

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
December 2, 2013**

Presentation

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

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

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

Here.

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

George Hripcsak?

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

Here.

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

Charlene Underwood?

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

Here.

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

Christine Bechtel?

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

I'm here.

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

Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Mike Zaroukian?

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

Here.

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

Marty Rice? Joe Francis?

Joseph Francis, MD, MPH – Associate Director – Veterans Administration

Here.

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

Neil Calman?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Here.

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

I think that's all the people I heard that were on. Is there anybody that is on that I missed?

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

Me, Amy Zimmerman.

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

This is Art Davidson.

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

Good morning Art. And do we have any ONC staff members on the line?

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

Okay, I'll turn it back to you Paul.

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

Great. Thank you Michelle and thanks everyone for participating and I hope you all had a nice Thanksgiving. Since both George and Michelle have to leave a little early, we're going to try to speed things up. The two agenda items, we're going to hear from the combination of the Consumer Empowerment Workgroup and the Consumer Technology Workgroup respectively from Policy and Standards Committee and then as feedback – as input into going over Category 2 recommendations. So let me go ahead and transfer it over to Christine and Leslie. Thank you.

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

Great. So I'll start. So as you guys all know, the Meaningful Use Workgroup asked the Consumer Empowerment Workgroup of the Policy Committee to look at issues around patient-generated health data and specifically the two PGHD related objectives in meaningful use. One being specifically labeled patient-generated health data and you can see that on your screen now. And then the other being amendments. Next slide, because those are, in fact, patient-generated health data as well.

So we held a listening session in July, that was very robust and I'm going to give you the kind of key takeaways from the listening session now. And the first thing that we did to look at these issues is to understand first what patient-generated health data actually are. So there was a great white paper that was prepared and commissioned by ONC that defined patient-generated health data as data that are health related, including health history, symptoms, biometrics, treatment, etcetera. But these are data that are created, recorded, gathered or inferred by or from patients or their designees to help address a health concern. They are distinct and different from data generated in clinical settings because patients are primarily responsible for capturing or recording the data and because patients typically direct the sharing or the distribution of the data to healthcare providers or to others. Next slide.

So with that sort of base definition, what we also heard at the listening session was patient-generated health data isn't new, we sort of have a new name for it in the last couple of years, but it's not actually new. It's already used, valued and incorporated in the electronic health record today or any health record and we also got real clarity around the fact that as you guys know, providers under Stage 3 draft recommendations would actually choose, hopefully in collaboration with patients, which data are the most important for their care delivery and health outcomes. And that's actually a very important factor that I'll talk about in a second.

So there – we also heard from folks at RTI who had done a great study of how patient-generated health data's being collected and used in the world today. And they basically said it's coming through three main channels. One is secure messaging, two is surveys, which is the one that we were really asked to look at. And third is biometric or device data. We also heard that when the data are being collected, there are four essential things that providers need to be able to do with the data. They need to obviously receive it, right? They need to be able to look at it, review it. They need to be able to respond to it, in other words, to acknowledge back to the patient that the data was received. And that's important because what people figured out is that when you don't acknowledge or tell patients it was received, you get a lot of follow up questions from patients saying hey, did you get it, did you get it, are you doing anything with it? So for workflow efficiency, you need to be able to respond to it. And then finally, you need to be able to record it, so you need to be able to bring into the record that data that are really the most essential for you. Next slide.

So what we then sort of looked and realized, right, Meaningful Use Stage 3 definitely sets up the ability to receive and record it. We did ask the Consumer Technology Workgroup of the Standards Committee to look at whether or not we can do all four things, not just receive, record, but also respond. We also heard that because the Stage 3 objective is really essentially provider driven, again hopefully in collaboration with patients, but that providers will be choosing the data that are most valuable to them, then the issues around volume, for example or unwanted data, they really get addressed, because it's a very specific data set that is being collected.

And then when you have the ability to receive it, review, respond and record, and you implement things appropriately, your workflows, then in fact, the use of patient-generated health data isn't sort of this special new thing anymore, it actually becomes routine. But that is going to require developing some really good workflow and some policies and procedures for both clinicians and for patients, around patient-generated health data. And that is going to include, of course, communicating the policies and the expectations in the workflows to patients and families. Next slide.

So I mentioned the liability component, which is that it's reduced or eliminated when you are choosing a limited set of information, because you're developing some policies and procedures around that. We also heard a lot about HIPAA and it – really setting – establishing some rights around corrections and some around amendments, but a lot of recognition that it's really absolutely a floor and not a ceiling. And then at the end of the day, we – every speaker we heard from was very clear to say that providers and patients are very much aligned around wanting information to be high quality and accurate, we just need to make it easier.

So, with that, we heard a lot from the listening session and we asked the Consumer Technology Workgroup to help us understand how ready we are from a standards perspective, because what we really heard was that the field is a little bit more advanced than perhaps our draft recommendation or recommendations are, from the Meaningful Use Workgroup anyway. And we need to figure out how ready we are and how far we can go. We also heard a big push for consumer device data to be added to Meaningful Use Stage 3, we needed to understand how ready we were for that. And so at this point, I'm going to turn it over to Leslie, who's going to talk about the work that her group did.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks Christine. Next slide. So some of the things that we were asked to consider was the use of the NwHIN Maturity Index and to look at both the maturity and the adoptability of standards. And so we asked Dixie Baker for her advice in this process. The group had a very high sense that we wanted to use existing standards that were already part of meaningful use and see what those standards could be, or how they could be used. So therefore something that was high perhaps for the use of provider standards and might be low in that same standard used for patient, comes out somewhere around in the middle. And that's where we ended up with most of our criteria, because we took a bias towards using existing standards. Next slide please.

So the recommended standards, or at least the standards we think that are ready for this, are reflected in the yellow boxes, and I'll just review. We looked at the whole continuum of patient-generated health data from messaging, which is pretty clear, it's the Direct message that we currently have that format in place today and it's part of Meaningful Use 2. The structured questionnaire is the next level of patient-generated health data, which is the expectation that when a provider asks the question digitally, they would like a response digitally, and so questionnaire is very highly adaptable to a workflow. It has the ability to be consumed inside the EHR at field level.

So we looked at the Consolidated CDA structure under HL7, which has been going under review and comment over the last year to incorporate the patient, their caregivers, family members and others, based upon the actual research standards of CDISC, that defines all of the individuals that could participate in a care team. And modify the Consolidated CDA at the header level. What this means is that any future CDA will look at all team members in its creation and constrain the use cases around those particular members of a team that would be involved in the care. So it's a very high-level incorporation. We also looked at the HL7 Care Team Roster definition. And this has also been normalized across the Consolidated CDA research and the care team roster, because before we can move the care team in the future, we first have to know who they are and what their role was within the particular use of patient-generated data, or any generated data.

The next phase of the PGHD is unstructured or narrative data. And the Consolidated CDA does allow for a very highly structured envelope, per se, with a narrative in this section, or in the middle of it. So we went forward thinking that Consolidated CDA as an adopted standard, with the modifications to include the patient and the care team roster, that we could be quite well positioned to accommodate patient-generated health data.

