

**HIT Policy Committee
Certification & Adoption Workgroup
Transcript
September 27, 2013**

Presentation

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Certification and Adoption Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder this meeting is being transcribed and recorded so please state your name before speaking. I'll now take roll. Marc Probst? Larry Wolf?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I'm on.

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

Joan Ash? John Derr?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC
Here.

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

Carl Dvorak?

Carl Dvorak – Chief Operating Officer - Epic Systems

Here.

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

Paul Egerman? Joe Heyman? I know Joe is here. George Hripcsak?

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

Here.

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

Stan Huff? Liz Johnson?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I'm here.

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

Charles Kennedy? Donald Rucker? Paul Tang? Micky Tripathi? Are there any ONC staff members on the line?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator

Mike Lipinski.

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

Thanks Mike and I'll turn it back to you Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, I wanted to welcome everybody back we had a very engaging hearing back on Monday and our charge here is to begin to make sense of that and to figure out our next steps, the general expectation is that we'll get some recommendations to the Health IT Policy Committee that will then make their way to the Meaningful Use Workgroup for inclusion in Stage 3 and their thinking for stages beyond Stage 3.

In some of the lead up to today's call there was some discussion about how we got to where we are. So maybe I can put Michelle and Mike, and myself on the spot and we can just put everybody in context because there was sort of a flurry of activity at the end that got people to the hearing, but there actually was a fair amount of work early starting in the spring to get this framed up.

So, I guess the highlights, I'll give my highlights is ONC came to Marc and I and said this area of advance directives is getting a lot of attention. We heard comments during the – how to engage the ineligible providers it's a continuing, you know, area that we feel to be addressed and we'd like you guys to organize a hearing.

Leslie called from the Patient Engagement Group said this was really a hot topic for them so she kind of joined us as a three-way co-chair exercise in looking to define a set of panels that would broadly represent the topic and could help us frame what was going on and maybe give a voice to some things that weren't getting enough of a voice and then to feed this into the MU process.

And then we had problems just getting dates, we hoped we would do this back in maybe even early part of August and then it was the end of August, and then it became September. So, I don't know Mike or Michelle is there something you want to add in terms of more of the charge to the group?

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

This is Michelle I'll just add that, you know, as Larry said a number of different groups have brought this topic up from different perspectives and at different times, you know, as Larry mentioned there has been interest from the Consumer Workgroup as part of Meaningful Use of course and then there is the care coordination piece with the Meaningful Use where there was interest and then there was also interest from the Standards side from the Clinical Operations Group as well.

So, because of all that interest that was part of the genesis for this hearing and I will remind folks, you know, just kind of being operational that for Meaningful Use itself the current objective that is in Stage 2 just requires eligible hospitals to record whether a patient 65 years or older has an advance directive for more than 50% of patients.

And it is still a menu item and currently there is no requirement for eligible professionals. So, I just kind of want to remind everybody where things stand for this discussion and that also there were questions asked within the Request for Comment back in the fall, Mike actually was the one who summarized those comments so he could probably speak to them better than me, but most of the public did ask that we push further on this and do more than what is currently in Meaningful Use.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator

Yeah, I mean, I would just echo Michelle's comments, there have been different proposals coming out of both Policy Committees since Stage 1 that haven't made it through the rulemaking and into any final MU requirement or final requirement for certified EHR technology just correlated to the MU objective, EHRs only required to be able to record the advance directive. So nothing further than that.

So, you know, coming out of this, you know, if it changes or, you know, recommendations for MU Stage 3, if possible I don't, you know, getting involved with the Standards Committee what type of recommendations you would also see feasible in terms of modifying the certified EHR technology related to advance directives as well.

I understand that is somewhat outside of scope for the Policy Committee as this is a Workgroup for the Policy Committee, but to the extent that we can and the involvement as Michelle mentioned about the Clinical Ops Group and the Standards size if any type of recommendation like that can come out as well would I think be helpful. So, that's it.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let me give one piece of framing then maybe we can get some comments from the group and then start to put together our work plan. So, I was hearing a variety of themes come out of this and one of them I think is important background for us which is, we've been talking on this call about this as advance directives and you may have noticed that the title for the hearing actually changed sort of at the last minute to care planning and we heard many of the participants using the phrase advanced care planning or advance care planning. And I think that in some ways gives a broader context for this that this is not just focused on a DNR order, right?

This is not did the physician writes an order, it is visible, did we make sure we didn't lose it, this is really stepping back and asking for what is the patient's statement here of their plan, what they want done and as much as there was a lot focus on the plan and what should be included in it and what it says and all that, that it really needs to address whether there is a health proxy of some kind and who that is and that the most important part in many ways was the conversation between the patient, their health proxy, patient's family and the larger network of people in their lives who would be impacted in any actually decisions if they became unable to make decisions as well as the conversation with the health team and the many members of the health team.

So, I thought it was actually very helpful to shift this out of the less quick, get a standard to define this and let's look at it, what is it that we actually want to define and maybe as we think about what we want to do going forward we should be thinking about a two part go forward, one is to summarize what we've learned, what the current situation is and then maybe out of that some recommendations that could make their way into the Meaningful Use pipeline.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Hi there, this is Elisabeth Belmont I just wanted to let everyone know that joined the call.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Oh, Liz, very good timing.

