

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

Presentation

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there is public comment on the agenda and the call is being recorded so please make sure you identify yourself when speaking. I'll now go through the roll call. Paul Tang?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, George. David Bates?

David W. Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, David. Christine Bechtel?

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

Good morning.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning, Christine. Neil Calman?

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Neil. Art Davidson?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Art. Paul Egerman? Marty Fattig?

Marty Fattig, MHA – CEO – Nemaha County Hospital

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Marty. Leslie Kelly Hall? David Lansky? Deven McGraw?

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Deven. Marc Overhage? Charlene Underwood?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Charlene. Mike Zaroukian?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Mike. Amy Zimmerman? Tim Cromwell? Joe Francis? Greg Pace? Marty Rice? Rob Tagalicod? And any ONC staff members on the line if you could identify yourself please?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Michelle.

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

Elise Anthony.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Elise and with that I'll turn it back to you Paul.

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

Thanks, MacKenzie, so welcome everybody and thanks for the great attendance today and during summer, we continue to have good and important work as we prepare to prepare our draft recommendations for the full committee in August and then our final recommendations in September, at least for the Meaningful Use objectives and criteria. So, today's agenda is to continue discussion of the Subgroup 2 on Engaging Patients and Families, and Christine Bechtel is going to lead us through that. Christine?

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

All right, good morning, so let's go to the first sort of substantive slide, okay, so these are – this is a list of everything in our Subgroup, we went back over the last couple of months and did work to respond to the public comments and to clarify things. So, let's just dive right in and go to the next slide.

Okay, so the first biggie is view, download, transmit of course and so you can see sort of highlighted in red the additions and changes that we made. So, the first is that we did, as you guys recall, consolidate the amendment function into view, download, transmit and we struggled with the idea of should we create a common user experience by having a standardized branded button, the answer to that ended up being "no" and so we've just clarified it and left it as provide patients with an easy way to request an amendment to their record on line, which would be offer corrections, updates or additions to the record and that's consistent with HIPAA we just need to make sure that the technology supports a fairly easy and obvious way to do that, in fact our old language said in an obvious manner and folks wanted some clarification. So, this is the piece that we settled on as a Subgroup. Any comments on that?

Okay, so the next is a menu objective that we refined and this is the Automated Blue Button. So, the objective is to give patients the ability to designate who and when a summary of care document is sent to someone or some place that they prefer. So, this is again, leveraging the Automated Blue Button Initiative that ONC has been shepherding and that is going very well.

So, the measure here is to capture patient preferences for 50 percent of unique patients and I would just add one thing here. So, there are some examples that we've included of designated recipient, so, first would be, you know, a one-time request to send information from a specialist back to primary care or something like that.

The second would be standing request, that's the automated piece, to always send an updated care summary when certain events arise. So, when a primary care doctor changes my medication list I'd like a copy of that to go to my cardiologist for example.

And then the one thing that I would add that we certainly intended is or they have no preference and they don't want it sent anywhere and so that would of course count in the recordings. Any comments or questions about that?

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Yeah, this is Neil, I have a question, in the last bullet it wasn't clear to me what we were suggesting. Were we suggesting that there be like a drop down list of which of the following events – for which of the following events would you like us to always send and update or is it kind of like are we dichotomizing this so that, you know, the second bullet really is every time anyone of these things happens we're going to send an update and that list of those happenings is the same across the board and part of our requirement? In other words, are we prescribing what that is or are we giving people options to select various triggers for the automated updates, you know, I think this can get very complicated.

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

It's a good question Neil and I'm not sure how the ABBI Initiative is doing it in practice. I don't know if Leslie or Michelle or anybody from ONC has some insight into that. We can certainly find out, but I think, you know, the root of your question is a good one, which is – or the point you're making, which is, you know, it needs to probably be a standardized and easy way to do it so it doesn't create lots of confusion, but I think we need to ask how it's happening in practice.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

And the other question is really that's also related is because we're saying that we want people to have the ability to designate to who and when, that could be like a very complex matrix, right? So, I want my, you know, cardiologist to only get something when there is a medication change, but I want my primary care doctor to get something under these four conditions and I want my other doctor, my psychiatrist to only get something, you know, if it's related to a mental health diagnosis.

It's like, you know, it can be – we're developing multiple orders of issues here both in terms of variability in what we want sent, to whom we want it sent and under what conditions. So, I think it's, you know, since this is our first sort of go around at really doing this, I think we need to think about keeping it fairly simple so that people really can engage in this discussion with their patients.

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

Right, so I agree with that and I would just say that is – I don't think we're trying to design here for everything under the sun and it's the reason why there is a one-time request option so that if there is a fixed list and we can certainly suggest that list then if your needs aren't on that list then you use the one-time request feature.

I also would just point out one thing, which is I do think that this has a direct relationship to help building the list of care team members in the care summary. So, I think you're getting in some ways a twofer here because you can really link those two together.

David W. Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

This is David Bates, it seems to me like this could just create an enormous amount of extra work for providers. It's not clear to me why we would ask the patient to do this.

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

So, is this – yeah, I mean, sorry.

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

I was going to add another piece and then potentially make a suggestion here. So, another piece is you say, patient preference account for 50 percent of unique patients, now the matrix you heard Neil describe, then I have another doctor and what do I do go back and do each of those selections for the new doctor and does that count as part of the denominator, at any rate, so you can see how complex this is becoming.

Potentially one suggestion is that this is something – it's almost like a preference you set up on any website, you know, notify me if, so is it possible that we should be saying this is something that you provide the capability on the patient portal or the PHR.

So, the patient obviously is doing as much or as little about this matrix as the patient wants to do and can do it across the board, but it doesn't make it a doctor or hospital's responsibility to do something with the numerator or denominator.

So, the EHR vendors have to make this possible and the providers have to turn it on and, you know, we can to through our usual discussion does it turned on, is it a percent, but it seems like that's less confusing than having to deal with all these permutations.

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

The – I think, this is George, I think we need to step back and say what are we solving here? So, number one is if you're admitted through the emergency room you want your PCP to hear about it but that's a different objective I think, right, so that's that purpose.

Two, if the purpose of this is to not only say I want to send my – this information to my psychiatrist and that to my internist what you're really doing is trying to control the flow so that other things don't go there then you need a different system which says what not to send not saying what to send, so I don't think the purpose of this is to restrict information.

In order for this to work HIE has to work, we have to have provider directories. If all that stuff works then why do I need to send the summary of care can't the second doctor just request the information when they want to see it?

So, it seems to me we're mixing together the ability to get to the patient record which should be done as a pull instead of a push with the desire to notify your healthcare provider that there has been an event that they should asynchronously hear about.

And then the question is what's our threshold for importance, being admitted to the hospital is probably high enough, changing the dose of the medication is important but I don't know if I want every provider to get an alert every time one of my providers changes the dose slightly. So, I think this is duplicative.

I think we have three sets of objectives and we only need two of them and I don't know which two, but one of them is emergency "I just got admitted." Two is, be able to get to the information when I need it. And three is to send the information, you know, preemptively. I think this one is really duplicative of the other two.

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

So, it's Christine, I would say a couple of things. I think the goal of this is to make care coordination a lot easier and a lot more patient centered. I'm struggling a little bit because ONC has a whole initiative around this, there was a White House Summit around this exact topic and they want this to go forward. There was a lot of discussion at that summit about how great it is that there is a menu objective in Meaningful Use for it and how important that was.

So, I'm struggling to reconcile both sides of this, because this is a big priority it seems for the administration. I think patients clearly would benefit from this, but the goal is really to facilitate a much easier process in care coordination that takes some of the burden off the provider of responding to requests all the time for sharing information.

Now the other thing I'll point out is this is a menu objective, so if you don't, you know, want to do this as a provider you don't have to. My suggestion would be that we go get a little more information before we make changes from ONC because this is again a big priority for them.

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

So, this is Mike, if I could take the consumer side of it, so I agree fundamentally with what Paul says but I also resonant around the other points. The biggest thing, if I were taking the consumer perspective is if I need the ability to be able to transmit the health information that needs to be made available to me on my portal for example it would be nice to have not only the ability to manually decide, in other words, my preferences are to transmit none of it unless I actively make the decision on a case-by-case basis or to set up some rules.