We looked at the device data and I actually attended the Consumer Technology Show in Las Vegas about a year ago, before we even looked at this – to see if there were any emerging consumer standards that could be used. And where we ended up was that the consumer standards are emerging, but in general, easily adapted for data coming out of an EHR. We see this now in our Blue Button implementation, which looked much more like industry standards – all industry standards, than it does just healthcare specific standards. But data going inbound to an EHR really has to reflect the standards of the EHR, because the risk of use is the physicians, when its inbound data, or the provider. When data is outbound, the risk of use is really the consumer. So the group really discussed this at length and came forward with the consideration of the Continua standard, which represents a variety of different device types, but accommodates both an individual feed from perhaps a device that's prescribed by a provider, like a cardiac device that's sent home. Or it also accommodates a cumulative feed that might be coming from a HealthVault type of a product. So it's quite wide ranging and in pilots today.

We felt then going further on into care planning and collaborative care, we really aren't there yet. In fact, we have the ability to adopt the care team roster, we're ready for that, but the whole idea of versioning and revisions and revisions by whom, regardless if the patient is involved in the creation of that data that is still yet emerging. And in fact, we had recommended and Doug Fridsma and others are coming together to say, how can we move forward with more of a collaborative care model for documents versus this asynchronous mode of documents. And as we look to the future for that design, it would be with all care team members involved, including the patient and the family members. So – next slide please.

So we looked at the Direct transport, the HL7 Care Team Roster standard, the Consolidated CDA for structured and unstructured questionnaires and consider the Continua standard for data and devices. We also understand that mobile access and mobile data is proliferating; however, what we see is that there's not a need to mandate specific standards in this case. Most organizations are doing responsive design so whatever they create can be device agnostic, so we didn't feel that it was necessary to do anything there. Next slide please.

So we have, as I mentioned, considering and S&I Initiative to create a collaborative care document structure is needed, and we think that will take some time. So we will probably launch something in the next few months for work over the next year or so. We also felt that there could be an opportunity to align consumer product and provider standards more carefully, and looking at a structure that might invite that so that as we get to things like, how do I upload a FitBit that's perhaps not provided by my provider? What kind of standards would we look at to help that process that's both consumer-friendly and friendly to health data standards?

We also felt that the advances being done on the Blue Button and the API approach; we might want to consider at a future date another API based approach for patient-generated health data. We acknowledge that the Trust Framework that's being established needs to be expanded for consumer and patient adoption in emerging technologies, like what we're talking about with Blue Button. And then we also would like to see a consumer vocabulary work being done.

Now that's something that I think there's a high degree of interest, we had talked already about aligning this with the vocabulary workgroup to investigate and hear about emerging consumer vocabularies. For instance, Kaiser donated some work that they have done in that area. We have industry leaders like IOM and Healthwise and others that would probably provide us insight to consumer vocabulary; so, there's work to be done there. However, that's not anything that would get in the way of the recommendations on the patient-generated health data questionnaires, unstructured and structured. Because there is a high degree of alignment in structure, there's also a high degree to use other standards within – or already associated with meaningful use. I'm sorry? Okay. So we feel that these are things to work in the future, but they are not barriers to adding patient-generated health data at all. Next slide and I think I'll turn it back to you Christine if there are no questions.

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

Yup. Great. Okay. So I started with giving you a sense of what's happening in the field that we heard about in our listening session. Leslie just gave you a sense of what's possible using standards, if we wanted to expand what's happening in the field in a more standardized way. So we have a number of recommendations coming out of all of this work over the summer. So the first is that overall yes, we're ready for patient-generated health data in Meaningful Use Stage 3, but that we're actually suggesting some modifications. So number one modification would be to give providers some additional options for incorporating PGHD, not just through the structured surveys, but potentially through secure messaging and certainly through provider-approved devices, okay? So we can talk about that.

So number two is to – intended to really clarify the fact that our recommendations apply to amendments and corrections as well, since they're a form of patient-generated health data. So we need to think about that in terms of how the recommendations are structured – or I'm sorry, the meaningful use objectives are structured. But that we definitely need to make sure that in terms of amendments, the EHR technology needs to allow providers to receive them, review them, respond to them and record them, particularly for amendments and corrections in the record. So our third recommendation is that for people who choose the PGHD menu item in Stage 3, they should establish policies and procedures for handling those data in advance of implementation. And we are suggesting that that be – include, rather, how the data was going to be received, reviewed, acknowledged and recorded, including provenance. And we heard a lot about that and we do have standards for that as well, as you heard from Leslie.

So number four is that we also heard when we – when the data is received in the record as patient-generated health data and tagged as such, sometimes that data will then leave the record and be shared for other purposes, treatment, payment and operations. That's an example of where we do need to make sure that the sourcing of the data, as patient-generated continues that tag, follows the data, even when it is provided to others. So – and in doing that, we've got to figure out, right, how to make sure that that works for everybody. So number six is really a recommendation for ONC around how to give providers very clear guidance on doing the things that I just described. Which is to say, what are the policies and procedures that define what patient-generated health data is and how it is handled, how it's communicated out, how the workflows are developed, things like that? So the whole review, respond, record, those issues really need to be disseminated through mechanisms like the Regional Extension Centers, the National Learning Consortium, through CMS' Tip Sheets for Meaningful Use, so people really can do a good job implementing, because we know a lot about how to implement patient-generated health data. Next slide.

All right. There were some questions in our hearing around – are new and actually sort of that came, I think in part from this group. Are new policies needed around patient-generated health data? Do we need to do anything additional here, and if so, how would we go about doing that? And in the end, basically the consensus from the group was no that HIPAA is enough and it does govern the data that's in the record, so right now that's absolutely fine. There may be some work in the future to look at data sharing from consumer devices and apps, for example, that providers would use in clinical care. But right now HIPAA is sufficient. There are some issues that need addressing in the medium term, really the workflow and liability issues around unsolicited PGHD. So, that doesn't really apply to the meaningful use objective here, because it's not unsolicited, but in – we're already seeing consumers wanting to share all of their FitBit data or whatever with providers and we're going to have some policy, workflow and liability issues that need to be looked at there.

Leslie talked about Direct email addresses that was a big focus for both groups. And so we're recommending that interoperable Direct addresses are made available to patients, because that will make it easier to share and collect and use patient-generated health data for providers. Let's see here, number 10 is just a simple, yes, we support the amendments objective in meaningful use, that that's good, we're ready for that as well. And then number 11 is that we need to really get some experience with patient-generated health data in Stage 3, but also in future stages, to figure out how else do we want to receive and review and record patient-generated health data. And I'm going to hold secure messaging out, because we're going to, I think, have most of our discussion today will probably center on our first recommendation, and we can talk about that.