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

Yeah, so Larry maybe we can turn it over to Elisabeth and then turn back to the conversation, sorry.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

No that's okay I don't want to interrupt your thread, you're welcome to finish that.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, actually it might be a pretty good place to leave those thoughts with people.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Okay.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

As, you know, what is the context of this including proper ways to frame it language, you know, what are we calling this and what the key elements are, and that the second piece is as we go forward to the Policy Committee that there should be two parts, there should be kind of the context that we learned and then the recommendations piece. And so actually I think this is sort of perfect for you to give us some more of a legal perspective because the opening comments we had at the hearing also were very helpful that way, so go for it.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Sure, do you want me to kind of summarize the various questions or would you like to me questions? How would you like to do this and I'm sorry I didn't catch your name and want to be able to appropriately address you?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Oh, sorry and we should all be using our names because this is going to be transcribed, so this is Larry Wolf, Co-Chair of the Workgroup.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Hi Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And we have several of the committee members on, Workgroup members on the call, so, yeah I think if you gave us really highlights out of the areas we asked you to address or things that we didn't ask you to address but you were scratching your head going "why didn't they ask me that because it's really important" that you should offer that as well.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Sure, first I'd like to thank the committee for being so gracious I had a significant client emergency that prevented my participation on Monday, so I've never had that happen before when I've agreed to do something for ONC. So, thank you for being so gracious.

By way of background so you know how I've come to have my thoughts on advance directives and I would be in favor incidentally of using the term advanced care planning because I agree that it encompasses more than a DNR order, it encompasses more than the actual form, but there does need to be discussions with the family.

So, in my role as Corporate Counsel for MaineHealth, which is the largest integrated delivery system north of Boston, I do deal with these issues on a weekly basis. Additionally, I have participated in a number of State and National Workgroups on this topic and have actually authored a number of resources for the American Health Lawyer's Association relating to end-of-life planning issues for both healthcare consumers and the broader healthcare community.

In terms of experience with the implementation of advance directives I can speak most intimately with what Maine has been doing and Maine became very active in implementing advance directives in the early 1990s and our experience to date has been very positive.

In addition to having a general advance directive statute Maine also has a statute authorizing advance directives for mental health treatment, as you might imagine having an advance directive for mental health treatment because there is still a stigma attached with certain psychiatric diagnosis there is not as much use of that advance directive as there is with the general advance directive.

We also – we have a statewide consensus form that providers across the state use for advance directives which is more comprehensive than what you normally see and I do have for the committee, which I will be submitting hopefully later today or this weekend at the latest, a package for you with some examples and a summary of this experience because in the time allotted this morning I will only hit the high points.

In terms of a POLST Form we do have a standard POLST Form as well. One issue that I think the committee may wish to consider is the fact that there can be conflict between what a POLST Form says and what an advance directive says because they may be executed at two different times and a patient's condition may have changed between the time an advance directive has been executed and when a POLST Form has been done and for that reason I would ask the committee to consider some direction with regard to integrating the documents.

The preference of myself and others in the state would be to have one document which contains both the advance directive and the POLST Form to ensure that no conflicts exist and that if you have one form it's arguably easier to update as well.

In terms of information that should be included either with a patient's advance directive or in the medical record obviously having a copy of the advance directive form, the POLST Form would be helpful, but that sometimes doesn't give you the whole picture and I think it would be very helpful to have a healthcare provider document any conversations that they have had and also to identify who the surrogate is.

Quite often when you are looking to actually – during the course of a hospital admission if an issue comes up you want to have that information readily available and I've had countless experiences where the provider will say "I know the patient had the advance directive" but they can't immediately put their hands on it and they may not have a relative or other family member that they can call to ask to have access to that information.

In terms of how the Meaningful Use measure could be approved, this was question three that was posed, I would favor your consideration of changing the age threshold from 65 years or older to all adults age 18 or older and my reason for asking you to consider that is that if you look at the CDC reports most deaths occur today after a period of chronic progressive illness and by specifying age 65 the Meaningful Use measure arguably discourages healthcare providers from discussing advance directives with younger patients.

And I can tell you from the traffic that our emergency department sees we have more severe accidents involving younger folks than we do older patients and I think it would be helpful to have a broader age category.

With regard to question four and concerns about the use of advance directives in an electronic environment, EHRs, as you know, are a good news/bad news bear, they make some things easier, they make some things harder. In certain EHR environments it's not possible to program the format of a POLST Form into the EHR and while you can scan it into an EHR the scanned document may not necessarily translate into identical physician orders, so I think it's important for healthcare providers to look at the physician orders contained in a POLST and come up with some way that they can be integrated in an EHR environment.

Another issue that we have seen as a result of our recent EHR implementation is that if you have a medical record with a patient who has one or two chronic conditions it's often voluminous and to go searching through that record for documentation of advance care planning and the advance directive and identity of the surrogate can be challenging.

So, I'm in favor of having a separate tab in the medical record that contains the advance care planning discussions, the advanced directive, a POLST, other related information so healthcare providers can immediately go to that tab and have instant access to that.

I do think there are number of advantages of having the advance directives available through a statewide health information exchange and if we have a situation where we are unable to contact a relative or a caregiver but we can access the advance directive through the HIE that would be very helpful to us.