But again I think the whole point is if the availability is present in the certified technology, if I have the widgets I need to be able to say certain things always go to my PCP and only certain other things go elsewhere that's fine, but again, rather than it being the burden of the provider the patient has full control over it which I think speaks to some of the desire to protect patient privacy and what they choose to share and transmit with others.

So, I think if we can do a combination that supports that, but again, mostly in what either certification allows for or what the patient has control over in the portal rather than capturing the patient preferences let them go ahead and designate those preferences themselves within the portal.

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

So, just to clarify again, Christine, this is Paul –

David W. Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

Go ahead.

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

Just to clarify, Christine, I think each one of us who has spoken is in support of the Automated Blue Button and the patient's control. I think the comment is the way this is written it almost takes away some of that control from the patients. In other words, this is now saying the provider has to be the intermediary of setting the preferences when really you would like the patient any time day or night to be able to direct things to and fro and that seems like a win/win. So, not only does the patient have control the patient expresses their wishes, it can change at any time, it's not adding to what goes on in the exam room, which you want to be mostly on the care side.

David W. Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

This is David Bates, I'm in support of what George talked about any time there is an emergency you want to know about that, the one-time thing is okay. The way things work in our record now, let me give you tangible example, I get notes from every doctor who is treating one of my patients say for cancer, most of the time they're just getting their cancer treatment, there is nothing new and I don't really care about it that much.

I only care about it if there is some change in what is going on with them or if there is something that I need to do for them and I'm very happy to hear about those things, but right now I can't tell what's what. I get sent all these notes and I have to spend quite a lot of time going through them and trying to figure out is there anything that I should care about here or not and I would say 98 percent of the time there is nothing that I care about and I can imagine that we would start sending a whole lot of things about people's medicines changing to providers and they just would not find it useful.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

You also, as you increase volume you run the risk of missing things that are really important.

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

So, what I hear Paul proposing would not address the issues that David and Neil are raising though, it's still going to – I mean, it's still going to – whether or not you just make the functionality available on the portal and hope patients see it or ask them what are your preferences then you're still potentially going to be enabling the patient to direct what they think is important in terms of information sending and receipt.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

This is Deven, I guess the thing that I'm getting stuck on here is, you know, the menu objective leaves this at the discretion of the eligible provider to determine whether or not they are going to do this for their Meaningful Use eligibility purposes and having it be menu is what's needed to facilitate the technical capabilities to get it done. So, since nobody is required to do this but some people may in fact want to offer it if that technical capability is there I guess I just don't understand the push back.

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

So, this is Mike, part of the reason is that menus become core and then the way the menu is written becomes the burden of core later and you don't have a choice of how you implement it afterwards.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Well, that's not necessarily true, I mean, we as a working group and then the Policy Committee we actually make – we actually consider whether all menu items or when menu items are ready for core but – automatic step.

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

I understand but I also have the experience of living through it, so all I'm trying to say is that if we're going to try to get a menu item right we should try to get it right and again, the last thing I want to do as a primary care provider is go through this long elaborate interview process for their preferences for how they want to get documents sent to who which could change two weeks later after their next meeting with the cardiologist and now they have new preferences that they should be able to manage.

David's point is a really, really important point. We can at least coach our patients through the issue of your automatically routing stuff to me that doesn't matter.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah.

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

And I want to be careful of that and meanwhile I'll trust my oncologist to send me the notes that do matter in that regard and I can have that professional collegial relationship, but there is definitely a risk of too much noise to be able to catch the important signals if everything comes all the time.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Deven, there is one other thing too, which is that, you know, I think if you make it so complicated that nobody picks the menu objective we haven't really gotten anywhere.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Right.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

I mean, the way to do it is to make it practical and real so that a lot of people pick it because we're trying to move this forward and the last thing I would want to do is make this one of those menu objectives that everybody looks at and says "we can't possibly do this."

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Right, which I get and I get the noise issue too actually. What if the item were for fewer patients so that it was offered more as an experiment that the provider could choose to do with a smaller select group of their patients, would that make more sense?

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

In other words that the threshold was lower?

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

This is Art –

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah.

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

Yes.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

A lot lower.

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

So, this is Mike again, you know, and Paul and I have made these points at some of the earlier meetings –

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

And my apologies for not being part of those conversations.

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

No, no, no, no that's okay, no I just wanted to summarize for those who –

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

That's a Subgroup though Deven you weren't on the Subgroup so you weren't supposed to be there.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Right.

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

Yeah, so, I just wanted to reiterate some of it, Paul, I think described it quite well and Paul you can speak up, but the notion is we want to have this capability available. I would love to have it there, I just want to manage it. I also want to encourage patients to use it but I'm not fond of meeting a certain threshold or trying to figure out numerators or denominators. If it's in place, if it's activated in my practice I will have some patients use it. The easier it is to use the more it yields the benefits for them and their caregivers, the more they will designate the transmission when it's helpful to them.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah.

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

And that's fine, but the key issue is it will evolve as it shows itself to have value to patients and the providers they work with.

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

So, I think your proposal on the table – but I want to make sure Art – Art were you trying to speak up?

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

Yeah, I was making another – go ahead and I'll come back to this in just a minute, go ahead.

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

Okay.

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

And there was just one more – I just want to add one more dimension in as we think this through, which, again as you think of in talking this through in terms of patient preference there is just a lot of different types of communication to patients so that process in itself could get complex, but that being said, again this is assuming and the conversation that we're having is that there is a single patient portal at every hospital and every physician practice and in some cases there is a centralized means where they go to the, you know, the state portal or that kind of thing.

So, again, as we think this through, you know, if the patient signs up and there is a common shared portal for them, because maybe they don't want to go all these different places then we also have to consider that case as we think this through and I don't think we want to preclude that in terms of view, download and transmit capability.

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

And I would agree with that Charlene, I think though, you know, that those preferences could be captured and then transmitted at that point. So, I agree with you we need to be sort of agnostic as to how, but I think what I'm hearing is there are two proposals on the table, so one is have the measure be that patient preferences are captured for 10 percent or let's throw, you know, some smaller number of unique patients and it's a menu item.

The other is to say it's still a menu item but it is offer patients the ability to designate who and when a summary of care document is sent. So, it's just an offer, but there is not a requirement to capture a certain threshold of preferences.

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

So, this is Art, I just wanted to go back to what I thought was one of the original complaints and that was the last bullet that I think Neil pointed us to, so what would happen if we just said that there is a one-time request as the first bullet says and then just that there is a standing request for care summary updates and leave it without the, you know, specific certain events that would get to the matrix that Neil described because I think that – I think you're hearing us Christine say that this is all something we agree with it's just that we don't want to make it too complex.

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

This is George, can I just clarify, I'm not sure we all agree. Number one, remember the burden is not on the provider who picks this menu objective it's the other providers who receive these things from everyone who picks this as a menu objective that's number one.

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

But, George, just a second, I was not talking about providers, I think that's what Christine is suggesting that this is about other caregivers getting this information as well.

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

Yes, we have to include other care providers, all right, all right, yeah, yeah, yeah, yes, yes.

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

So, this is Mike, it depends on who has to capture it whether it's the provider who capture it, the system captures it through patient actions that do not require the provider input, the other part is if we make a standing request to always send an updated care summary when any event arises then I as an oncologist, I'm not an oncologist, but if I were an oncologist I might ostensibly get a change in a care summary that indicates the patient is going to be seeing a dermatologist because they're primary care physician set something up, but technically that's a change to their summary care record and then I'm going to get a copy of that only to look for that one signal change in a sea of other things that are not different.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

And –

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

Let me just finish – so the long-term goal, I think, is that we have what feels like a comprehensive longitudinal record that's available for that patient's care within limits of what privacy limitations I want to put on it that's our goal. I think this tends toward throwing 100 pieces of paper around the system.

So, what I would suggest is that we work so that providers get only alert for the events that they need to be alerted about and that goes in that other objective and that this sending of summary of care records is for non-providers to help the care team and their part, but that we're not sending it to the person who could just go on-line and get it via HIE anyway so I don't need to get 100 copies of the summary of care record.

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

Right, I agree.