And then finally, we do have some work to do, as Leslie indicated, to explore shared care plans and the standards that would integrate consumer device data, as opposed to the provider approved device data. So, we've got a lot of issues on the policy side for shared care plans around how do you control the versions, how do you reconcile and harmonize data? How do you share them appropriately? Things like that. That really needs to get moving now in advance of Stage 4, where there is a big placeholder around this kind of a shared care plan. And then, of course finally, the device data piece. Again you heard from Leslie that we're – standards do exist for provider approved devices, so when the provider says, here's the blood pressure home monitoring device I'd like you to use and send the data back, that we're ready for today. But really the consumer device data piece we're not quite there and there's some work that needs to be done.

So I believe those are all of our recommendations. We might want to go back to the slide previous, because I think Paul that most of the discussion is going to focus on that first one. So can we move those previous slides – folks at Altarum? Anybody.

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

Go to slide 10 I think.

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

Yup, there we go.

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

There we go.

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

Yup, so that first one I think is where we really want to focus, which is, the group hearing from the field we're definitely ready for the patient-generated health data recommendation in Stage 3, but focusing it only on semi-structured or structured surveys is too limited, based on what's happening in the field. So, the group's recommendation is to consider expanding it to include secure messaging and provider approved devices, in addition to structured or semi-structured questionnaires, so that anybody who chooses this menu item has more options, more channels through which they could get credit for receiving patient-generated health data.

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

Okay, comments from the group or questions? Thank you very much Christine and Leslie, excellent presentation.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

This is Neil. I'm fine with those recommendations I think they're excellent.

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

So this is Mike. I also want to congratulate the group this is really great work. I do have a concern not so much about the concept of secure messaging, but the assumption that that's going to end up with a more efficient or comprehensive collection. We work pretty hard to make sure that we have questionnaires patients can fill out that go to structured data fields that can then inform clinical decision support, etcetera. And the thing that gets in the way of that is the patient who sends unstructured secure message in free text form on the same subject that they could have done through a questionnaire. And so I'm a little bit concerned that both providing a Direct address, which in concept is a great idea, but again, I'll have to coach my patients pretty hard to say, here's why I want you to use our structured forms and here's how they'll help you if you would please use them. Compared to the patient's use of a different approach, which then actually slows down the process of getting their totality of care and the various decisions that are made around it. So, I just have some concerns about that.

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

So Mike, what these recommendations are suggesting is that if you to use secure messaging for PGHD, you can, but you don't have to. If you only want to use questionnaires, you can, but you don't have to. If you only want to use devices, you can, but you don't have to. So all we're trying to do is say, you can do any one of these or all three of them or whatever you want in terms of meaningful use, but you do it in a way that you're setting up the workflow for and you're choosing the data set. So it might, for some people, it won't make sense for them to use secure messaging at all, and it won't make sense for them to use a survey either, they may only want to use provider approved devices, for example. You may only want to use questionnaires; you might want to add devices, whatever, but the recommendation would look, it comes in through these channels, so providers should get credit, but it's a provider driven approach.

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

Okay, so thank you for that clarification. If number one does give providers that flexibility, that's great. My other – how about my other concern though about patients having a path to provide the data by having Direct email addresses?

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

Well, it's not required, I mean again, I guess I would say they're not – it's not required, but I think the issue you're raising is not a path issue, because secure messaging, regardless of whether it's a Direct address or not, secure messaging is already part of Stage 2 and continuing in Stage 3, likely. So I think the issue you're raising is less a pathway and more a workflow issue. And so what we heard from the listening session over the summer was yeah, there really is work to do to engage patients around how...which channel is most appropriate to use for which purpose. And the whole set of recommendations around ONC helping providers to establish clear policies, procedures and workflows around patient-generated health data would apply, whether you're – to secure messaging, too, because that's already happening.

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

So how would I keep a patient from using Direct message me if they're not my patient or if they're otherwise not somebody who I've given secure messaging privileges to because they're agreeing to follow the rules, etcetera, etcetera?

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

Well –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

You haven't given them your Direct address.

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

Well –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So when we're talking about issuing a Direct address to a patient, the patient might have one, but they might not know yours.

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

Well, so maybe it's on the next slide then, you can clarify it for me what you meant, because I thought it – I thought on slide 11 you were talking about giving patients access to all providers Direct addresses.

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

No. It just says interoperable Direct addresses should be made available to patients, meaning, their own. So I would have an interoperable Direct address as a patient.

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

Okay, so maybe I just need to re-read it, but I just want to make sure that ends up being very clear.

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

Somebody move to that slide please.

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

Thank you.

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

Yeah, no – no problem Mike, but could somebody move to slide 11 please, there you go. Yeah, made available to patients, so we can clarify that, but that's – yeah, we didn't mean like, although I'm not opposed to that, but we didn't – that's not in scope at all for us.

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

And this is Marc Overhage, just to follow up on that thought. When you think about the notion of interoperable Direct addresses for patients that implied some kind of identification authentication authority that's trusted across providers, which is a pretty big deal. And in fact, the little bit of research that's been done on this, says we don't trust each other to do it, we want a third party to do it and there are three or four papers that suggest that. So –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So Marc, this is Leslie. So one of the things we're asking is that the Trust Framework be expanded to include the patient. And so that work will have to continue, and it's already started. But you're correct.

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

Well, and it's non-trivial, I think, to get to the point where as Neil said, where because I can spoof – I mean there are all kinds of issues, if that patient isn't properly authenticated on the other end.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Correct.

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

So let me see if I can help us here, because this is not completely within the scope of the discussion, but I see how we have brought it in. So I think Leslie, it's accurate to say that there is work that is happening to explore these issues around giving patients Direct addresses, right?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

There's work underway that's doing that? Okay. So perhaps what we could do is just reframe this number whatever it is, nine, to say that the work currently underway to provide Direct addresses to patients should continue, because that – we – the concept is an enabling concept because that does make it easier for providers and patients to provide and receive patient-generated health data. But I don't think we meant to get into all of the deep issues around – that Marc and other folks are raising. And –

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

But if you're contingent on that, we've got to be very careful, I mean because that's not a solved problem by any means.

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

Right, it's not –

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

And if you want to give a recommendation that depends on it, I think we ought to make it very clear that that's dependent on a very weak link at the moment.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Perhaps what we need to do is delineate there's secure messaging that's associated with the portals and there's secure messaging that is associated with Direct. That work needs to get further, and you're right, it's not trivial and we need to expand the Trust Network. Secure messaging associated with a portal though, should also be counted as patient-generated health data and so we want to make sure that that's still – that that thoughts not lost.

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

So, yeah. So, I think it's – I'm glad you said, Marc, that the – raised the dependency. It's not dependent, I mean we're really, as Leslie said, that – what we heard from the field is that people are using secure messaging, but it's not the secure messaging that is Direct address enabled, necessarily, they're using it as it sits and exists in Stage 3 of Meaningful Use and previous to Stage 2, as a –

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

Right, so they're acting as their own authentication authority, which is not interoperable and not scalable.

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

Correct/. Correct. Correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Um hmm.