I think one of the challenges, however, if you're going to have an advance directive available in either an electronic health record or a statewide HIE there needs to be some assurance that the form you have is the most current form and I'm not sure that there is a failsafe method that exist today for doing that.

For that reason I think for an annual wellness visit or if a patient has a change in a chronic condition then it would be great to review the current advance directive and POLST Form and make sure that what you're dealing with is the current form and have a note in the record that reflects that.

You also inquired about privacy issues and an advance directive has the same issues as with any protected health information. And again, if you're dealing with a State such as Maine that has a mental health advance directive then you often have the heightened privacy protections that you see for mental health information.

Question five asks about legal implications arising from transition of care and as you are probably aware there are different requirements in the states for advance directives. A number of states however will accept an advance directive from another state if it meets that state's legal requirements.

With regard to question six you asked whether there would be an approach that would allow a single advance directive to meet all medical needs similar to how a single Will functions. I think that conversations with the patient or their surrogate are always in order. Wills, as you are aware, are drafted to be implemented after a patient's death and I think you really need to have the periodic conversations with a patient.

One of my favorite examples that shows why this is important is that if you have an elderly person say for example with a DNR and no life support advance directive who comes into the hospital for palliative surgery or an acute minor issue that could be quickly resolved in the ED, a healthcare provider may blindly follow an advance directive without talking to the patient first and the patient could die during that hospital visit contrary to the patient's own true wishes. So, I think, again, just having the form is not sufficient, there needs to be the conversations.

Question seven, are there legal concerns regarding when the advance directive was executed and last updated? Maine and many other jurisdictions do not place an expiration date on advance directives. Again, we would recommend that physicians periodically engage in the advance care planning discussions during wellness visits or if there is a significant change in the patient's condition.

And in addition to the statutes that I have cited we do have a group of stakeholders right now who are looking to take the Maine Consensus POLST Form and perhaps add that as a statute and I believe that if we do that then we will, statutorily, look at the availability of integrating the two documents into a single document so we can ensure consistency with the patient's values and care preferences.

So, those are some of highlights. I do have more detail which is flushed out for you in my written testimony. To be respectful of the committee's time Larry why don't I stop there and see if you or other committee members have any questions or wish me to elaborate on any of the quick points I've made.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, Elisabeth this is Larry and you certainly know our format, this would be the time for the members of the Workgroup to ask questions. So, why don't we take a few minutes and do that. Is there anyone who has some questions?

Joe Heyman, MD – Whittier IPA

So, this is Joe, and I want to push back a little bit after having heard the hearing and hearing Elisabeth's comments today. It seems to me when I'm thinking about all of this, well first of all something that I often say is that you can't fix everything in medicine with Meaningful Use and when I hear what you say and I think about a single physician in a physician's office having that advance directive in their medical record, while there is certainly no harm to that, I think it's a great thing, I think making it a requirement won't fix anything.

Because the truth of the matter is that when that physician sees the patient in the hospital that chart is not necessarily available and as you said earlier, in your testimony, you said that somebody can remember that there is an advance directive but not have access to it and I think that even a health information exchange doesn't solve the problem of knowing that that is the latest advance directive, even if you have a statewide health information exchange.

And I thought I heard some testimony, which I was very impressed with, about having a single website where everybody goes with their advance directives and then when it's updated you always know that's the latest one and it's always available to everybody no matter where the patient is when the need arises, and it just seems to me that that is a much more rational solution than trying to fix this with Meaningful Use. So, I'd like to hear what people feel about that.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Well, first Joe, I agree with you that Meaningful Use may not be the fix for everything. Secondly, I understand where you are coming from and I am aware that for example the US Living Will Registry, you know, is attempting to do what you've said with websites. I'm also aware of Virginia, Idaho, Montana and West Virginia have said that they're going to start a state advance directive registry. Washington has had to drop out of that because of budgetary cuts.

So, my concern is from a healthcare provider perspective it may be one more place for a provider to go and check and when you need to find a document quickly that might not be the most expeditious way to go. It certainly wouldn't hurt to have a copy of the advance directive in the record as well as use those other directories.

What I think is more critical than having the form is again having documentation of the actual discussion, having the identity and name and contact information of a surrogate and a backup decision maker so a provider knows what to do. The way things are today not everyone has a copy in their medical record, but for those where there is evidence of the discussion and there is the information that person's care preferences are going to be honored on a more consistent basis.

Joe Heyman, MD – Whittier IPA

So, let me just ask one other thing.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Sure.

Joe Heyman, MD – Whittier IPA

I've been in practice for 40 years, it's hard to believe but it's true, and in all that time the only patient that I ever had that died was during my training period when I was learning to be an obstetrician gynecologist and I will confess to you that I rarely discuss advance directives with my patients because I'm never put in a situation where I actually need one and it's just – it's an added time to my, you know, it takes time to do that and I'm not a primary care doctor, so I don't usually have that conversation.

So, putting a burden on me to add that to the many other things that I need to do and keep in my medical record just seems to be going too far to me. But, on the other hand, you know, I could ask a patient do you have one and just put it in the document whether or not they do, but having to have the entire conversation is a very difficult burden for a lot of specialists.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

I totally agree with you that as an OB/GYN physician having that conversation with the patient and retaining it probably is not the most or best use of your time. Please bear in mind I'm coming from a hospital perspective and one could potentially argue that the folks who should be responsible for the advance directive are the primary care physicians as you have noted or looking at it from an institutional requirement I think, you know, hospitals, long-term care facilities, clinics they are probably in a better position to do this and we're the ones who most often need it.

