

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
January 6, 2014**

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup, as their first meeting of 2014. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Paul Tang?

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

Here.

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

George Hripcsak?

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

Here.

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

David Bates?

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

I'm here for the first half hour.

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

Thanks David. Christine Bechtel?

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

Good morning.

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

Neil Calman? Art Davidson? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Marty Fattig? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

David Lansky? Deven McGraw? Marc Overhage?

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

Present.

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

Patty Sengstack?

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

I'm here, good morning.

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

Good morning. Charlene Underwood?

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

I'm here.

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

Mike Zaroukian?

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

Here.

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

Amy Zimmerman? Tim Cromwell? Joe Francis?

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

Joe Francis is here for VA. Happy New Year and Tim is no longer with our organization, so I'm representing him as well.

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

Thank you Joe. Greg Pace? Marty Rice? Rob Tagalico? And are there any ONC staff members on the line?

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

Good morning Michelle, Elise here.

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

Hi Elise. And with that, I'll turn it –

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Good morning, Juli...

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

Oh, sorry, Julie Crouse. And with that, I'll turn it over to you Paul.

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

Great. Thank you very much Michelle and thanks for the great attendance, sending some California warmth to you all that are by the fireplace with your hot chocolate. This is a Meaningful Use Workgroup call and I'm going to quickly go over our – the rest of the agenda, I want you to move the slides please. This call we're going to pick up some of the – that we didn't finish in previous calls and then George, Michelle and I are going to lock ourselves in a room next Monday and try to do some editing work. As you know, a lot of the questions that people have are because we weren't clear in our intent. So we're going to try to go back and do some editing to try to clarify what we think we intended, before we review the whole shebang in the following two calls before our presentation in front of the HIT Policy Committee. Any questions on that?

Okay, let's move on, next slide, and the slide after that please. So, John Halamka's joining us from the HIT Standards Committee. He can only be here for the first half hour, as David Bates as well, and we're going to go over a couple of the topics that are left over from last time we didn't fully discuss. One is patient-generated health data and the other is med adherence, which we didn't, I don't think started last time, but we're also talking to the Standards Committee about. So why don't we go ahead and John, you want to just brief us on the findings, the summary from the Standards Committee discussion on patient-generated health data please.

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

Absolutely. Well thanks very much. And Leslie Kelly Hall did present to us the output of her working group and what standards that working group thought would be appropriate for content, vocabulary and transport of patient-generated data. And like with any standard, what we try to do is evaluate those standards for maturity and suitability for purpose. And after hearing her presentation, we reflected back to her working group that there were probably some use cases and a little bit more specificity that would likely be required for us to comment on suitability for purpose. And let's go through what I mean in a little bit of detail by Michelle, it's the slide called "Standards Recommendations," probably slide 5 in your stack.

So what Leslie and her team had recommended is that ONC should consider Direct transport for secure messaging and data from devices. And we certainly concur that Direct messaging with its S/MIME, SMTP and its XDR SOAP approach as part of Meaningful Use Stage 2, certainly something that provide-based systems as part of certification, need to be able to generate and accept packages using the Direct protocol. The only issue is that today, when we look at the devices that are actually transmitting telemetry, whether that's a bathroom scale or a blood pressure cuff or a glucometer, at the moment none of them are using the Direct standard. And so, I certainly think it's very reasonable to say that if there is a personal health record application, such as the HealthVault type of application or a novel app that is created for a mobile device, Direct certainly is a nice way of getting a package to an electronic health record, which should be able to ingest it. But there's a standards maturity issue.