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

So I think the challenge that I actually had with secure messaging in this case is a little bit different than what's being raised here. We can make these clarifications, but if we – it has some implications to think about bringing secure messaging into the menu objective – it is at a – the menu objective on PGHD. At a minimum it basically becomes like a two-fer because you have secure messaging as a separate objective that is, I think core by Stage 3, which you've got to do anyway, so, that's there. And then you're getting sort of a nice two-fer if you want to use that for patient-generated health data, but I just want to make sure that – those two things would get a little bit confusing, that's what I'm worried about. I can't tell if it's a two-fer, in other words, does that make sense? Or if it's just going to complicate matters.

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

Right. So this is Mike, I think it is a two-fer in the sense that a secure message sent by a patient with data that's obviously relevant to their health is patient-generated health data, that's fine. And for people who can and want to absorb data that way, that's not a problem. I think the bigger issue becomes, to Marc's point, I – we carefully identity-proof our patients, then we give them authentication credentials, and then they authenticate. We have no confidence in other approaches and need something like the Trusted Framework to be able to do that. Opening up another method for them to get to us without us being sure that we've got an identity-proofed, authenticated patient is a challenge, and we can put that off until later.

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

But Mike –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right. But Mike –

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

I think the other bigger part is, for those of us who've set up our menus in a way that encourages them to give us structured data, we'll – as long as we're able to continue to do that. And make the – if none of these forms fit your needs, feel free to add some free text comments instead with a secure message, otherwise that's fine, as long as it's not the mandatory approach.

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right. And it could be in the future you might want to actually, as the provider, issue a Direct address based on the fact that you have done the authentication. So, I think that that's still evolving and emerging, but you're right, the Trusted Framework we need work on. The idea of secure messaging, and Christine's right, it's a two-fer.

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

Well right, but here's – so here's the issue that it raises for me, that is, we did not talk about in the Consumer Empowerment Workgroup, because it's out of scope. I think this is in-scope for meaningful use, which is, if you have secure messaging as a core requirement in one part of meaningful use and then you have it as a potential menu item, or one channel for the PGHD menu item. Does that require you to then figure out how to delineate between the secure message that contains patient-generated health data as we defined it on one of my very first slides versus a secure message that contains some admin data around appointment rescheduling or something, because just the one thing I worry about is do we over-complicate things. So it makes total sense to me to revise the objective to add in, provider approved devices but I want to make sure we're – we understand the implications of adding secure messaging to that, given that this is secure messaging that's really driven around the content, that has patient-generated health data in it, as opposed to anything else.

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

So this is Mike, I would hope we would be able, without getting too complicated, to count any way patients give us information, whether it's a questionnaire or non-questionnaire. If we're asking that vendors be able to distinguish administrative messages from health-related messages, then that may make it more complicated than –

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

Right, that's what I'm raising. That's what I'm raising.

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

– can be handled. I would like to think, although I'll be wrong on this, I'd like to think that any time the patient sends us a message of their own choice that ought to count.

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

Well if we –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, the – this also is the –

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

Hang on Leslie one second; can we please go back to the slide that has the definition of patient-generated health data? Because it really does – it does have to be health-related, like – I mean, appointment reschedules –

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

That's health-related to me, I hear what you're saying, but that to me is health related.

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

I agree, absolutely, and very important for care management.

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

It can change everything about how the patient's treated, whether or not they get the care in a timely manner, whether or not things work –

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

Well, right, right. So let's look at the data. I mean, the definition that's already been established is health-related data that addressed a health concern, and it's this – right, we know it's distinct from clinical data in that sense. But I just am not sure that an appointment reschedule is really within the spirit of what most people would think of – hey I need a –

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

It's account for 3% of the logic in our care management roles, our appointment data.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I know, but – this is Neil. I really don't think it's within the spirit of what we're trying to do either.

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

Saying, I need to move my appointment from Tuesday to Wednesday is just not –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Right. That's an administrative –

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

But it actually is it's a huge issue in care management. I – anything like that has dramatic impacts.

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

Tuesday to Wednesday may not matter, but if it's my third reschedule in the last three months and I haven't seen you in the requisite amount of time, etcetera, etcetera, it's of huge importance. So it only varies between small and large, it never gets to none.

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

I, I think –

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

I have another example that might help, missed appointments is certainly a health – a piece of health data.

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

But remember, you guys are talking about a piece of health data, wha – I think that the spirit here is the patient provided a piece of data, a piece of health data relevant to a health concern. So I don't think moving an appointment day, I mean, is really in the spirit of what we're talking about or even necessarily asking a question. I mean again, it's health data to inform care, not necessarily – you know what I mean, so I don't think that stuff is within the spirit.

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

Let me try one more Christine, and this is essentially the social determinants of health, something I'm working on a lot. So the fact that someone missed three oncology appointments because of transportation needs, that really severely impacted her health, it's something we could have and should have and need to in the future consider as part of essentially health data. That's a different point.

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

So how would that be considered patient generated?

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

Because the patient took – the patient took an active role in saying, I'm going to cancel this appointment. That is a signal having to do with her health, it happens to be a social – what's considered social determinants, it's not a medical, but I think in the spirit of what we're talking about, it really impacts her health. And if we continue to not – if we continue to ignore these social determinants, we will probably be missing a lot of data that impacts health.

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

Ri – and I'm not saying that these are not, and I think Neil, is not saying that these are not important signals, but they aren't pieces of information that providers would benefit from knowing, but it is totally different in my mind from patient-generated health data –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Maybe we need –

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

– not what is intended here.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Christine, this is Leslie and I think that the spirit of this is absolutely right on. From a standards point of view, there is nothing within the standard that indicates content type –

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– so we would not be able to, from a standards point of view on the Consolidated CDA note that this particular content was administrative or not. On the secure messaging, you would even not know that, you'd know that this was a secure message, but there's nothing from a standards point of view that would say this has particular definition.

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So my concern is we would not want the standard to have to be modified at this point in time, because that might delay all the other things we want from patient-generated health data. So it could be that the market might help us define this as we go forward, at least from a standards point of view, we really have to stick with what we've got, which we can identify that it's a secure message. We can identify that it comes from a Direct address; we can identify the type of data if it's coming from a device. We can identify it's a type of Consolidated CDA template, whether it's unstructured or structured questionnaire, but we can't say that this is administrative or non-important or clinical or not. So from a counting point of view, the standards wouldn't be able to help.

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

Christine, this is Amy. So is the concern that if we blend and we allow the appointment scheduling issues or missed appointment issues to be blended with the patient health generated data as you've – as we've defined them in terms of other data, is the concern that providers will only implement and use it in a scheduling way and not move to the other? Because I'm trying to figure out, if they're both used, what's the downside, other than the fact that you're – that there's a concern that they will never really get to accepting what the other intentions here for patient health generated data. Is that your concern?