Now Joe you commented that you only had one experience when you were a trainee and again this sort of highlights the difference in the settings and when they come up. I literally get a call at least once a week if not more often about some issue relating to advance directive or DNR order.

And so I think we're more apt to see it in the, you know, hospital setting. So, perhaps there needs to be some distinguishing between the settings that are important for these advance directives.

Carl Dvorak – Chief Operating Officer – Epic Systems

This is Carl and I wanted to contribute a little bit on this, Carl Dvorak from Epic by the way, and I've sat in many meetings on this topic with organizations and I agree with Joe, I think there is an element here where we have to be extraordinarily careful to make sure there is one single master copy and everyone knows where to look for the single master rather than possibly multiple different versions floating around that were created at different times in the patient's life.

We really have observed that much of this situational and that if a patient survives this episode then their perspective changes. So, I would be a strong advocate for a single statewide or maybe even federal registry for this.

And then I do think Joe that the EHR may have a role in it in that you could define, much like you do for some clinical trials forms, a process by which an EHR could sense that there is not one, could ask the provider or the care team somehow to try to initiate one and then if one is successfully completed post it to the national or the statewide registry and then any time that patient presents the EHR could be required to check in with the registry and if there is a document make it known to the provider at the time of care.

So, I think you could have some elements in Meaningful Use for what an EHR's role should be but I would be a very strong advocate for putting this where it really belongs which is in a statewide or a program maybe a Medicare or a Medicaid Registry so that when people sign up for Medicare maybe it's required that they fill this out and have it on file in a single location that everyone knows to look should it become necessary to find it.

And I do think we have to really recognize that the situational elements do exist that I might have completed last year when I was facing a particular situation might be different this year now that I'm past that situation.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

And again all the more reason for making sure that you have the updated form. I worry about what will happen in the interim until there a national registry which everyone wants to get on board with because quite often in the hospital setting when you need the current form you need to have it quick in order to make appropriate care decisions and that's why from a hospital perspective also having, you know, a copy here would be helpful or again at least some documentation in the medical record of notes of the planning and who to call to find out.

Carl Dvorak – Chief Operating Officer – Epic Systems

I think that would still be possible, you know, computer systems clear hundreds of thousands of electronic transactions in real time for things like eligibility and verification. So, I think if there were a national registry to access it would be perfectly practical. I think the real key is getting a national registry set up but this single issue seems to have the level of importance and the level of cost from futile care associated with it that this thing might actually be one of those items where we should strongly recommend that they do set that up, because it could make a significant difference in the cost of care.

Joe Heyman, MD – Whittier IPA

I would...

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr; I was wondering whether in Maine you included quality of life in any of the advance directives? I know we, in the S&I Framework, for – I represent long-term post-acute care and I know that we were looking at how we could include quality of life elements and I know that makes it a little bit more complex, but that was brought up in the hearing on Monday a number of times that it's just not the medical part but really quality of life. Have you incorporated that at all into your Maine Project?

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

That is a great question and as you said it's kind of a challenging one. We haven't addressed it generally, however, under life sustaining treatment choices we have given an example relating to Alzheimer's disease or other dementia and talked about what the later stages of that disease involves. So, that's as close as we get to quality of life. I think people can make inferences if they choose or opt not to choose artificial nutrition and hydration that there might be some quality of life issues, but that's as far as we have gone with it.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

This is Liz –

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John again, a follow on, I was just hoping that as time goes by like Alzheimer's you brought up, like I like to write books, a few other things do marathons and if I can't do those things I want to have a choice at that point in time and so I think as this whole thing evolves and then we can do sort of a first step into some but not forget that quality of life is very important as we all grow older and live a lot longer that maybe at some point in time we say I can't do all the things I love to do and in the State of Washington where I live you can check out.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

I totally agree with you that quality of life is a very important issue.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, this is Liz Johnson I was going to ask a question about the age requirement. I think most of us in the healthcare business as providers understand that we shouldn't – 65 is not a magic age, but I am concerned about the fact, and I think a lot of young adults with the exception of those with chronic diseases have their first entry into the hospital in a traumatic situation. So, if you're counting on the hospital to have had that discussion we may be up against a wall.

I hear, you know, I think we both understand and all of us understand it's not a matter of not wanting to ask the question and it's a burden on those who surround the patient at that point is phenomenal but how are you dealing with that? I mean, do you have – is that – have you self-imposed 18 in the State of Maine or is that just a suggestion?

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

We do and I can talk about, we actually have a new initiative going partly in response to the Meaningful Use but partly because we think it's important to involve younger people in this and I understand your point that, you know, hospitals might be, but I presume many if not all of you are familiar with Dr. Ira Byock who has written a number of books on dying well and I've done a number of projects with him through the American Health Lawyer's Association, and he did something really interesting when his kids went off to college.

He sat down and had a discussion with each of them and had them sign an advance directive and I know a number of primary care physicians here do follow suit with younger kids partly because of some of the behaviors that you see associated with the younger crowd and partly because there is a belief consistent with the Medicare condition of participation on this that advance directives shouldn't just be limited to elderly people based on CDC reports.

