their experience and there are a number of instances, you know, thinking about people like Beth Schindele who did have access to, it was Blue Button data from Medicare that helped her with her father.

It may or may not be too early for some of that but there are consumer advocates who definitely can speak to these issues and we could even ask some of the successfully attesting hospitals to identify some of their patients and families.

Cincinnati's Children's is one of them for example, they put a couple of patients and family members on their design team for Meaningful Use and they were actually part of implementing it together, I think that's, you know, been very helpful to their success certainly in Stage 1.

So, I think there is a lot they can add and I think as the taxpayer is paying for the program they absolutely have a right to be there and I think they actually have a lot to offer.

Paul Egerman – Businessman/Software Entrepreneur
And I hear that it's just that in my mind there is no debate about the value of Blue Button and it's more an issue of what were the benefits and challenges in –

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Well, it's a balancing act.

Paul Egerman – Businessman/Software Entrepreneur
The way we implemented it, you know, and that's –

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
It's a balancing factor though, I think it becomes harder to, you know, not think about enablers, I think, it becomes a lot harder to just complain about burden when patients and families are sitting there and going, gee, you know, how do we feel about this system and, you know, is it worth it. And, you know, it's absolutely possible that they're going to come in and also say things like, you know, my providers looks at the computer screen instead of me. I mean, there can be some negative experiences that we want to learn from as well here.

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
This is Marc, I think we do have to be careful, you know, we're getting far enough down the road that I think we have to start thinking hard about getting beyond anecdote to evidence, you know, I love anecdotes and we learn a lot but at the same these are very expensive undertakings that were – you know as a nation, as a health system, undertaking and we do I think need to begin asking the question do we know that this is useful. Because many things that there are anecdotes case reports about, you know, people cured by x, y, z and you find out it's actually hurting these people in the long run.

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
So, this is David Lansky, I mean, I guess I'm agreeing with Marc, but from a different angle, from the purchaser's side I think the question for them and for this kind of a panel is whether Stage 2 is delivering the value that they're looking for because what I'm seeing in practice in the market is they're saying we're going to write our own requirements because we're not getting what we need from just saying do you have Meaningful Use Stage 2.

And so some of the RFPs they're writing for ACOs for example are adding additional IT requirements and that was the kind of thing I think would inform our thinking and again it goes to Christine's point about balance that there may be a lot of issues we hear about from providers and vendors but the ultimate users in the community are going to have another set of input whether they're patients, consumers or purchasers about whether Stage 2 is delivering what they want.

So, I think I my vote would be to an extra panel where purchasers and consumers as users of the system are reflected, but I'm also okay folding it into existing panels. So, Paul, I'd agree with adding three hours –

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

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
But whether we do it by adding a panel or stretching these panels I don't have a strong opinion.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, let me make a proposal. I actually like what David Lansky just said and would look at panel three as really deriving the benefit from HIT, you could look at it from the provider, the "ACO" thing, you could look at it from the purchaser, you could look from the consumer, it's really the value panel, the outcomes panel that I would picture, but Christine if you really want to move it into the providers, you know, we can do that too.

But, panel – so let's – let me put out a strawman of let's extend the time to three hours and have two 1.5 hour panels for the first day and let me move to the – advance two slides please, and then for the second day also extend it to three hours the first panel – I forgot to – on panel one it's with Marc your experience something with Stage 2 and let's refocus all of the description towards the how do we do better with, you know, how do we get the most – how do we enable Stage 3 instead of like let's worry about Stage 2.

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So the same thing –

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
What did we learn that we should –

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

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
How do we move forward, so let's make sure all of our description is how do we move forward and get the most value out of the people reporting. So in the second day also three hours and two panels let's say an hour and a half each, that's been our standard anyway, and the focus of panel one is how do we look towards getting the value, getting the evidence for the value from HIT support of advanced models of care and that we hear from people who benefit from that consumers and purchasers, and the people who are living that new model the "ACO" kinds of arrangements. Does that – how does that sound with people? Am I addressing –

Paul Egerman – Businessman/Software Entrepreneur
This is Paul Egerman, I just want to make an observation so that I'm hearing this right, for a while I've been hearing, I've been asking how is Stage 2 going and everyone keeps saying it's premature, it's premature and now we're trying to find out how Stage 2 is going and the comments are we want to make sure it's not negative, we want to make sure there are lots of positives and let's really focus on Stage 3, let's really not spend a lot of time talking about what's wrong in Stage 2.

And it's almost like we don't want to know that some things went wrong in Stage 2. And we're not going to be able to do Stage 3 correctly unless we understand what went wrong in Stage 2. I don't understand why we're afraid of that topic.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Well, I guess I wouldn't phrase it that way. I'm saying let's try to have people's experience with whatever state it is in May inform how to make Stage 3, which we're in the business of writing the rule for, or suggestions on writing the rule for, how do we make that the most valuable we can based on the existing evidence we have for Stage 2, it's not only to look back at Stage 2 that's the main point.

Paul Egerman – Businessman/Software Entrepreneur
Basically –

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
Paul, I think just to note that – I think several of us who had looked at the agenda when it was first drafted saw four hours of discussion exactly as you described it of what did we learn from Stage 2 and zero time devoted to this other set of issues we're talking about, so I think it's just a matter of finding enough balance that we get to learn what some of the outside stakeholders are also experiencing as well as –

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

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
I don't think we want to diminish three hours or whatever time we need to capture the concerns that might have emerged from the implementation side.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Are you talking to Paul Egerman?