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

Yeah, that's my concern, which is, then do people really – well first of all, if you – I just want to first make sure, if you do choose to do a menu item in patient-generated health data, then you should have to meet the kind of spirit of it. But if that's going to require that if you pick secure messaging as the primary channel you're going to use, then we have to somehow know the content of the message, that's not realistic. And it's going to create –

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

Right.

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

– it's just like, that's not good. So in my mind, I think the option is you leave it in and you know that there's going to be a lot of stuff that is not actually patient-generated health data that could count. Or you say – you don't add secure messaging in, but you do add provider approved devices so that they can use either a survey or provider approved devices, but you hold secure messaging out separately.

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

Do we have – this is Mike – do we have data on what percent of secure messages sent by patients are not health related? It seems very uncommon in my own experience.

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

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

Arthur Davidson, MD, MSPH – Director – Denver Public Health Department
(Indiscernible)

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
– it's not health related, it's patient-generated health data, which is different than just any piece of info that happens to be health related.

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

Patient-generated messaging to me, that's what I'm just trying to get to, a patient sends me a secure message. And do we have data on how often that is not patient-generated health data, by your definition?

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

You mean – you're asking how many times it's just related to appointments?

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

Yeah, I have – yeah, exactly. How often are patients sending us secure messages that are not related to – that do not meet the criteria listed for patient-generated health data?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Well, can I ask it a different way? If you have a system that allows you to access an appointment schedule and you can change appointments and stuff like that, is that considered secure messaging?

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

It wouldn't be in our system.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think not. If it's coming through a patient portal and it's coming through a function like request to schedule an appointment, it is a function of that portal; it is not considered a secure message. If it's coming in as an email to my doc, hey, I'd like an appointment, that's probably the rarity. In general the portal function would have – even the untethered portals have a request to schedule, a request to change as a separate function, not part of a secure message.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

So as long as we're clear that that would not – that using that kind of a portal around appointments is not – would not qualify. I think we're – I think it's safe to just leave it open, the definition for what the secure messaging content would be because I would agree that it's very rarely used for appointments in our system, because there are other ways for people to do appointment changes. And usually that's not a message directed at a provider, it's a directed – it's a message directed elsewhere.

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

So the que – I think the question that Mike raised is very interesting about is – I mean are most – the vast majority of secure patient messages patient-generated health data? And I understand where we're coming from, how we started the conversation, but I'm wondering if that inadvertently became limiting of saying, we only care about the – there is something called patient reported outcomes, and that's a separate topic. But from a patient-generated health data definition as you have on this slide, I think Mike's right that the vast majority of SPMs are patient-generated health data.

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

Well, I think we can certainly look at that and see if that is the case. I mean, I'm thinking it's not just about appointments but what about, well, I changed my address or my phone number or I changed my insurance carrier or, I don't know.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, that's generally coming through a function on the ad – in the portal that's coming through an administrative function –

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

Correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– as a separate item –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

It's rare –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– because they want to feel discretely changed. So when you think about what's in a portal where there are field level changes that need to carry through the EHR completely, that's coming in as a separate section, it's an actual function of the PHR.

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

And that – .

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Or untethered PHR.

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

That makes sense, as long as you have – are on a portal. So I think we can – I think that's a good question and we can see – the RTI paper did have a lot in it, so there may be some things in that or the environmental scans that have been done. So we can just double-check on that, but I think what I'm hearing the group say is, assuming that the vast, vast majority of secure messages would contain patient-generated health data, is the group then comfortable revising the Stage 3 recommendation to include not just structured and semi-structured questionnaires, but secure messaging and provider approved devices.

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

I'm looking at –

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

So I have – this is Amy and I have one other question. Do we have any idea how often patient-generated health data as you defined it Christine end up coming in through a portal by other means? Like so I'm asking a question about a test result and I share some additional information that's important, how does that get weighed in and counted, or does it not? I'm struggling with the blend between what a patient puts in through a patient portal versus – like in a question or secure messaging through the portal, even if it's beyond appointments versus sending a separate secure email message saying...I mean I get it if it's a questionnaire and you're giving background information. But I have to believe that there is patient-generated health data that goes back and forth through messaging through portals.

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

You're absolutely right and in fact, many portals use secure messaging as the vehicle to communicate between the portal and the EHR.

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

So Amy, I don't und – I mean, that would count here, I guess, so I'm a little – I'm not understanding your question.

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

I can try to answer Amy's –

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

So my question is how, if we don't somehow combine these, I don't know how you're going to be able to tell. So let's say I am in the portal, I look up a lab result, I have a question for my doc and I ask my doc. I send a message to my doc and I ask a question about my lab result and in the meantime I give some additional information about myself, oh by the way, I had this problem four years ago, you don't know about it or I had something similar or I took some medication. Whatever the case may be how does that then – does that relate at all to this other patient-generated health data requirement?

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

Amy, let me try to explain the – on the portal, and I think this is what Leslie's been saying as well. In general, all of the message to doc or clinical team goes through the secure patient message and for purposes of convenience and efficiency, you separate the administrative stuff like I want to change my address, I want to change my insurance, I want to change – I want to make an appointment. The reason that's typically done in all these products is because the provider – I mean you want to separate those two because they go to different people to execute. And also as Leslie pointed out, and most of the appointment requests and demographic, even try to go as fields so that it's more easy to accept it. So in – it's already naturally the market product, already naturally just separate the clinical from the non-clinical. So for example, you're example of, I have a question on my lab, and I ask other questions that would all be done through the secure patient message.

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

Okay, so tha – but that is still different, that's still going through the portal and I thought we were also talking about other options for patient-generated health data like Direct or other things, so, that's where I thought we were – so I may have misunderstood how we were – the confusion between the admin and the non-admin. But you're saying, whether you send patient-generated health data through the portal, through Direct, through a questionnaire, whatever, that will all count if it's more medical clinically related and our discussion and debate was more around how to count the admin part. Because we can't –

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

Correct or how to –

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

– because I thought you just said we can't distinguish them.

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

Right, or how to – but not necessarily just how to count the admin stuff, I mean, what happens if I send a message that says, are my lab results in yet? That is not patient-generated health data. That's a question I just asked, but I didn't give you any data about health in that, so that's what I'm raising as a concern and it sounds like most everybody else is not concerned about having to dis – because we can't distinguish those. So –

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

And because the clinical – clinically related messages swamp those, it's just – it's not worth having to develop a standard, having to count it, etcetera. That was our point.

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

Right and this is Mike. My preference would be, if that's really a concern, see what we can get from the literature, adjust the threshold accordingly and let's keep moving, because docs do not want to have to deal with the nuances here and –

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

Yes, and I agree with that. I completely – I think that it's not an option to try to deal with the nuances, so let's get some – we'll see what data we can get around the content of messaging. And if it's negligible, then we'll not worry about it and if it's more than negligible, we'll come back and we might talk about the threshold as Mike just suggested.