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

So, I think the goal is that when the – well there's a lot of goals, right? Cost reduction is one of them, because you want, you know, one provider to know when, you know, a test was done so that perhaps they can get access to the results things like that and they don't have to repeat it, but I think the core of this is patient is on the care team and is able to share the information that they think is important as it changes and then back to Mike's point there will certainly be some need for coaching with patients to say, you know, I don't really need all of that you're sending me I only need X, Y and Z.

But it reminds me of all the, you know, experiences that many people have had where doctors are giving out a cell phone or e-mail and many are hesitant to do it but they find that when they do it patients don't actually use it that much because they want to be very respectful of, you know, the practices time or the doctor's time. So, I think what I'm hearing is it sounds like the better approach here would be to offer patients the ability to designate without having a required threshold for how many patients actually record their preferences.

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

I think that's right and I've been thinking all this time, since David brought up the point, about the overload how to get around, you know, how to address that. The difference between the giving out your cell phone, because people understand, oh, I'm going to contact – there is no way actually for the patient to understand – the patient wants everybody to be in touch with everyone, they are probably not thinking that if I keep sending all this stuff it is going to be hard for the recipient to sort through it.

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

I'm not sure I agree with that.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Not just hard, it really is dangerous.

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

Yeah, I totally agree with that.

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

Wait, wait, wait.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

It's more than just difficult, it's dangerous when you have – I mean, it's the same as alert fatigue, it's the same as all these – when you're inundated with information that's irrelevant you tend to ignore all of it because there is no way to sort through the stuff in a way that's timely and practical and so, you know, from my perspective I think the first bullet is terrific and I think it accomplishes a lot it says, you know, if you want somebody to send this record you go on-line, you go to your portal, you tell somebody please send this to my care manager and the patient knows when an important event has happened, and I think that they then go – when an important event happens they go in and they transmit the record one time.

But, I think, these standing transmissions are really going to be problematic in multiple ways and, you know, I think we should discourage it in the beginning until people, you know, I'm going to say it, I'd rather have the provider say, listen any time this happens, any time you go to the ER please send me a copy of your record, you know, but now we're getting this stuff through exchange, you know, or have a care manager say, listen if you want me to really be able to do good care management and care coordination with you I want to – and help you coordinate your specialty visits, every time you go to one I want you to go on-line and send me a copy of this record, of your record.

So, I would rather see this be, you know, a single sort of, you know, stress the bullet and have people then encouraged by their care management people and by their providers to basically to do this and make it – because that engages them more in the process. I think just going in and doing a standing order is not even – shouldn't even be considered patient engagement because this stuff is just being splattered all over the place.

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

Christine, would you –

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

So, let me just say one thing here. When we, in the Subgroup when we were having this discussion actually we were having a similar discussion about the care summary and we – about patient generated health data and we talked about the ability, which I think Mike you were the one that talked about how you have this ability in your system today for the provider to review and accept only those pieces of information that are relevant.

So, in that case I'm less concerned about the danger of – you know, in that case I think my concern is that what we're doing by saying the – we're saying the burden is on the patient instead of the doctor, that every time you know there is a medication list update and you want that sent you've got to go in manually do this and it reminds me of PHRs how when patients had to do a lot of manual work they didn't do it.

So, I'm worried that if we shift the burden to the patient we're not really going to solve it and this won't be in use that instead I'm suggesting that we leave the transmission in there knowing that – the automated piece, knowing that providers have the ability to review and accept and knowing that they have the ability to work with patients and explain the circumstances under which they should have a preset automated piece, right?

So, all we're doing is saying, instead of, oh, you just – every time this happens you have to go in, the provider is saying every time this happens just set up an auto feed so that every time that particular event happens I know about it, but it makes it a lot easier for the patient, it's still the same coaching process.

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

So, this is –

David W. Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

This is David, the way that we do this now is we do it and it's been very popular and we've done it for a long time, but the patient doesn't have to choose. I mean, every time somebody shows up in the ED gets admitted to the hospital, you know, gets discharged from the hospital we send a note to the primary care provider and, you know, that has worked very well, it's automated and nobody has asked and the messages reliably go.

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

I think that's covered by a separate objective, right?

David W. Bates, MD, MSc – Senior Vice President for Quality and Safety – Brigham & Women's Hospital & Partners

I think so too.

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

Don't we have a notification of ERs or something like that.

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

Yes, we've got that under, this is Charlene, care coordination.

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

Care coordination, yeah.

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

All right, so this is Mike, a couple of comments in particular because of that issue of the ability to decide what to accept. So, part of the beauty of the system that we have and actually both systems in one way or the other is the ability of what is basically part of its exchange whether patient to provider or other provider to provider, a way of getting structurable data so that a change in the medication list appears as an updateable medication list entry that you can either accept or reject it's not in a piece of paper that might be 10 pages long with the medicines represented in one or another place that one has to search through.

For patient questionnaires, again the questionnaire answers appear in the exact forms that you are going to be finalizing so it's very easy to take the message that came from the patient see it in the context of the work flow and finish the work. So, I think those are ideal states and help to speak to what will succeed over time, but it's not the same as what could be every note from every provider in an unstructured format that could be full of note bloat and other things that represent barriers.

So, I think we just – and the other thing is the issue of thoughtfulness about what to send, so the notion of patients actually seeing what they're sending has merits but also there are some merits to certain documents we all do not object to getting, so we all want to see the patient's emergency department report or at least the important pieces of it, likewise an admission H&P or discharge summary, but that's not necessarily true for every kind of note and the key is to have the functionality reflect that.

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

So, Mike, it's Christine, I just want to clarify, I – and if we need to build a certification criteria to do this we should no doubt about it, but I am assuming that we need to have the capability not to share just a PDF necessarily that if you're going – you know, that you can essentially have both options so that you could have structured data and if we need to build a certification criteria that allows the provider to easily compare the structured data they are receiving with what's in their record and understand the differences and therefore click in, which, you know, right, similar to an amendment then we should build that if it doesn't exist, because that would reduce provider burden through automation.

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

I'd rather look at the feasibility of doing that and explore that with some of the technical staff of ONC then give up right now on the automated feed piece. The other idea that I have is very similar to how we promoted the best practice of having an information screen when a patient does view, download, transmit right? So, that's what Medicare has for example. We could have a screen on this that says, by the way, you know, before you set up this automatic feed make sure you've contacted your other provider's office and discussed what's important.

Neil S. Calman, MD, ABFP, FAFP – President & Cofounder –The Institute for Family Health

Oh, my God.

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

The other thing –

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

But, Christine –

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

Charlene's point earlier that I just want to reflect on too is actually in a way if a patient has a single portal that will make life easier, my big concern is what if the patient sees 10 providers with 10 different portals and sets up rules...

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

Right.

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

Yes, agreed.

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

To send things and they're going 9 times to 10 different doctors.

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

So, Christine, I wonder if – this has really been a really good discussion and I don't think any of us knew all the other things that we've heard. What do you think about the possibility of going with bullet one as your first step on the way to a second step and maybe including certification criteria of enabling some of the second steps, but trying to get some experience, this is very new stuff, get some experience and it's a combination of getting some experience but also culturally changing this entire enterprise on this alternative flow and figuring out how to manage it in a safe way. Would that be a compromise that helps us get to where we all want to go but in stages so that we can learn and adjust on the way?

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

I would –

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

Your biggest point last time that I remember is, gosh if it's too hard or it's even too complex to even think about they just don't do it that's not good either. So, it's a better first step to have everybody do something than to have nobody do anything because it's too complex and we haven't really figured out how to solve all the complexity.

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

So, and I get all the issues that are raised, I just – but I have concerns and I don't love this. I hear that everybody else though is not with me on this point.

So, I think what I would like to explore, the willingness of folks to do, is have that approach, you know, be on the table absolutely but I'd like to go back to ONC and the folks who are doing this already in the field and figure out exactly, you know, the state of play, because if we're not ready we're not ready, but I don't think any of us on the phone are part of the ABBI work. So I'd just like to figure out what's, you know, happening really and what the technical capabilities and the work flows are. So, if we could get some answers to that before we completely go to that proposal Paul I think that would be great for me.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

That's fine.

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

Paul, can I ask a question? This is Art I just wanted to understand again so is there some other place where the patient designates where they want their information to go to other care providers not necessarily medical providers but others in the community their kids, their adults whoever that are around them taking care of them, where is that patient preference indicated here?