So, many of our practices, which are hospital-based, so that's how the hospital gets involved here, but I agree with you that again it would seem that the primary care physician whether hospital-based or not hospital-based is in a better position to have the discussion with the patient.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr again, I had a – maybe an out of the box type suggestion not to take away the conversation with the primary physician or that, but, you know, unless somebody has an episodic occasion they don't go to a hospital and I'm a pharmacist why don't we maybe include the pharmacist because everyone goes to get medications and that and whatever age you are you are on some medications or vitamins, or something like that.

Maybe this is a role the pharmacist could take under and be able to make sure everyone has an advance directive and then the physician and the hospital would be able to get it and have a conversation, but the requirement to fill it out and have one could be a pharmacist.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

It's really interesting that you make that suggestion because in Maine because we have the statewide consensus form Walmart for example at their pharmacy they actually have copies of these that people can pick up and, you know, there's a note to discuss it with your physician, but again, if the goal is to get the word out looking for other points of care where you're apt to get in touch with the younger population merits consideration.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, this is Larry, let me jump in with a theme I'm hearing here, which seems, at least – and maybe because it's Friday and it's a new day, but while there was emphasis on the discussion aspects in the earlier hearing I'm really hearing that very strongly today that the form is a form and it's nice to have it and it's nice to know the history, and in crisis moments it's important to know what earlier conversations were, but in fact it's those conversations.

So, there was a lot of discussion about conversations between patient and their proxy during the hearing itself. I'm hearing an equal emphasis here on discussion, capturing the discussion between the providers and the patient and that becomes another component that might be in the EHR as well and should be easily retrieved to know in this setting have we had this discussion, what was the discussion, who was engaged in the discussion because now things have progressed and we need to take further action.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

I would agree with that and just add not only capturing the discussion but, you know, plan to update those discussions either during an annual wellness visit or if there is a significant change in the patient's condition.

Joe Heyman, MD – Whittier IPA

This is Joe, it just seems to me that that is such an important discussion and I just can't see somebody doing it during a 15 minute visit, it just seems to me that there needs to be adequate time devoted to that specific discussion rather than just catching it on the fly and I have –

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

So would you be in favor then of like scheduling a specific visit with your physician?

Joe Heyman, MD – Whittier IPA

Well, yeah – I actually – when we did ours we did them with an attorney rather than with a physician, but I think if you're expecting a physician to do it they really would need to have a special time to do it. I mean, I don't know because I've never had that discussion with a patient really. So, it's hard for me to opine on it but I certainly think that before we made a recommendation we ought to find out from some organized medicine group what that would involve.

But I certainly think it's a reasonable thing to do I just am worried about – when I heard John talking about doing it at the pharmacy for example my experience at the pharmacy is I get a drug and they hand me a bunch of stuff and they make me check a mark off saying that they educated me. I don't really spend much time with the pharmacist and I'm just worried that if we do it this way where you just get a form and you check it off it isn't really a genuine thoughtful thing about something that's extraordinarily important.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Well, I think that –

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Joe, this is John, I didn't mean to say we just do that, but they could – because they see medication changes and a pharmacist is really a pharmacist like G who is the CEO of Walgreen's is trying to get the pharmacists more involved in care and they are there that if they see something change they could just mention it and then if we had a registry it could be put into there because they have, you know, computer type capabilities, but it might be just a check. I didn't mean that it was you had a conversation you've got to have that with your physician.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

And I would –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Let me pick up on John's comment and Joe's comment and Elisabeth's reaction and others. So, we've had a lot of other discussions about a shift to team-based care. Are there other people besides the physician that could meaningfully have this conversation with the patient and record the substance and actually have that as primary material for the physicians to work with and not necessarily see that they're the only ones having the conversation?

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Well let me –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, thoughts about that from other team members?

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

I think that makes a good point because you're right we are looking at team-based care. With the new initiative that we have going on advance directive we recognize that sometimes there is not going to be the time for the 15 minute wellness visit.

So we're actually working with the Southern Maine Agency on Aging to train a number of facilitators in the Gundersen Methods and then we will have those facilitators sit down with a patient and preliminarily complete an advance directive. They will then go back to their primary care physician having had that conversation and an opportunity to think about it, review it with the primary care physician and then finalize it.

So, that's, you know, one way of trying to, you know, stretch our resources and even though I'm a lawyer and many lawyers do prepare advance directives I think if you have a chronic medical condition going back to the quality of life issue having the conversation with your physician as opposed to the lawyer, I think that there is just no substitute for that, because the lawyer can tell you what's legally correct but the lawyer may not be able to answer the questions or point out how your particular illness is going to affect you as you age or as the illness progresses and what that means for your particular situation, which would affect perhaps the patient's wishes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

You know that's one of the things, this is Liz again, I think that's one of the things, as I've listened to the conversation I'm following I realize that when we think about what we need to achieve today in terms of advising the Certification Group and the MU Workgroup and so on is sort of, you know, do we want to make a change on the age, do we want to make a change about menu versus core and it occurs to me again as a clinician that when you talk about advanced care planning which is a really intriguing way to do what we need to do, it's just so much more complete.