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

Okay. I have another topic, if we're ready to move on. One, I wanted to reiterate, this really is excellent work. I think you've done a terrific job enumerating all the topics and the development path to getting to where we are – from where we are to where we want to be, and I think that's what's given us the ability to have this rich discussion. Some you pointed out our available, some are available and adopted, some topics are being worked on and some you've identified work needing to be done. So that was extremely helpful. One of the things having to do with your first recommendation, which I think is your cornerstone recommendation, number one, is you talk about the flexibility, and I totally understand that and I think a good concept. One of the key phrases you have is provider adopted device or provider –

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

Approved.

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

– approved, sorry, and I think also that's a very slick concept. The implications, however, let me just ask about. Once you do that, even though the provider has the flexibility, it does mean that this is a mandatory thing for the vendors and now – and I'd like the concept of provider approved, but doesn't that mean that the vendors have to then interface to all devices, because they don't know what's approved by this provider for this patient?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

One of the reasons, Paul, we are using the Continua standard is because – or recommending that is its very broad, it incorporates a lot of different technical choices, still provider system focused. So there's nothing in the Continua standard, for instance, for FitBit, there isn't in it for the zillion mobile apps that come out every day. But for the things that the doctor's using within that standard, it's pretty well recognized.

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

So the question though is, we've already asked this of the Standards Committee and what we got is that yes, there is a Continua Alliance, but I think everybody I've asked says that it has not been adopted.

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

Right.

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

So there must be something – some reason why the market has chosen not to adopt this and that's – so I think we're still stuck on –

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

Paul, Paul, well let's ask Leslie, because that's exactly why we, the Consumer Empowerment Workgroup asked them to weigh in on this specifically because we heard both ways. So we said, can the Standards Committee tell us, like what is the deal here because we have some people say they're adopted and some say they're not, so Leslie –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, but part of it is the Alliance has so many different standards within it that they name and recognize. So for instance, some of the HL7 device data standards are within it. They do things a lot with diabetes types of devices – devices for diabetics, and there are many, many others. So there's a range of standards within it. Some – this is one of those chicken and eggs, because there aren't any patient-generated health data device standards that are highly adopted, period. And partly because that confusion exists, it's very difficult to know what to do, where to go, how to implement. And so by constraining this somewhat to devices that are provider centric, and we don't yet know how to word that, but something that you're likely to send home with a patient, does it meet standards under this umbrella group, then great, it has a better chance of being adopted than not meeting anything. So this is somewhat of a chicken and an egg.

Now the Continua Standard Groups reported, and they reported high adoptability in some and lower in others within their Alliance. We had some in pilots as we were reviewing, for instance, there was a race in Europe in pilot of patients with diabetes on bicycles across Europe uploading data to a variety of medical records and a variety of systems around the world to demonstrate the flexibility. So there was a – there is a wide range of adoption within this Alliance, but –

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

That still is a problem. Does – I thought the Standards Committee has already given us a final answer on this, are you saying they've changed their mind?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is –

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

They basically said this is not – this is not something they would move forward with because of its low adoption rate.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well and this is a difficult one. When we discussed it in the meeting, and we didn't get into deep discussion, we are going to come back specifically on the devices and discuss it with it more.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But it's one of those things where no – anything we recommend, any standard we recommend for this has a low adoption, just because of the nature of where we are in the business. So if by naming a standard, does it allow for more innovation because people can constrain and build to it, or less? So I'm going to argue that –

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

Can I just interrupt one second and say, Paul, I'm – I think in terms of a process issue, because we've gotten a lot of different feedback, as I was trying to flag earlier, my suggestion would be that this workgroup, which is a workgroup of the Standards Committee did come up with these recommendations. So perhaps what we could do is have them presented to the full Standards Committee and hear from them as a full group.

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

That would be great. No, that would be great. And then the second part of my question is, once you make this a requirement, then how do you address the fact that all of a sudden the vendors have to interface with all devices, not just provider approved?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

They have to interface with the devices that are named within the standard. So we could constrain it Paul, if there's – if there's a high-level use case where you think on the policy side would address a large percentage, then from the policy side you can constrain it. From the standards side, you can say this Alliance will accommodate many.

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

Okay, so let's – let's follow up on Christine's suggestion, let's have your group present back to the full Standards Committee and give them that question, one, can we adopt all of Continua's standards? Or two, are there certain ones that are both high value and high adoption? But if they can give us that input, I think that's critical for us.

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

Yup.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

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

The other gap related – I'm sorry, go ahead.

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

No, go ahead Marc and then I'll add in.

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

I was just going to – I mean the other thing that I'm concerned about is sort of this menu approach, I'm not quite sure – is we focused here on the, okay, can you get data? Are there standards and so on? At the clinical care level, are we ready? In other words, take for example blood pressure devices. Great, wonderful thing, Paul's done some nice work in this, for example. But all the clinical care guidelines in the US don't accommodate home measure blood pressures; you kind of go, okay, what do I do with that? And in fact, I think if you look, there's only like – there is very, very little patient recorded clinical data that you could find either evidence or clinical guidelines to support adopting in practice and yet we're saying, okay docs, go pick some stuff that makes sense. So that feels like a big gap here between the what could you do technically and what makes sense to do clinically and do you have evidence on which to base doing that or is it just, sounds like a good idea.

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

Marc are you ra – it's Christine, I'm just trying to clarify. So you're saying, it may be technically possible, but clinically it may not make sense?

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

I'm just – yeah, I mean, while I think – so I don't want to say that, because I – in my heart I think it clinically will make sense, but as a – if you put your quality measures, clinical guidelines, clinical care management hat on and you say, so what am I going to do with this data? I'm hard pressed to find good evidence on which to base a recommendation to say to my docs, we should pick weights because there's strong evidence that measuring weights at home is a useful thing or that measuring exercise at home is a useful thing.

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

I see what you're saying. I mean we, in terms of the work that we did, yeah, so we did not – so the main thing is – did form this recommendation originally; we based it in part on the paper that RTI did. That said that people are doing this and they want to do more of it, but it's hard and it would be made easier by standards. So perhaps we can circulate that paper but that's the best answer I can give at this point.

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

I mean I'd love to take a look at that, but like I said, I mean this is something I spent a fair amount of time on and I don't know of much data. And on top of that, I'd say that there are ten other things that are much stronger evidenced that we ought to be doing that we're not, so why does this elevate to the level of, we should be spending energy on this?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

On patient-generated health data specifically Marc?

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

Pardon?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

On specifically patient-generated health data, you think there's ten other things –

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

Correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– we should be doing?

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

Correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

What would they be?

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

Well, I mean there are a whole host of things, we're not even executing on the very basics of getting people on aspirin, for example. We're not executing on getting people to quit smoking. I mean there are all kinds of other things to do before we create processes and workflows to – I mean based on the evidence that's available.

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

Well, but those are more – I mean, we're looking at EHR functions and so not necessarily getting people on aspirin, doesn't require I think a new function of an EHR and so –

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

It doesn't require a new function; it requires us to use the functions we already have in EHRs.

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

Right, so that's great –

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

We don't need new ones until people have used the old ones.