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
Yeah, I just wanted to respond to the sense that we were not interesting in hearing from them –

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

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
I think we do want to hear the lessons learned we just also want to hear what do we need to achieve from the point-of-view of the other users.

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

Paul Egerman – Businessman/Software Entrepreneur
I think it's important that we be reality-based and we need to understand what people think about Stage 2 that's my comment.

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

Paul Egerman – Businessman/Software Entrepreneur
And we can't just say, well let's make sure we hear positives, let's make sure we understand how great Blue Button is and let's just focus on Stage 3.

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

Paul Egerman – Businessman/Software Entrepreneur
There has to be a moment here when we say what happened in Stage 2, what went wrong because there was a lot that went wrong and we need to understand why that stuff went wrong. If we don't then we're not doing our jobs.

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
So, getting back to Marc's point, is there a way to get more systematic evidence about what Paul just said? Because, I think no matter how we do it the panel ends up being anecdotal with a small number or examples who may or may not be very typical. If we had a little more, I don't know, additional research evidence or survey evidence, or Charlene do you have some evidence that would be more systematic to address the kind of comments Paul Egerman just made?

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

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
Well, out of "x" many thousands of users what are the incidents in certain kinds of implementation problems that we're already hearing about anecdotally? How do we get some evidence, as Marc said, of really what's happening in the field? What are really the system systemic difficulties of the program rather than whatever anecdotes we hear from a half dozen presenters? Or Marc from your company is there more evidence you have from field people that would give us a quantitative basis for assessing where the challenges are?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
Not that I'm aware of, I wish there were.

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
We might ask ONC and CMS, I mean, they seem to have more data sources than we're aware of, I'm always surprised by that, so we might ask them for some input, but certainly one option would be to have them do some framing up front as well.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
And this is Charlene, at a minimum we could – and I know they track this because we're always asking them questions, we could at least see where the, you know, where the phone calls are coming in and for what purpose, we can get some balance on that, because I know – so there is some data that – we should just ask them what data they have that's representative of their experience, because I know they've got some.

Paul Egerman – Businessman/Software Entrepreneur
Yeah and this is Paul, I mean, when you look at the 2015 NPRM there are a lot of changes that have been made through the 2014 edition, so a lot of changes made to the transmit function, a lot of changes made to transitions of care, to the use of the Direct protocol and there must be some reason why this thing is getting changed, you know, there must be some feedback that there is a need to change it. I mean, if it was all successful I would think they would leave it alone.

And so there has got to be some data there that is an issue and the fact that there is so much being proposed, being changed in 2015 I think ought to be a signal that potentially there are some serious issues here.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
This is George, I think triangulating is important and the purpose of a hearing, and this is how the government works, is to gather anecdotes because if you do a meta-analysis sometimes you do miss things in the other direction.

So, the purpose of this is to do the hearing version, however, as a Workgroup we can make suggestions to ONC on what kind of studies we think they should commission and we can also do some research and see what has been published in the area. So, I agree with wanting to get more evidence but that doesn't mean that a hearing is not useful.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, this is Paul, I'm going to try to – Paul Tang, I'm going to try to manage the time here. First, Michelle, do we have – what other calls do we have in April or before the hearings?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I'm looking, Caitlin if you get it before me –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, I think what we would appreciate, and it's a little bit –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
There is another call on the 16th so that's next week.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, let's do some thinking, I mean the dilemma we're in is Marc Overhage recommended we seek information and he answered his question of unfortunately there is not a whole lot of evidence out there. So, if we can – if people can submit any leads they have that we can pursue for – and there are some, for example, I think CHIME has done some surveys as an example, I'm sure AHA has done some. So, let's try to get what's available out there and find a way of infusing some of this hearing information with that, with the existing data to George's point –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Paul, maybe we can invite Jennifer King who does the presentations at the Policy Committee and she might be able to work with us to provide the data that we're looking for.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Say that again, please, who did you suggest?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Jennifer King from ONC –

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Oh, got it, yes.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Who presents at the Policy Committee.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Correct, absolutely I think she would have, you know, she'd be tapped into the RECs and all kinds of things. So, we can have her give us some thoughts the next call and it's dedicated towards flushing this out. I think our draft approach is that we're going to have two 3 hour sessions, two panels each and try to get a combination of data and more in depth experiences from individual panelists.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Paul, I'm sorry I missed it did you say – are we coming up with a new time for these calls or going out...

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
No.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Starting an hour early or what?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Oh, yes, it would be new times, Michelle, do you already know or do we have to figure it out?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
For the 20th we can start an hour early but that would be 9:00 o'clock so that would be tough for West Coast people, Paul, so we might want to think about moving that one, because there are other FACA calls that day for the 20th, 27th I'm sorry, we could extend it from 10:00 until 1:00 o'clock so we have more flexibility on the 27th. So, we could look for a time in June, we're just getting further out.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I can talk to David Lansky and see if we're willing to get up – I mean, I could do the 6:00 o'clock but –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Well, even for the people that we invite to present.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right, right. So, we'll work a bit on the timing and scheduling, and if people could submit either ideas for data or people who can be very articulate not about a single point but just try to give us more insight into the situation on any of these panels that would be appreciated and we'll raise this next call. Does that make – do we have time for that Michelle –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Yes I think so.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay. Okay, any other final comments before we open up to public comment? Appreciate you're going through the reconciliation of the standards information and for the discussion of the hearing. I think there is a lot of information to gather and we'll just try to get it in the most efficient way. Let's open up for public comment please?

Public Comment

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Operator, can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute
If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, well thank you everybody for your participation and talk to you next week. Send in your suggestions.

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

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

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

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
All right, bye.