But when I think about the patient's I've dealt with over the years the complexity of the options that exist for them – I'm hoping that you mentioned Gundersen, I'm not familiar with it but I will find out about it, if there a way to make that somehow rational and what I mean is you're dealing with a patient who, you know, it would be great if they were in a less emotional state than they are sometimes when these decisions are made, so let's pretend they're not in an acute situation and they start to talk about the options of what could happen, and we all know that the options are limitless, so I'm trying to figure out how you have approached that and made it sort of rational, regardless of how we get it done.

I mean, we'll need to talk more about how we get it down but what is it that we're going to do is what I'm trying to figure out. What do you do in Maine? Advance directive is not the same as advanced care planning.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Okay, so you actually were going in and out on me, so I heard about three quarters of what you said.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Oh.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

So, you're specific question is, how do we get the signing of advance directives done in Maine?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No, my question is advance care planning –

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Yes?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Is much more complex in my mind than advance directive because in that scenario you're really looking at options, all the options or a large percentage of the options, explaining them to the patient so they can begin to make, you know, informed decisions beyond do you just want drugs, do you not want, you know, ventilation that's sort of where we started, that's the early stages. What are you doing today to make that more of a care planning effort than a simple set of decisions?

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

We are including it in wellness visits. We are, as I said, just have started this new program where we're having facilitators who are trained in this in the Gundersen method and I can send you a link to that or in fact I'll include it in my testimony so you have it, and by having that preliminary conversation the early reviews are that it makes the patients more focused when they come to the physician to have that.

You are right there can be, you know, a number of options. I'm not sure there is really a one-size fits all. There are certain bullet points that the physicians follow with this discussion and part of that looks to the skill of the physician to keep the discussion on track and to focus on the most likely things that could happen.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, yeah, I'm looking it up now, because I think it may help inform our discussion.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Sure, no I'll be happy to include that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great, thank you.

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

Hi, Larry, this is Michelle.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay?

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

I just wanted to kind of look at the time and think about, so the committee, the Workgroup is actually on the agenda to provide recommendations to the Policy Committee next Wednesday, I'm not sure based upon this discussion if we'll get there so I just wanted to kind of think through that, there is a half an hour left to today's call, a little bit more should we possibly push that back to a future Policy Committee meeting or is there something that you think you possibly could work in the next half hour to summarize and bring forth?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, so, I know we put this call together so that we could have something for the Policy Committee but my sense coming out of the meeting on Monday was it wasn't going to be simple and I didn't think that we could actually nail it down on our time today and I think it's really good to have had a little bit of this testimony as a way to sort of open up the conversation again even though it does make it harder for us to get to any kind of closure.

I think we're more likely that we get an update through the whole committee, but I'll put that out to the other members of the Workgroup. Do you guys feel like you have a trial horse? Anyone want to play Paul Tang and give us the trial horse recommendation that we can use and go forward with?

Carl Dvorak – Chief Operating Officer – Epic Systems

This is Carl, I think this, again, as I mentioned before, this seems to be an area that's important enough and significant enough, and complicated enough that we may want to make a recommendation for a national or a program-based registry for these things and then define how EHRs could interact with that registry to contribute, make physicians aware and signal the presence or absence of these documents.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Carl, when you say that are we sort of starting with advance directives as we know them today? Are we introducing the concepts of advance care planning?

Carl Dvorak – Chief Operating Officer – Epic Systems

I was thinking more along the lines of the POLST work that sort of body of information.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Carl Dvorak – Chief Operating Officer – Epic Systems

More so than a care – you know, the advanced care planning can be a little bit more complicated and nuanced and I think we should – one thing that I was moved by, I don't know if other people looked at it, but that TRIAD VI preliminary slides for Pitt Ethics I was amazed at the variability in interpretation of these things so I think this is an area that we should be as simplistic as possible but not simpler than needed and keep it very clean and straightforward to start with so that we don't wind up in a situation where we have people filling out forms that are later used in ways that they didn't anticipate, you know, this is the ultimate let a patient die scenario, right? So, I think we've got to be extraordinarily thoughtful and careful about what we're doing with this.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, yeah, that would answer my question about advance care planning versus – and I know I'm sort of like yourself I'm kind of sitting on a thin piece of ice here because it's – you know, I think we thought of advance directives in many ways as a way to respect the wishes of someone with, you know, a terminal or late in life decision and now – and it's certainly been expanded for a long time, but now we're starting to say are there other care decisions we would make around palliative care, I mean, the list goes on and on so I agree with you we ought to start simple and I think a registry is a really great idea at least the suggestion of one.

Larry, was there anything in the part of the hearing that talked – where the legislation folks came in or congress came in and there was a discussion about something being proposed and unfortunately I had to join a little bit late, can you talk about that at all? I mean, does that inform this discussion?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's a really good point, so I want to back up to recognize that we really have multiple things, right and Elisabeth even pointed out that sometimes they get joined together and that might actually be a useful thing to do in terms of the document structure whether it's advance directives or advanced care planning is really a patient stating their wishes, stating their desires. The POLST, the P is or the PO are physician orders.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So it's much more reportable orders, it's much more focused on the provider making actionable what the patient has said they want to do and I think they're sort of very related but they're not the same thing as well as this notion of knowing who the proxy is or a backup for the proxy and how to get a hold of them.

So, I think that there's a whole question about what is it that is being put in this national registry or put in a state registry, or interoperable state registries, but that whole notion of having a registry and accessing documents I think is also really a key concept and I agree with Carl's notion of, you know, that becomes a way to address where the most current one is, because we say there's a registry, there's a registry.