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

I understand what you're saying, but this is – that's not what we heard. I mean, so this has been a recommendation in Stage 3 since Paul, I don't know, gosh, how long are we working on this?

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

(Indiscernible)

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

A long time.

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

Yeah, that's true.

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

But it's a big gap, right? I mean, if you – why? I mean the whys are pretty important here and I think the timing – maybe it's a timing question. I mean these are important things to do, the question is, when?

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

And this is Mike; I'll just weigh in on the clinical end. Evidence notwithstanding, I think there is certainly a patient desire to be able to share some of their patient-generated health data from devices with physicians. There is some cautious interest by physicians in the same thing –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yup.

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

– with the alternative being looking at the chaotic diabetic blood sugar log, assuming that adds value to Marc's point. But the bottom line is, those data do come to us and we have to do something with them. Then there's the issue of assuming we take the information in, how do we make sure that we don't see a giant haystack with the needles hidden, so the whole notion of the requirement also then leading to data representations that are actionable and understandable to both patient and provider. So there's a lot to be done to this, but I think to go back to the main point, the main point is if people wanted to implement this, would they have a process for doing that? And is there anything we can do to move the market forward with regard to making it easy and possible for this kind of transaction to occur.

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

But if you make it a requirement for people –

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

It's not.

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

– it's more than making it easy and possible.

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

Right.

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

It's not a requirement, it's a menu item. You don't have to pick it and you don't have to do devices. You can do – if you decide that this is a useful one to you, and if you guys adapt the first recommendation, the work that our group was making, then you can pick secure messaging, you can pick a survey or you can pick device data, if that's what makes sense for you. We're just trying to keep up with where the field is already at, which is what's in the RTI paper. But it's not a requirement, it's a menu item.

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

Our track record is that menu items become core, so we just need to be thoughtful about that as we think

–

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

Yeah, but I have to say, I've heard that logic before and I think that held up between Stages 1 and 2, and probably coming into 3. But after this stage, the ballgame changes dramatically with the advent of penalties, so, I don't think that we can assume that at all anymore.

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

I'm just telling you what physicians will conclude.

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

Okay, so I think we need to probably move on. Maybe I'll make a couple of global comments. One, this is se – we want to preserve the tremendous work that's been done here and so I'm thinking a little bit, like our last conversation about deeming, there's a lot that we want to communicate about the thoughtfulness – the thought that's gone into, whether it's deeming or patient-generated health data, and not lose it. And also, it's almost like a trajectory for where we want to go, some of the work that has to be done and some of that preparatory work may have to be done before some – a requirement, whether it deeming or PGHD.

I think we've agreed on your primary recommendation number one, certainly to add SPM, and I think we have some work to do on the provider approved devices. But again, I think that's a really nice concept from – and I'm still worried about how do you eliminate everybody or have a certain scope so that people don't have to – it's good for providers, but I think the vendors would end up having to connect to everything, and is that possible? So that's work we have to get done with the Standards Committee. And may – maybe want to flesh out some of these other recommendations and the thought behind them, because I think we do want to preserve them for our recommendations going in on January. And again I draw the analogy to deeming in the sense of we do not want to give up on the concept, but we want to further inform the process of getting to the goals that we want to get to. Does that make sense?

M

Yup.

M

Yeah.

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

I guess I'm asking Christine and Leslie.

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

So – well yeah, I think everything you said makes sense except that I think what – the last part I think I lost you because you were saying sort of keep getting to the goals, but are you suggesting taking anything – are you suggesting any changes to the current objective, the menu item?

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

Well I think we – let's go – I want to try to transition –

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

You're saying yes, add secure messaging –

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

– into moving and that's your first recommendation, and find a way to articulate, document the thought that's gone into these recommendations, so that it can be part of the record and part of the planning process, frankly, for both ONC and CMS. I think we – this discussion has been far more advanced and – you've advanced the ball a lot in this discussion compared to when we put it on the matrix in Stage 1, and we now know how to get there, I don't know the timing. That's, I think, our main – everybody's main concern, because there are so many things to work out. But I think you've really advanced the ball in –

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

When you say the timing, do you mean with respect to – are you saying that we're – there's a possibility that this – that this recommendation – I'm sorry, this functional objective, that the Meaningful Use Workgroup has had for a long time, could be removed entirely? Or are you just saying the question is really about the timing of like whether the device piece –

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

Correct, it's the latter.

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

Oh, okay. Okay.

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

So for example at – I think we want to transition into starting the Category 2 review in which this will be one of the top things, but one of the things that everybody seems to have already accepted is add the flexibility, where we can, without creating the unintended consequences, such as what Marc was talking about. And so SPM seems to be one of those, but we can start working on that as we go through the review, but just want to make sure – make it clear how valuable this is –

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

Okay.

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

– and that we capture this for our recommendations.

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

My suggestion would be then that we go ahead and add all three components, but we have the provider approved device data as sort of a little star next to it or add the two, I'm sorry, until we can hear back from the Standards Committee.

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

So I think that's the ne – let's make that recommendation as we review our recommendations.

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

Okay.

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

Yeah. So, any other further comments globally on this? I think we want to capture what's gone into this and we can move to the recommendations and include this in that. Okay, so can we move to, I don't know what slide it would be, where we start reviewing the recommendations for Category 2.

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

Yup.

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

Okay. Good. Are you passing the fir – Michelle's not here anymore, so I don't know which one of these have any further questions? Let's go back to that first one, which was I think your slide two – one more. There was something, I thought –

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

Something incomplete here.

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

So, add – advance one please –

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

Slide one or previous one.

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

Well, let me just go through this agenda, this is our work plan right now. So we're having our call now, we were trying to get through the recommendations from the consumer workgroups feeding into the Category 2 recommendations. Next time we get recommendations from – feedback from the Standards Workgroup I hope we can include feedback on the device standards and then continue in Category 1. So that's our work plan. It's going to be tough to do this. The next call at least is two hours. Next slide please.

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

Hey Paul, this is Charlene.

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

Yeah.

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

At the same level, I think Leslie did a great job with Christine in terms of looking at standards around certainly patient-generated data and at least putting an approach up there, which I think is very powerful. The other piece, I know there's a lot of feedback on the part of the vendors relative to the care coordination standards, and those were recommended from the Standards Committee. So I hope – we need some clarity in that space, okay, relative to – it could be the vendors haven't looked at them yet, but I think that would be helpful, if you have the Standards Committee coming back to the table. So that was in the slide set today, but it was – we didn't get to it.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Specifically for which items Charlene?

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

These were under notifications and the four use cases under care coordina – under the CDA, under sharing the patient summary data.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

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

And so Charlene, do they already have that assignment?

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

I – they –

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

Sorry, this is Michelle, I am still on, but I'm on the plane. They don't have anything from Category 3 right now that they're looking at. They're looking at notification – I should say that, but other than that, they don't have anything else. So Charlene, can you follow up with me offline, because the Implementation Workgroup has a call, so –

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

I can do that – fine.

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

Okay thank you.

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

I will do that. Thank you.