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

I think that –

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

This is Michelle on the last call we discussed adding that to the care summary at least a yes/no if there is a caregiver, but that hasn't been finalized. Charlene and I are working on some language but that needs to be brought back to the group.

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

Yes.

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

I mean, when you – can you subscribe to your own care summary after every visit?

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

Well, yes that is already an objective in Stage 2.

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

Is that in this or another objective?

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

It's in another objective and it was part of Stage 2 that you get a – well at least for EPs, well no that's not true, and for hospitals you get a discharge summary or an after visit summary within in Stage 2 I think it's 4 business days and we proposed 24 hours in a couple of slides from now.

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

Okay, so this...

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

For after visit summary, but that's a little different from the care summary which is provider to provider.

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

Michelle, is there an appropriate person to update us on ABBI and experience existing experience and, you know, give them some of the questions that we do have to see what experience there is out there?

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

To be honest I don't know who it is, but I will reach out and identify somebody to speak to it maybe on our next full Workgroup call which I think is the 16th I can have somebody speak to that piece.

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

Yeah, I would start with Erin Poetter, because –

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

Yes.

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

She's been the lead on the White House Summit on patient access and Automated Blue Button so she'll know who to talk to technically.

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

Okay, thanks, Christine.

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

All right, are we ready to move on?

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

Yes, it sounds like we have a plan to get more important information.

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

Okay, great, thanks everybody. All right, so amendments we actually just covered on the last slide so we'll go to the next slide after that is the patient generated health data. So, this is again a menu item and the change in here was just really in the framing and simplifying it because the RFC comments came back and originally this had talked about patient generated health data with respect to high priority health conditions and that confused people because they thought it might be limited and what are they, etcetera. So, we just have generalized it to provide 10 percent of patients with the ability to electronically submit patient generated health information through semi-structured questionnaires.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health This is

Neil, so if you have the ability why are we providing – this is the first time I've seen something like this where we're providing an ability 10 percent of the time. Why wouldn't we be providing the – once you provide the ability in the system are we suggesting that there is a way that we turn this on and off that we say to one patient you're able to do this but to another one that they're not able to do this or are we saying that 10 percent of the patients will do it. I guess I'm confused at what that means.

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

Yeah, I think it's 10 percent of the patients would, you know, you would collect patient generated health data whatever you find most valuable, so we could clarify that instead of provide the ability it would be something probably more like collect patient generated health data from 10 percent of patients.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Or I would just say – why don't we just say provide patients with the ability to submit – I mean, because once you turn it on and you're providing patients with the ability to do it all patients would have the ability to do it.

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

Right, so this is Mike if I could jump in because I do this a lot, you know, so certainly anybody who signed up for our portal can do this, it takes a fair amount of coaching to get a significant number to do it, because it is not yet the easier process than coming in and filling out a paper questionnaire, at least for many, or they may just not see it as urgent or they just may not remember.

So, I think what we want to do again, to the theme that Paul and I have shared over time, is make sure it's available for everybody who has access according to the usual mechanism and it could be electronic other than a portal too by the way, so I mean, it could be things people are doing in the office but – or with other devices separate from a portal, but the point is to both have it able, enabled for the system and then to have evidence that it's being used and if we want to push a certain amount of use we could have that discussion separately, but I think we mostly want to make sure it's in the repertoire, it can be used and then again we work to make it easier, simpler and faster.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

What's the semi, its Deven, what's the semi-structured questionnaire? It's not the clipboard is it?

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

So, this is Mike again, I'll just use my example. So, some of them could be structured data fields like systolic and diastolic blood pressure entries, glucose, it could be the answer to a question about past medical history or review of systems and those are absolutely structured, they fit into a space within the note and can be verified and changed from patient entered data to provider verified, but there might also be another thing that just says comments on how you're feeling.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah, okay.

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

You know, are there other issues you'd like to discuss that would be the unstructured or semi-structured part.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Okay, thank you.

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

You're welcome.

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

So, I think Neil, I'm trying to think of the analogy – we've done this before it's sort of, you know, you do this for X percent of patients but the threshold gets exceeded usually, so that was the approach that we were taking.

We can clarify that it's more, you know, collect patient generated health data from 10 percent of patients and it's a menu item. So, you know, people I would imagine would probably greatly exceed the threshold because the flexibility is so great in terms of what you would be collecting and if you select it then you obviously have kind of a business case for it if you will.

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

Right, so this is Mike, I would say that's possibly true in principle and in fact I'm a strong advocate for this I think it's a really, really good thing to have, whether or not people achieve the 10 percent or 50 percent or whatever will depend on how well the vendor has implemented it at the portal level or device level, how well they've made it easy for the provider to use it in the EHR and then how well trained people are in the process. So, I'm agreeing with you but I'm not quite as sanguine about if it's in place it's kind of a given that people will exceed the 10 percent threshold easily, it kind of depends.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Right, is there a – Mike it's Deven, is there – so, a point at which you could try this as a menu objective and then if in fact the interface is not working as well as you would imagine you still have time to sort of pick another 1 or 2 menu objectives or how does this end up working, you know, again noting that it frequently is the case that the technical piece, no offense Charlene, doesn't work as well as one would hope and that sometimes is a function of the technology and maybe even more often a function of sort of work flow and whether the office can get adjusted to using it.

But, you know, is there a point at which, and this is always, you know, something that we deal with in terms of setting specific objectives that, you know, people could make a good faith effort to try and then find that it's a lot harder than they thought. The fact that it's a menu objective sort of enables them to bail on it, but what is –

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

Deven, its Christine –

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

In terms of meeting menu objectives overall I guess is my question?

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

My guess is though that they wouldn't want to bail on the objective they would want to change the type of information they're collecting. So you could imagine, the definition of patient generated health data is so broad.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah, right.

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

That you could imagine that people, you know, maybe they try to collect information about functional status or, you know, readiness to change patient activation which have really large impacts on clinical care and treatment recommendations but if they can't get there for some reason they've used an instrument that is too cumbersome or whatever they could pivot and say, okay let's do pre-visit agendas which applies to, you know, the entire patient population and ask that folks, you know, submit before they come in their list of, you know, topics for example.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Okay, that makes sense.

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

I think they are more likely to shift the content than the menu item.

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

Right, so this is Mike, and again I think that's possible but again it depends on the overall functionality, the other part that I think we need to define for the vendors as well as for the providers is what constitutes semi-structured from the other end of it? So, you could imagine setting up a portal saying that it's structured but if it doesn't connect the structured data fields in the EMR then is that still a structured or semi-structured questionnaire, because it certainly would have –

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

No, the structure –

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

Less value to the provider.

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

Like the structure is in the questionnaire it's not necessarily the data and actually it used to say structured or semi-structured and we can go back to that language, but it's really about, you know, we're trying to set up the capability so that if you want to easily integrate that it is – you have the capability to do that because the data is structured, but it's not necessarily the requirement. This is where we're trying to make it easier for providers to integrate information in an automated way into their record but it doesn't require them to do that it's just – the semi-structured or structured is really a modifier for the survey instrument itself and it was the only way to really keep a broad range of data, you know, open for what providers, you know, might choose to collect.

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

This is Paul, let me make a couple of observations, one, even when the – even for the structured data that's entered in the majority of cases even though it's captured as a pick list in a sense, in the questionnaire that's not the same thing as saying that it will be matched up with something that the providers used to in structured data in the EHR side.

So, you might be saying, the patient enters a blood pressure well that's just like a blood pressure you have in your record, no it's not and it's typically stored in a separate place, it may or may not be able to graph it etcetera, so just let me – it's all connected with interoperability and we have yet another source of data that's not interoperable so just to clarify that piece.

The other comment is – of our Stage 2 objectives and criteria, probably the one that the majority of people are having the most trouble with, at least feedback I get is actually the 5 percent secure patient message, that seems like a low number but it's not a low number for a lot of the specialties and then what will happen is people start gaming or find other ways to make that happen to fulfill the requirement but that sort of undermines some of our primary intent, that's even a problem for – we have probably one of the highest penetrates in terms of patient portal, you know, over $\frac{3}{4}$ of our patients are on-line with us and yet when we run the report, you know, a fair amount of doctors won't qualify.

So, we've got to be sensitive, so even though you say 10 percent it seems like a low number, if you go across specialties it's actually a pretty high number and you don't want people to just fill out a report and not get the value out of it, because it's a new kind of functionality. So, those are my two comments, one is it's unstructured and it's not interoperability.