It also, I think, highlights the need to be able to record the discussion, what was the thinking in this care setting by this provider about what is going on that may happen just prior to taking action or ideally this happened in some lead time ahead of a decision having to be made or ahead of an action having to be taken.

So, I guess in my mind, in this way it sort of is complex but maybe the recommendation is we heard it here are some key aspects and we recommend that the Meaningful Use Workgroup is looking at these things even maybe as part of the Continuity of Care Subgroup or maybe one of the other Subgroups include this and here's sort of information that we've gathered that they should include.

I like the emphasis on the national directory piece, but now backing up to your question Liz about the legislative proposal, I was having technical difficulties and I missed the beginning part of the presentation from the senate group.

We do have the letter from the house group and like I said this is sort of a unique situation for me where I don't think we've had in the past legislative proposals that were presented to us where we commented specifically on a proposal so it's new territory.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

And I'm happy to get input from others.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

And –

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

This is Stan Huff just a couple of thoughts, I mean this is a, you know, I agree absolutely this is a very important area and we've heard some good ideas, I'm hesitant to make a recommendation that we know enough now for instance to say we should require a registry or that sort of thing. It seems to me that we're at a position where what we should recommend is that people fund a trial or a prototype, or other ways of finding out how this would really work.

You know, I've been in this business long enough to know that you have good ideas and they're wonderful ideas and you want to accomplish good things for the patient and there are unintended consequences from – when you actually implement you find out there are practical issues you may not have considered, you know, when you conceived the solution, and you know, if there were – and maybe it's just a matter of finding out what's been done.

Maybe somebody somewhere has already put a registry in place and it's working well and that could serve as standards, you know, that we could work towards, but, I mean, one thing about it, you know, even a state or a national registry is patient identification, you know, our experience is that you're going to have somewhere around at least a 5% error rate in identifying people and being able to find, you know, if you're talking about something that's a national with no national patient identifier it's a little tricky to actually, you know, find your patient in three hundred million patients that could have advance directives.

So, I think it's too early, I think it's the right time to do experiments and prototypes and get real data that shows the effectiveness of some of the things that are being proposed and I would be very much in favor of that.

I'm hesitant to say that we know enough or just based on our good ideas that we could really predict what the health outcomes would be based on requiring or suggesting that a national registry or some of the other pharmacists interventions all very good ideas.

I would just like to get some practical experience with them to know that we're achieving what we hope to achieve before we make that as a requirement for the nation.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

I think that's fair.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, Stan, this is Larry, picking up on that thread, we did hear some examples of States like New York that had been running a registry, but I think, you know, as they say the devil's in the details. So, I agree that before we went to do something very broad we should better understand what's already been done, exactly how it works and then how that should influence go forward thinking.

Joe Heyman, MD – Whittier IPA

This is Joe, I was going to tell you we're implementing a regional health information exchange here in my community, it's actually my job, and we're planning on having a place for advance directives and having it be possible for patients to upload it also as well as physicians.

But I would hate to make it a requirement, because we haven't done it yet, we don't know whether it will work, so I'm sort of coming in on the same level and even if we did make it work it would only be in our region, now we're going to be connecting to the statewide one and I don't know how well that's going to work either, but I just worry about unintended consequences of actually making requirements.

And I'm really concerned about making requirements for things that everybody agrees is not an ideal solution. It seems to me that that's not a very good idea. I can see that hospital ought to be able to get advance directives and I certainly think that making a requirement for EPs is not a very good idea at all and I'm not sure what the requirement would be for a hospital.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think we're sort of thinking our way through sort of even what are the pieces and how do they relate. So, notions that there are conversations that are happening in the community with people with their lawyers, their families, their physicians, they draft some documents that could reside in the registry. Typically today, you know, conversations with patients wind up in some form in progress notes if their provider feels they're significant they'll put it in a progress note.

I suspect that conversations that don't really come to conclusion get minimal documentation in the record unless the fact that it didn't come to a conclusion that was felt to be important by the provider and that those records, you know, that's going to be in unstructured parts of the record most likely as part of a general note and so getting access to that not only is a question of record interoperability but even finding it if you could get to that record.

So, I do think that in some ways this is all sort of very early in our thinking but I'm sort of curious and I'll put it back to the Workgroup, in the past there has been a lot of discussion about putting this as part of the documentation that's transmitted at transitions of care whatever we call that thing, whatever we call that consolidated CDA template that we're using. Any thoughts about that as a position to or a replacement for some kind of registry.

Carl Dvorak – Chief Operating Officer – Epic Systems

Larry, this is Carl, I think we should formally note that the potential for unintended consequences if we require everyone to start creating these things in silo is the unintended consequences of many versions outdated, not certain how to find the most recent version could lead to. I do think that that's a strong factor in my thinking on why, if we do anything it should be focused on a single storage location and methods to recall or contribute to that single store given the gravity of what this is all about and the likelihood of technology in this case actually proliferating multiple versions and obscuring the source of truth could be significant.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

This is Elisabeth and having served on ONC's unintended consequences of Health Exchange Taskforce for a couple of years I agree that this is a valid point.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I just thought it was worth pointing out that that approach of putting it in the transfer documents had been the place it was getting traction before and it has not come up at all in the hearing.