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

Yeah, great. Thanks Michelle. One more advance slide please. And, I think we're – where's the slides – okay, hang on right here. Okay, let's work off of this then, Christine. How do you want to change this?

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

Ah, okay. So this would say, provide the ability to electronically submit patient-generated health information through structured, semi-structured questionnaires and then the e.g. And then I think so after the parentheses, we would say comma, secure messaging comma or provider approved devices with a little asterisk.

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

And that asterisk we need to have addressed by the time we present in January.

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

Yeah.

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

And also I believe this has been changed to 5%, which is the same as Stage 2.

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

No, this is PGHD, you're thinking – which isn't in Stage 2, you're thinking of secure messaging –

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

Sorry.

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

– which is – yeah.

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

Okay, I did confuse those.

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

And this is just a provide the ability; this is totally different than a use –

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

Got it.

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

– which is what secure messaging is.

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

Okay. Okay.

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

Now – but again, my only concern here is I don't know which version of the objectives we're going with, so we should – let's see here – yeah. I don't think there is a change to amendments, except that we just need to make sure in the same way that we want providers to be able to receive, respond, review and record PGHD, same thing with amendments, but I don't think we need to edit the objective itself.

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

Yeah, in a sense this has – you made the assertion that amendments are PGHD, this actually is a separate objective, would you like to include that with this one or do you want to keep it separate?

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

Well, I thought about this and I think the challenge is we wanted to keep it separate because it was – remember that we – this whole thing started with the obvious manner, like we needed to provide patients a way to do this that was not just easy, but it was like obvious how you would do that. So I think the intent was a little different, the intent was not really necessarily to collect PGHD, it was to make it easy for patients because we know that there are many problems with data in the record and once patients see it, they can spot those things. So we just want to make it eas – so my instinct is to keep it separate.

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

Which I think turns into a certification criteria only in a sense.

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

It still is a certification – amendments is – has always been a certification only criteria.

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

So any other chan – so what does the group think, so Christine's amendment to our previous recommendation is that we include comma SPM comma or provider approved devices asterisk, the discussion we had.

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

So this is Mike. As long as I don't have to be able to sift through the secure messages to figure out which ones meet or don't meet the patient-generated health information criteria, I'd be okay with it.

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

Well I think we agreed in our discussion that we – unless someone brings forward evidence that all of us who use this already our anecdotal information is that the vast majority is PGHD.

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

Right, but even if we did uncover evidence that that wasn't the case, I think it's not an option to make people sift through messages or make vendors try to figure out a standard, we would just have to remove the secure messaging channel from this.

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

Right.

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

Okay. Okay, great. Thanks. Next, I don't know where the next –

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

Well that's it from – I mean, those are the two – we did have though – my only other question is, I mean, we – I'm not sure which format we're presenting to the Policy Committee, because we keep having this one in here, but then we had the other one with the columns and it's confusing to me. So I do have on my list to send Michelle some edits to the version that has a column on the far right hand side, because I think that we didn't quite articulate the outcomes correctly. There are some other things that I think got lost in translation, but I don't know which version we're really presenting.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And Christine, we're still using secure messaging, correct? I mean –

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

Uh huh, yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– possible – yeah, okay.

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

Altatum, is there any other slides that have our Category 2 recommendations with the three columns?

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

This is Michelle, no. There was a word document attached that has them from Stage 2 –

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

Okay.

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

– but this one just has the former ones that were presented in August and then the current ones in the middle. The plan for the next meeting is to remove that gray column on the left and there will just be two columns.

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

So –

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

Okay, so I think – I know that I owe you Michelle that I said it right, I'm halfway done with it, making sure nothing got lost in the translation for Category 2, because I think some things did, like on secure messaging, it didn't translate over because – it came over as a provide the ability, not a use. So, I need to – I'll do that in advance of the next call, so we're ready.

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

Is there any other item from Category 2 that we need to review Michelle, in case you are still on?

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

There was a VDT question to the Consumer Technology Workgroup, but I have to drop now.

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

Okay. Thank you. Bye, bye. Is there –

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

So Leslie, that's Leslie's group. What was the VDT question, do we know?

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

Um, certification criteria around translating medical information into plain language.

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

Ah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, and there really – we looked at that, there is no standard. The Center for Plain Language talks about a checklist that can be done to work on plain language, but there is no certification body today that actually is certifying for content. So we could recommend that in fact plain language is available for patient instructions or patient instructions to be written in plain language and the languages that we've mentioned in meaningful use. But – and we could state that as identified by the Center for Plain Language, in the recommendation, but it isn't a certification body per se, or a checklist of – or something that translates or verifies that the language is plain language. It would be something that someone would self-attest to, to say, yes, I've used the Center for Plain Language criteria for defining plain language.

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

Okay –

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

Well I think – can I jump in? I think –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah.

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

– when, because we got this feedback from I think it was actually a bunch of public comments or some letters, I forget, but, and I think it's right on, but when we were thinking about how to respond to it, we were talking about things like connecting the Medline Plus Connect.

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

Correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah.

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

That's just a medical jargon thing, not overly complicating things and requiring a bunch of standards; it's just Medline Plus Connect.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, that would not be appropriate because that's mandating a government solution only and eliminating market opportunity. So –

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

Ah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– you can't do that. So, we would not recommend, just as we wouldn't recommend an EHR that the government had put up as the only standard for EHR. So to get to the plain language issue, we can note that plain language is a preferred and we encourage organizations to use the checklist as defined by the Center for Plain Language, but there is not a certification body and we would not mandate use by a government entity.

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

Okay, we can give it as an e.g. of course.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

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

Yeah.

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

Okay, I think that – hopefully then that covers our Category 2, because we have to end this and open it to public comment. The next on the list then would be to cover Category 1 on our next call, after we get feedback from the Standards Committee on some of these issues, hopefully, although it's a fast turnaround, on the PGHD as well with devices.

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

Yeah Paul, I think that's right, I just want to reserve the right to make a couple of corrections to –

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

Sure.

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

Okay, so – but they're – it's all stuff that we've already talked about and agreed on.

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

Okay. So if you just pa – work with Michelle on that and I'll take a look at it and we'll try and get that –

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

Great.

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

Yeah. Anything else before we open to public comment? I appreciate everybody being on the call and having this robust discussion. It's certainly something, as Christine pointed out, we've had on our minds since the very beginning and I think it's been very helpful to enumerate all of these things we have to get worked out.

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

And Paul, we are on tap to present at the Policy Committee, to do the same presentation. I'll revise it a little bit, but to do the same presentation, if you still want us to, Leslie and I.

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

Uh, let me – can we chat a little bit offline, I can even chat right after this call, just to sort of –

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

Sure.

Public Comments

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

– yeah, brainstorm a little bit on that. Okay, can we open to public comment please?

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 and Technology Officer – Palo Alto Medical Foundation

Very good. Okay, well thank you very much and look forward to seeing some of you in a couple of days. Talk to you next time. Bye, bye.