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

Right, so this is Mike, I want to dovetail on Paul's first comment, because our experience and that of others I've spoken with is that the value in the semi-structured questionnaires is there linkage to structured data fields in the EMR? The minute they lose those is the minute they become just another document that somebody doesn't have time to review and so in our system for example all of those home blood pressures are listed in home blood pressure fields and you can compare those and graph those against the office-based ones and use them to make decisions, decide what a working blood pressure is, etcetera, etcetera.

And so I would want to be very careful to not settle for something that's not likely to move the field in the care quality forward by saying it's structured on the patient end but it just turns out to be a flat file document on the receiving end. I don't think –

Marty Fattig, MHA – CEO – Nemaha County Hospital

Yeah, this is Marty, I think this functionality is going to become very important as we move to population health and so anything we can do here I think will be advantageous down the road.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah.

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

We probably need the Standards Committee, I don't remember if they've weighed on this – it's pretty hard to weigh in because when we stay structured or semi-structured questionnaire well it doesn't define – well, what is it about vital signs, is it about functional status, is it about – and that's where you almost need each one of those, anticipate what are the most common questionnaires that would come in that would be useful and then see whether there are existing standards.

So, one of our most successful pre-visit questionnaires which would fit this model is for pedes as you can anticipate some of the things that very pediatrician needs to ask as people are going through their growth, their well-baby and well-child care and that's an example where you could program it so that it is exactly the fields since you want the same data, it's not as easy for all of us in specialties, it's just an example, OB might be another good example, but many don't have this program.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology

This is Mary Jo Deering, I wonder if I can jump in here? I think some of you have heard before, especially the Subgroup has heard this, that ONC commissioned a technical expert panel on generated health data and specifically asked them to look at some things that could support both the phase 3 recommendations as they were being drafted and then it would continue on later and look more broadly at the field.

And in Christine's other hat or under Christine's other hat for the Consumer Engagement Workgroup there is going to be a listening session on patient generated health data on July 18th and it will include a presentation from the technical expert panel, which does include among other things exactly what you mentioned Paul, you know, having looked at examples in the field of how it's being done among their, you know, observations are, as they frame it, you know, the information that is perceived to be of greatest value to providers if available and so in that presentation you'll see some ideas for some sets of information that are considered, you know, widely appropriate and then wider and then other broader menu of information recognizing that of course all the information is context specific.

So, I don't know if that – if we're at an asynchronous moment here and the timing is bad, but I know that many of you should have been invited to that July 18th listening session and perhaps it would offer some insights that would help with this discussion.

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

I think that's a great point Mary Jo, so perhaps we should take the discussion today and listen in on the 18th and then come back. I know we have – we're going to do something similar with the ABBI piece and we have one other open item. So, perhaps we should take a pause and add this to the open items list. What do folks think of that?

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

This is Mike I'm good with that if I could get an invitation to that because I don't think I've seen it, that would be awesome.

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

Charlene too.

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

That sounds really good and hopefully they'll think a little bit more broadly.

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

We'll just share it with the entire Meaningful Use Workgroup, sorry Paul.

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

No, that's fine.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology

Yeah, I'll have Caitlin send it around.

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

Okay, great. All right, so the next one is the clinical summary on slide 6. So, clinical summary, we didn't make very many changes here, but we had a lot of discussion about it because as you guys have probably heard, you know, in Stage 1 we got some feedback that the clinical summaries were really long and not particularly useful because the list of data required to be in it was so long in terms of the CMS requirements and so, what we did here was to reframe what we intended and make sure that people have the ability going forward to customize it.

So, those are the two changes we made, so the reframing reads now an office visit summary is provided to a patient with relevant and actionable information and instructions pertaining to the visit in the form indicated by the patient, if the provider has the technical capabilities, so that's back to the HIPAA discussion we've had so that they can get their clinical summary in the format that they prefer. So, the measure is essentially the same as it has been since we've been talking about Stage 3. So, within one business day for the stuff that was generated in the visit, for more than 50 percent of office visits.

What we did do though in terms of the customizability is that we learned that the 2014 certification criteria did already for Stage 2 create the ability for providers to customize the way the visit summary looks and the information it contains.

So, what we've done here is clarified our intent so that we're making sure the EHR can draw from the range of existing data but not necessarily have to include everything if it's not pertinent to the visit and then make sure that providers can include and exclude information based on what patients need and we're going to really monitor closely the implementation experience given the new certification criteria. Comments or questions on that?

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

This is Paul, Christine you explained it very well. I would strengthen the language in your certification criteria just to make it explicit that this is a list and then providers can pick from this list. It says that in the words but it is not as clear as what you said and yet that has been one of the things that has caused people to just do a data dump and, you know, caused the problem we were trying to address.

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

Right, okay. So, Michelle we can work on that.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology
Yes.

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

Any other comments?

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

So, this is Mike, just to be sure I'm hearing it right, so the certification criteria to me is very clear that to be certified the provider needs to be able to choose it and I think what I'm hearing – because the slide just came up so I'm trying to read it fast while we're talking, but in the form requested by the patient is that intended to imply that they get to choose the elements that they want or does it mean formatting related things other than content?

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

That's what Paul is suggesting, so, but that's what that line was intended to indicate based on the Subgroup's conversation that can enable providers to include and exclude, that was the language you suggested, Mike.

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

Yes, appreciate it, okay, so that's very helpful to me and that would resolve my concerns, so, thank you.

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

And Christine, this is Charlene, does that imply that it's dynamic or does that imply that it's set up initially?

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

Dynamic and that's what the certification criteria allow for. Do you mean customizable for a patient?

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

No, I'm saying every time I do a care summary for a patient I can dynamically choose what data to include or not, or is it something that I can just tailor when I initially implement my system because it's not clear.

So, you can imagine I'm going to, you know, discharge – I'm going to, you know, discharge my patient or I'm going to complete my visit, do I want to specify what data I want to include or not for that visit or do I want to make it something that's just – I specify on set up?

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

You know, I – we did not – we were silent on that and I'm happy to have a discussion I think it's a very valid question. My instinct is to continue to be silent because I don't – I'm worried about dictating the provider's work flow, so it maybe that they don't want to have to create the visit summary every single time because that's a lot of box clicking, but it may be that – so they set up a template that they like that includes and excludes it and maybe they make adaptations as needed, I don't know, but to me that feels like getting into work flow, so we did not go there as a group.

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

But it's just a lot of development difference in those cases, so, we're – you know, not that I'm – I'm with you I'd really rather not specify it, but there is a lot –

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

But are you saying, Charlene, that the vendor community has to know is this a fully, you know, is this a one-time setup template or is this an every visit time setup. Do you have to know that in advance? Is the coding so different?

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

All right, here's the problem – the problem really comes with certification. Certification has to know that, right? That's the problem.

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

Well, but is it terribly difficult to be able to do both?

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

Yes, actually.

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

It is?

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

The other thing I would say –

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

–

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

The other thing I would say is that the certification criteria is a good fit for what I would want in terms of include and exclude based on patient needs, but the objective is based on the form requested by the patient.

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

No, no, no, no that's a delivery mechanism, Mike, that's not the patient saying, here's what I want in my visit summary, those are two different things. It is, I would like to have this on the portal or printed, e-mail, etcetera.

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

Yeah, this is the provider decision.

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

Yeah, but before we go to – I want to make sure –

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

Okay.

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

Because Charlene I think is raising something that's important. So, you're saying it is really difficult to create both functionalities to have either a template that is customizable one time or a template that is customizable at every point in time, that's hard to do so we have to pick one or the other?

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

Well, no, I mean, I think you're going to get a range out there. So, I think you should put the baseline – maybe you put the baseline, but it's just in certification – I think it should be an approach where again you allow the market to compete, right? But you put your baseline there, you know, because otherwise certification is going to make it up, right? And then we're not going to know what to do until we get the specification.

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

Well, if we do need to do that so others should weigh in, but if we do need to do that then my instance would be to say you make it so it's customizable in each visit because it seems to me that you could set that template up from that approach but it will be harder to say it's a fixed template that can't be customized later, I don't think that's, you know, in the visit context, I don't think that was our intent. Right, so it works one way but not the other is what I'm guessing, but I don't know. What do others think or is this something we need for the Standards Committee to weigh in on?