So, I agree with Carl having it in multiple documents just increases the potential of old information being copied forward and thought to be new and we really loose provenance usually when we see those to make good decisions because you just don't know what you have any more.

Carl Dvorak – Chief Operating Officer – Epic Systems

And I think it was Stan Larry that made the suggestion maybe we do some sort of pilot, but I do think if there were an opportunity to pilot a scenario where there is a single defined storage location that served a population that you could depend on as being relatively closed it would be worthwhile, because I do think you could specify fairly clearly within the EHR system a check to see if one exists if not download the form completed and upload the form back to the registry and use it in decision support to make it known that there is or is not such a form.

I think you could pick out some really good things that an EHR could do and if there was a registry for these things it would have the potential to probably save a tremendous amount of unnecessary healthcare expense from the fetal care aspects that we experience today.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah and, you know, on the flip side we had people saying that misunderstanding what was intended resulted in bad care and maybe premature death because people didn't understand what were the specifics that were being asked for in the planning.

And I think, you know, I feel like I don't know enough about the New York testimony to know how much that they've already done but given that others aren't jumping in to correct me I am assuming that was a general, we heard something general about a registry in New York but we don't know enough about whether it actually could serve as this prototype or it might be a place to do some testing because they've already built a registry and then see if we want to replicate that in a few other places because, you know, healthcare is local and this is a hot topic.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Yeah, this is Stan again –

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, I – go ahead?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

I think a national registry has the most promise and I would just – yeah, I think we either need to get more information, more in depth information about state registries or other experience that exists or propose, you know, an experiment with a national registry that would give us experience and make sure that we understand the issues before we require people to participate.

I mean, it's a very promising idea, I really like it, I just think we'll learn a lot either from people who have already done something similar or would point out that we need to do more to learn how it should be done to make it effective.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

There's an old saying that good experience is the result of bad experience, so to the extent we could ferret what some of the challenges have been and adjust those in advance, I think that would be very prudent.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, getting back to MacKenzie's question about what we could have for the, you know, Policy Committee for next Wednesday. So, I'm hearing the sketches of our thinking that could certainly be brought forward.

I'm really reluctant to bring forward the recommendation from the Workgroup given sort of the scattered attendance we have on this call and the fact that this is really in many ways new in our own thinking and how much in some ways the conversation has shifted over the months of both the new thinking but an old conversation.

And so maybe to frame something up that this is sort of like an intermediate update to the Policy Committee and then get them something for early November for their November meeting. Thoughts from the Workgroup about those?

Joe Heyman, MD – Whittier IPA

I think that's a great idea Larry. I think you can sort of catalyze what you heard today and give that as sort of an intermediate step.

Carl Dvorak – Chief Operating Officer – Epic Systems

I agree.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I also like this notion of putting forward that we actually do some pilot testing, this is, in many, a new concept for the Policy Committee to take on. They've relied on others experience in general and haven't had focused testing before things wound up in Regs, at least not in this kind of conscious up front way and maybe that's really a good precedent to bring forward. Any other thoughts about that piece?

Joe Heyman, MD – Whittier IPA

The only thing I would say about that Larry is there are a couple of parts of Meaningful Use that I wish they had pilot tested.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

It's a good approach Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, Larry I would say I think Stan's, you know, thought about us being wary, I think we want these things and the enthusiasm can grow quickly, but the idea about piloting, which is sort of – and please react to this – other folks on the call, sort of core is about. I mean, what menu is about, is it gives us a real small piece but I think when you start talking about registries or that sort of thing or who is going to do the work. If you put it in core we get forced into it faster. So, lots of thought, you know, there to begin.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes, so really saying there are some things that we would like to try before we even put them in menu?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, this has been helpful for me, I feel like I have some clarity from the Workgroup and I really appreciate the discussion this morning. Any other comments before we open this up for public comment?

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Well, I would just like to thank the committee for the opportunity to participate and to make an offer if going forward your looking for additional help with the legal issues, as the past president and past chair of AHLA's public interest committee I'm quite confident I could round up appropriate resources for you if you did need additional help with any of the legal issues.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well, thank you it's been great having you on the call I'm glad you could make it this morning.

Elisabeth Belmont, Esq. – Corporate Counsel – MaineHealth

Great and I will send you something prior the end of the weekend and if there are no further questions for me I will let you continue your deliberations and thank you for being so thoughtful about this important issue.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thanks.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

That's great. Any other committee comments, Workgroup comments before we open up the lines?

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

Okay, it sounds like we're ready to open up the lines.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

There is –

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

Sorry go ahead Larry?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes, so I was going to say, thank you.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Open them up.

Public Comment

Ashley Griffin – Management Assistant – Altarum Institute

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

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, well I think I'll wrap this up. It sounds like I've got some homework to draft some things to get out to you guys, I'll look to get that out I guess it needs to be done Monday if we're going to get some feedback ahead of Wednesday morning. Thank you, glad to have some homework.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, thanks, Larry for doing that, we'll look for your stuff.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thanks, Larry.

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

Thank you.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Bye.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Bye now.

Carl Dvorak – Chief Operating Officer – Epic Systems

Thank you.

Joe Heyman, MD – Whittier IPA

Bye-bye.

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

Thank you everyone.