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

I don't know that – as Charlene pointed out, there is – the development of dynamically customizable is separate and then I think even another aspect is the work flow on the provider's side.

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

Yeah.

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

You might want to just start out – people are likely to program what an after visit summary looks like for all the patients and the market could say, if people decided that they want to customize it individually that's fine, but I'm not sure we would make that a floor for us.

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

So, again, this is Mike though, in order to operationalize the – and we moved forward a slide so if we could go back a slide again, but the issue is if it needs to be modified based on patient needs and since patient's needs are dynamic –

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

Yeah.

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

It's nice to have a default for what I usually consider important, I'd actually love to have something that alerts me to whether or not this elements of the after visit summary is different than the last version, but not withstanding that if I have a default but I can also then say I'm removing this one because it's a page and a half and it doesn't add anything new or I'm adding this because it's relevant in this particular case that is allowing me to adjust it based on patient needs.

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

So, you're arguing the case for the default and the dynamic version?

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

Yes, afraid so.

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

The dynamic meaning every visit?

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

It means I have a default so I don't have to do anything. I can set which of those are my usual component but for that particular patient when the after visit summary options come up –

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

Right.

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

I can see an option to delete one or add others.

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

Yeah, right, right, right I think that was our intent.

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

Yeah.

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

Okay.

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

Yeah.

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

All right now that is dynamic now.

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

Yeah it's dynamic.

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

Right but it's not required for you to do that in every patient.

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

Right.

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

Correct, I understand, but it does –

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

Yes.

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

Yeah.

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

In worse case scenarios I can just ignore it and go with my default. In best case scenario I can customize to the patient's needs and that's good for me.

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

Okay, so that – but we're going to be asking every vendor to be able to do this now.

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

Yeah.

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

Yeah, yes which I think is what the provider community has been asking for as a result of Stage 1.

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

I think they're asking for not printing out the whole chart every time, but that's fine. I have one more nuance on the verbiage.

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

Yes.

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

And it's just a nuance and it's the e.g. printout summary are available online, I would just switch that, the primary thing we're trying to address is the misinterpretation that people are wanting to print stuff out or required to print stuff out.

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

Yeah.

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

If we just switch it to e.g., available online or print out, if appropriate, something like that where you –

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

Well, so –

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

Or just say, you know –

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

Well, Paul, let me – I'm glad you raised that because when I read it again this morning I was like "ugh" I didn't like that either.

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

Right.

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

But the intent is actually the format not the form or maybe it is the form, but –

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

Right.

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

It's in the media requested by the patient and that's what got us into the HIPAA discussion, it's also what enabled us to consolidate the collection of communication preferences and make it only a certification criteria. So, I think we needed – I'm not sure that I would give those two examples – I'm not sure if I would give them at all, but if we did I might say – I might move that phrase so it says pertaining to the visit in the form requested or indicated by the patient, e.g., available on-line, e-mail, printout, etcetera if the provider has the technical capability.

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

Yeah, so this is Mike, that's exactly what clarifies it for me, I keep getting confused with the –

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

Yeah.

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

The parenthesis where they are but if you put it afterwards then form or format, or media all makes more sense to me.

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

Correct.

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

Okay.

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

So, all of those are helpful and I'd just move on-line way up front because we don't want to throw the printout up there.

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

Yeah, I agree with that.

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

Yeah.

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

I agree with that.

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

First preference first, yeah.

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

Yeah.

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

Okay. Okay. All right, great got it. Okay. Okay moving on patient education is the next one but as you guys recall this is one that we really struggled with as a full group, as a subgroup, as a committee, so we originally started with the top 5 Non-English languages spoken nationally provide 80 percent of education materials in at least one of those languages where publically available. We just got way too complex and so where the subgroup ended up is backing way off of that and just saying, provide patient education materials in at least one Non-English language in the format preferred by the patient if the provider has the technical capabilities, so we can again do the e.g. printout on-line, blah, blah, blah, reverse that, but you know what I mean. So, Michelle let's add that phrase again here.

But, anyway it's just provide education materials in at least one Non-English language and the measure is deliver one patient education material like one handout or on-line link to one patient in a language other than English. So, let's –

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

So, this is –

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

I'll tackle the certification requirement in a minute, but go ahead.

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

Yeah, so this is Mike, I think that's great, I think again just for clarification of the measure it may sound a little redundant, but also to say, in the form preferred by the patient, so that whole notion is I can do it without it actually being the patient's preferred language and technically my report would say, yes you complied, but I would like to be able to at least say, the patient indicated their preferred language was Spanish or whatever and that's what you printed or you delivered whatever. Does that make sense?

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

No.

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

So, just in the – other than English in the form preferred by the patient.

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

Well, we already had the language preference in category 1 right, so this would be a good way of exercising that you made that – that the system made that connection.

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

Yeah.

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

Right.

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

Yeah.

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

So, Mike, are you just saying, similar to what we just clarified on the last slide do that here?

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

Yeah, basically I want to make sure the measure is exactly the same as what the objective intends in terms of making sure it's in the form preferred by the patient. So, the measure –

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

Oh, I understand.

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

– about that, yeah.

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

Yes, yes, yes, yes thank you.

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

You're welcome.

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

I will say that I am a little concerned that we've come way back off of this and it's weak, but if nobody else shares that concern, you know, we'll move on.

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

Yeah, I think –

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

–

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

I think our point was that as long as it's available and patients have the preference it will be something we're inclined to do anyway, so proving that it can be done and that we're doing it is the big thing and the other is the limitation some vendors who are creating the materials have and not yet supporting more than 2 languages for most of their handouts.

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

Right, no I think my – I think my concern is really about you've done this one time that's it.

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

So, I just – I'm not sure exactly, this is Art, in the first the certification criteria what does incorporate educational resources really mean to the vendor?

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

It's the InfoButton standard, so with the same standards that were used for Stages 1 and 2 in terms of patient education material, so what we're saying here is there is going to have – and I'm actually not sure we have to enumerate the certification criteria number one at all because we never have before, but because the measure naturally becomes a certification criteria, the functionality behind the measure or the objective I guess, so maybe we want to take that out because I think it is confusing.

Michelle, correct me if I'm wrong, but this is, you know, essentially there is a measure and the system has to be able to meet it, so I don't know that we need to enumerate that particular certification criteria at all.

The second one we do because there is no measure or objective associated with it and I can get to that one in a second. But does that make sense to folks to just delete that certification criteria number one?

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

Yeah, I think it does, I think the language of the objective in the measure as it stands right now doesn't really draw any attention to the certified EHR technology as the Stage 2 final rule is stating. I don't really see how the objective in the measure right now –

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

Yeah.

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

Could be satisfied with must paper.

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

Right, so I think you're absolutely right, so we need to reference patient specific education resources identified by the certified EHR technology.

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

Right.

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

Yeah, that's a good call, Art.

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

So, this is Mike, I'll push it one more step then too, because it would actually help us with the signal to noise ratio, if a patient expresses a preference for Spanish let's say, should the EHR offer the Spanish version rather than the English version as the automated request?

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

Yes, but I think that's what we were trying to say when we said, in a language other than English.

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

Is that not clear Mike or is that what you mean?

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

I think it's not clear that the certified EHR technology has to suggest that specific education resource versus that resource in that language.

Neil S. Calman, MD, ABFP, FAFP – President & Cofounder –The Institute for Family Health

In other words that would also – that would also support the capture of the patient preferred language right?

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

Exactly.

Neil S. Calman, MD, ABFP, FAFP – President & Cofounder –The Institute for Family Health

If it had to be done in an automated fashion to match.

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

Yeah.

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

So, I have the luxury of an EHR that can show 8 languages for certain surgical postoperative conditions and the surgeon has to pick from the ones that they are interested in which is a list of 8 items and if it was tied to the preference they would see the preference and be reminded number one to do the right thing, which is a great feature and help them with efficiency.

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

Okay, I got you. So, I think it needs to say – okay, we have like way too many adjective phrases, so let us figure it out, but I think the key is you need to use the certified EHR to identify an educational material, the material itself needs to be in the patient's preferred Non-English language.

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

If available, yes.

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

Right?

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

Yes.

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

Yes, okay, so we need to do all three but we're going to have to probably translate this into two sentences. So, okay. All right.

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

And I personally, just to weigh in, I'm not confused by certification criteria number one and two both being there I could go either way but it really is nice within the rule itself to see what are the certification pieces this ties to. So, if you're going to show one it can be helpful to show both, but I don't have a strong feeling about it.

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

Well, I think –

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

Well in a sense we don't always write down our own certification criteria, the fact that we changed our measure to say that it's really – you're only getting credit when the system decides this is what the patient – that makes certification criteria fit that, so, I mean, that's what the ONC does on the back end.

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

Right, so I think we do need to take the certification criteria one out because we don't do that for every one. From a policy side we only enumerate a certification criteria where we don't have a particular measure or objective but we want a function to be available. So, to be consistent we'll take out number one.

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

Okay, fair enough, thanks.

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

Now with respect to number two one of the things you guys know in the first policy priority is a certification criteria to collect disability status, what we wanted to do here with the certification criteria number two that you see on your screen is be able to create the functionality in an EHR where if you have a visually impaired person then it would begin to help you identify patient education materials that are tailored to individuals with that particular disability.

So, this is just creating the function, but it's basically telling the Standards Committee we want to do that and that would – for those who choose to collect disability status it would help them identify appropriate education materials, so, that's what that criteria is. Any comments or questions on that?

Okay, all right, so secure messaging and I think we've talked about this before, but we went from the proposed 10 percent back to the 5 percent which is the same as Stage 2 was and then the second thing we did here was we created a certification requirement to enable providers to measure and report their response times so that they know if they're being responsive or not, so it's just a certification requirement so we know all systems have the ability to – many do today but not all, so that's what that is.

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

Just one comment, so people will ask, well what defines a response is it the first reply back in which case people can program I got your message and instantly qualify and the mode I guess what you mean is telephone or something.

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

Yes right, because you guys had raised on the Subgroup, you know, well what if I get a secure message but then I end up calling them and closing the loop and clearing out the response that way.

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

Right.

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

So, and actually Michelle spoke with a couple of different folks who were doing this in the field and they had suggested that as well.

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

The other one and I thought this was here so maybe it's in a different category, but the ability for the patient to indicate when you submit don't need a response, because when they're giving – there is a lot of times when they're giving feedback information, etcetera, which doesn't require a response and then if we put in a turnaround time we inadvertently or unintentionally create a burden and then create traffic that doesn't need to be there. Do you see what I'm saying?

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

Yes, sure. Okay. So, we'll clarify the mode saying and add the ability of patients to flag that no response is needed or to indicate that no response is needed. All right are we ready to move on?

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Yes.

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

Okay, so communication preferences is the next one, we talked about this briefly a second ago it's certification only so it was consolidated because the communication preferences need to be identified and tracked per the existing objectives around patient education materials, after visit summary and something else that I'm blanking on, but nonetheless so we're just clarifying here that in fact by Stage 3 you're not recording them as a separate objective but you're going to need to in order to meet the other objectives, so it's the certification criteria.

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

So, just a question, in the e.g. you mentioned text I hope that doesn't mean text messaging, lots of – I mean – HIPAA –

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

It does.

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

It does?

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yeah.

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

Okay, so, Deven is saying that's okay, but let me ask –

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

The same analysis applies, yeah.

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

Sorry?

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

The same analysis applies.

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

Okay –

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

But again this is –

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

– all of a sudden this is coming from somebody's personal cell phone because there is no other way to text, do you see what I'm saying?

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

No, no, no that's not true you can text from computers, I mean, that's how my dentist text me reminders for my appointments.

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

I don't know that everybody knows – yeah, I know that you can – somebody would have to have the App –

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

Right.

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

IT has to agree that that's possible to put, you know, they allow that –

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

Well remember – go ahead Paul.

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

So, there are a lot of things that would have to be in place you're really forcing people to install that App and maintain the App.

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

No.

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

No?

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

No because the HIPAA rule says, if you have it – you know, if you have it in that technical format, I have the language a little bit wrong, but so if you don't have that App you don't have to produce it.

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

Okay.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Right, it's just if you – you want to be able to count the use of the capability if people have it and patients want it.

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

Right.

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

So, let me ask for those who have this App when you send it via computer and they reply to that text message where does it go?

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

To your computer.

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

Oh, okay.

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

So, Paul, we have this App at Denver Health and we actually store it back in a program that sent the original message and we tie it back to that original message based on the phone number and the time of the message coming back.

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

And somebody gets alerted that that message is now there?

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

Yeah, it fit into a work flow.

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

Okay.

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

It's actually –

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

And it –

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

Pretty common now, it's getting much – I mean, it's common in almost every other industry but it's getting a lot more common in healthcare.

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

Okay.

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

We use it for patient generated health data.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Do you really?

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

And does it – is it structured, it goes somewhere?

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

Yeah, so it's structured, it reads just as Mike was saying it's got blood pressures, you know, diastolic and systolic and blood sugars, and step counts for diabetics.

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

It sounds like there is something more than simple text that there – are there links to websites to enter it or how is it getting in structured as a text message?

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

And with whose medical record number?

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

Well, it's coming back to the phone number and it's not going back into the EHR it's being structured into a report that is then put into an EHR, it's a separate –

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

With a medical record number?

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

Pardon?

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

With whose medical record number?

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

Well, it's tracked to the individual patient's phone number is then – as I said there is a message sent out to that phone number and then we receive a message back with the blood sugar or the blood pressure.

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

But that's not a unique phone number for one person.

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

No and that indeed has been a problem in some of the tests that we've done.

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

Right. So, I guess from my perspective just to help us with this I think the key is maybe to revise that wording on text a little bit to be a little clearer about what we mean by text messaging as non-cell phone to cell phone but rather text messaging secure App or whatever it is.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

It doesn't have to be secure.

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

Right.

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

We don't typically dictate the platform on a policy side at all, so I would be worried about that as a precedent setter, because we try to be platform agnostic.

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

Yeah and I'm just going to say we're going to be killing our providers here by –

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

You don't have to use it Mike.

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

Right.

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

You can't tell that you don't have to use it by the regulation.

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

Well, but I think, this is George, I think that text is similar to telephone, we have telephone written down but we're not expecting providers to pick up their cell phone and call every patient on it.

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

Right.

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

And I think it is analogous.

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

Yeah, we use it for appointment reminders. I mean, it's just a preference.

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

Right, okay, are we ready to move on or is there a proposal on the table?

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

So, we're okay recording preferences and ignoring them is what you're saying?

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

No, that's not at all what I'm saying.

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

Okay, so that's why I'm saying if we're recording preferences and we're recording preferences that are problematic to providers either because they'll be confused or they'll follow the wrong instruction or they won't be able to connect the dots back to another regulation about whether and how they need to use it or what they're supposed to be using, we are risking unintended consequences and that's all I'm trying to do is represent my fellow physicians.

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

No, because, so Mike when you ask patients what format would you like these to be delivered in you would list only those which you possess the technical capability to do and you have to know HIPAA. I mean, you do have to know the law.

So – and I know OCR has a lot of education resources for providers that's partly why we established, you know, or what we've asked RECs to do as well, but you would not offer something that you could not deliver. So, that's not expected, but there are many providers who will and so the system does need to be capable of collecting that particular preference.

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

So, maybe the thing that would help us with or at least help me with this is to either add a sentence or finish the sentence by saying, per HIPAA regulation whatever.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Well, I actually think you could, this is Deven, you could flush it out a lot more Christine, you're explanation provides sort of much more framing –

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

Sure.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Than what's in the current slide. So, it's, you know, providers will offer the, you know, options to patients that they can provide.

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

Yes.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

But what we really want is for the certification criteria to provide really a full range of options for the physician to choose from.

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

Right.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

That they're going to offer their patients, but it's not forcing them to use text if they don't want to, it's not forcing them to use any particular piece of software, but just to have a lot of optionality in the systems ideally, Charlene is probably ready to hit me.

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

Yeah I am.

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

– and that's not necessarily communicated with this one sentence on here that's all.

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

Yeah, no I agree and so that's why I started out by saying we do need to add the format readily producible thing, but –

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Yes.

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

We can add even more than that to clarify.

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

Yeah, the other piece here then is communication preferences for what, you know, because there are different types of communications that providers – if I want to communicate a result would I do this, if I want to communicate the care summary I would want to do that, if I want to communicate – so it's a pretty complex combination and the patients can choose, okay, if it's a result I want them to text me, if it's the care summary send it to my e-mail, if it's a – you know, so it gets to be a pretty, you know, it's a complex combination, you know, it's like when you go on-line and you sign up for how you want your bank or whatever to communicate with you, it's those kind of options.

So, I don't know how we narrow that, because it's just – it can get, you know, as you start to think it through in terms of what's really relevant here there's going to be different types of preferences for different types of communication. So, I don't know whether standards thinks that through or every vendor has to think that through and then the issue is you've got to certify to something.

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

Well, the certification is the list of, you know, right, it's the list of preferences and then associating them with the thing that's being delivered or provided. So, we've done this with language for example, it's the same thing where we've tied language to patient education materials, same thing. So, folks okay if we just clarify the language on this?

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

I think we're still going to be – to me it feels a little bit like that patient generated data where, you know, if – you can certainly provide those kinds of flexibility, but maybe then just the vendors decide how complex they're going to get, so is there a minimum field or is it – you know, there are just a lot of types of electronic communication that happens now with the patients.

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

I'm just not sure how to –

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

I know, I know –

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

Operationalize your –

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

I know, I'm trying to keep it from going out of the ballpark, you know, it's like –

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

Okay, so if you think of something let us know.

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

Yeah.

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

Because there is nothing I can do at this point.

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

All right.

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

So, this is Mike, what I heard and I agree it starts to feel like a matrix is what communication options should be and to apply to which types of communications.

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

Yeah, but –

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

Yes.

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

The whole goal here is I already have the right to request the information in the format that I prefer in as a patient as long as you have that option technically available. So, what we're trying to do is make it easier for providers to know those things and comply.

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

Right and all I'm trying to do is to say for certification purposes does the certified EHR technology have to be able to distinctly and specifically indicate I want my appointment changes to be by telephone, my other things by other mechanisms and actually have the capability to record each of those major types of communications with its own individual –

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

No.

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

Type of modality.

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

When we went through the consolidation process that we agreed to we said that would be the case only for patient education materials, after visit summaries, and Michelle, what's the third type of information?

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

Reminders.

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

Reminders for preventive and follow-up care.

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

Okay, all right, so you'll categorize – maybe if you just reference that back then, you know.

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

Sure.

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

Yes, I've already –

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

Here's the standard set of communication preferences or something like that is what you're saying.

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

Right.

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

And for these three is your minimum you have to do it for and providers and vendors want to do more they can do more.

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

Yes, exactly, okay, we will clarify that, good.

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

Yeah, okay, all right, thank you.

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

Yes.

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

Okay.

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

All right, so the last one is clinical trials and this is an open item. We, at the Subgroup level have lingering questions about the readiness of the research community and the ability for, you know, for them to accommodate standards that might be placed into an EHR.

So, the short version is if we said for example that EHRs should use InfoButton to, you know, identify some potential trials based on broad parameters so that patient and provider can have an easier time of identifying possible trials that they could participate in, if we do that we need to make sure the research community is also able to accommodate that, if they're not it doesn't do us any good at this point to include those.

So, we have a call scheduled, it unfortunately was not able to be scheduled before this call, but we have a call next week with a couple of folks who are a mix of researchers and Standards Committee individuals to figure out and determine that. So, this is still on our list of open items. Any questions or remarks, or thoughts on that? Okay, all right, so that's it for this Subgroup. Paul back to you. Paul are you there? Are you on mute?

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

I'm here but on mute.

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

Yes.

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

Thank you very much Christine and this was really a very rich discussion, we all learned a lot from each other and I think we are on the path to trying to do the best thing moving forward. So, we have to get a little more information in some areas, but thanks so much Christine for leading us through that.

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

Thank you.

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

I think that is it for today's agenda before we go to public comment, I just want to check with Michelle, am I correct?

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

That's correct, thank you, Paul.

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

Okay, any other comments? We have what one more call before we wrap everything up all the categories before making our draft, our first draft presentation to the full committee in August on the way towards –

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

Paul?

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

Yes?

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

I'm sorry, Paul, we actually have 2 calls scheduled there is one July 16th and then another one July 30th if we need it.

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

Okay.

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

And we may need the 30th because that listening session is on the 18th so we could do it over e-mail or something, but –

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

That was –

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

There was the listening session that we were going to have the Workgroup listen to on the 18th which –

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

Okay.

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

So, we might need that 30th meeting.

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

That makes sense, that makes sense. So, I'm sorry, so I stand corrected there are two calls and we do have agenda items for both calls. But, I think, you know, we've gone through a lot in these recent months in trying to revamp Stage 3 in response to our experience with Stage 1 and some of the discussions about Stage 2 and in response to the comments we got on the RFC, and in our rethinking about both the consolidation and our new alternative pathway of deeming. So, a lot is there and look forward to a rich discussion from the committee as well. All right, let's open it up –

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

Hey, Paul, it's Christine, just a quick question before we go to public comment, I just want to make sure in terms of our overarching timeline for Meaningful Use, you know, that we are going to be able to get recommendations to ONC in time for them to do rule writing that they could release, you know, like hopefully in very early January, because of the staging. So, do you know when we're aiming to have our final set and if that's enough time for ONC and CMS?

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

Right, so, working backwards we don't have any further guidance from the time that – so there wouldn't be any NPRM this year, so that's how we set the September date with Farzad. We don't have any update since then and there has been no public announcement about when they're planning for their NPRM. So, we don't have an official date to work back from.

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

Okay.

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

But our current commitment is to provide approved recommendations to move forward at the September full committee meeting.

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

That's great and I would just suggest, I don't expect that they can or will make an announcement but I do think that we should, you know, keep on a pace that would still enable them to issue Regs in early January if they so chose to, because that's the, you know, way to leave the best options open for not having to delay stages. So, I think if we can stick to our timeline that would be great.

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

Well, we have an approved timeline, the September –

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

Yes.

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

That doesn't say that – that doesn't dictate a January NPRM, but at any rate –

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

I know, yes, I know that, I'm very well aware of that, but I just want to make sure our timeline doesn't close that option out for them.

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

Right.

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

So, thank you.

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

Thank you, okay why don't we go to public comment, please?

Public Comment

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Operator can you please open the lines for public comment?

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. And we do have a public comment.

Paul Kleeberg, MD, FAAFP, FHIMSS – Chief Medical Information Officer – Stratis Health

Can you hear me?

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yes, can you please state your name and I'll be limiting you to 3 minutes, thanks.

Paul Kleeberg, MD, FAAFP, FHIMSS – Chief Medical Information Officer – Stratis Health

Sounds good, Paul Kleeberg, I'm with Stratis Health. This is the first time I've had the opportunity to listen to this live and I agree I really enjoyed the conversation here. I'm speaking in support of two things the first one on slide 6 when you talk about the clinical summary, I do support both the system configuration and the local configuration of the summary, but I'd like to point out a couple of things that you may wish to think about as you're doing this.

Yes the system may need – the system that uses it may need to set the standard settings for them. They may also need to set or wish to set defaults so that the pick list that Paul talked about, the individual provider can see the defaults and change them if they wish, the ability to potentially save provider preferences so say an oncologist who can save it across all their patients that typically they might want to have particular things to show would be another option and finally the ability, as you mentioned, to do patient specific preferences would be ideal. I don't suggest that you define those in the criteria, but it's definitely something that should be considered.

The other thing that I'd like to point out is on slide 7 when you talk about the patient education materials. Mike said his surgeons can be presented 8 items and having the language show the patient preference then the surgeon could pick it. I would also suggest in the certification criteria that the EHR use the patient preference to make that language document appear first in the list to make the selection easier for the provider or maybe even make it the default one that is picked and then the provider can chose another. I think that would assist with work flow and – just with work flow period. End of comment.

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

Thank you.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Are there any more public comments?

Caitlin Collins – Project Coordinator – Altarum Institute

We have no more at this time.

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

Well, thank you everyone for a great discussion and look forward to talking to you later on in the month.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, everybody.

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

Okay.

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

Have a Happy Fourth.

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Bye-bye.

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

Thanks, Paul.

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

Bye, thanks, Paul.

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

Thanks.