And what Leslie and her group did, which was thoughtful, which was a Continua Alliance as a group of manufacturers offering some 90 different devices, also have standards and implementation guides about getting telemetry from devices. And so the Standards Committee had asked that since Continua not so much a standards development organization as it is an implementation guide assembler, a convener that the Continua folks specify for us the exact enumerated standards that they think have been incorporated into these consumer level devices. So that we can weigh the use of the Direct protocol, which certainly again is supported by Meaningful Use Stage 2 against what Continua is now incorporating in devices, and try to come up with a good compromise to ensure that if we would require this in Meaningful Use Stage 3, there are devices that can support it. And before we move on to the other recommendations on care team, CCDA and other things, I mean Leslie, any comments you would make? I know you had Chuck from Continua who is going to enumerate those standards for us for our review.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think that's a good overview John. I think we have all – we've had the discussion about the chicken and the egg and especially with the patient-generated health data. Because there absent some standards, it could be argued that smaller organizations, consumer organizations can't enter the market because there is too much emphasis on their own R&D. So that I think, refining the use case is something we will do and also, I do think there are some experiments being done right now with Direct and devices with RTI, so we're looking – excuse me, Rhode Island Institute, and so we're looking at some of that as well.

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

And you might imagine, there could be a hybrid approach such as a third-party company, again, I happen to use HealthVault as an example because they have done some work like this. Works on those standards like the IEEE 11073 standard that allows data to come from devices into a repository and then that repository function uses the Direct standard to get them into an EHR. So you could imagine third-party aggregators dealing with devices directly.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And that's a great example because HealthVault has done both the aggregation to send really buckets of data, and also individual data streams. And we heard earlier on that it was important to providers to have either.

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

And so I think what I would summarize for you Paul is that there are probably two competing standards families here, the Direct family, which EHRs support today, but devices don't, and the IEEE family, which devices support but EHRs don't. And so our work is to, with discussion of Continua Alliance devices, figure out which of those two, or a hybrid of those two, we would recommend to you. And that is work we will do in the next month.

Paul Egerman – Businessman/Software Entrepreneur

And this is the other Paul. I appreciate the comments John and Leslie, what you're saying makes sense. My observation about the Direct messaging standard is that it is at its core like an email standard and email is not something that most – which is a hybrid approach makes sense to me.

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

And Paul, so what I'm seeing a lot of manufacturers do is actually select the XDR addenda to the Direct standard, so that they're using a SOAP approach, and I think we've signaled at the Standards Committee that we really like the work that's going on with RESTful approaches and as we start thinking about –

Paul Egerman – Businessman/Software Entrepreneur

(Indiscernible)

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

– the next phase, boy, devices directly using REST? That may make more sense, as you say, than email direct from a device to an EHR. And in the mean –

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

This is Marc Overhage. John, could you comment a little bit about, I think that's a really critical part of this thinking in the sense that support for the Direct protocol that exists in the marketplace today, do you have any sense of the XDR addendum versus the more SMP-based approach?

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

Sure, so what I have tended to see is that many manufacturers are creating their own HISPs and so it may be that you've got an athena or a Cerner creating their own HISPs and therefore they've dealt with the interface of whatever the HISP does back to the EHR, it may be proprietary. And that HISP-to-HISP transactions using the S/MIME, SMTP approach makes sense from a security implementation standpoint. However, where I've seen vendors like MEDITECH, which offers both an SMTP and an XDR approach to get data in and out to any HISP, it seems as if XDR is winning the battle as an easier way to get from an EHR to what I'll call a vendor-neutral HISP. And that you might see SMTP traffic more as a HISP-to-HISP only kind of exchange. And Marc, I'm curious, is that the sort of dynamic you're seeing, too?

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

I agree with you, that's what we're kind of starting to see.

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

And sort of argues that devices might want to be SOAP-based or REST-based rather than SMTP-based.

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

So, this is Paul Tang. Listening to this discussion, it sounds like we don't – there actually might be somewhat of a preferred approach, like your SOAP-based approach from the devices versus the Direct as sort of implied in here, and you have a bunch of these, "should considers."

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

Right.

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

I'm focusing in on that last statement you have of, if we pick something now that would stifle innovation, because what you've described as – what you've hinted as some of a more appropriate approach or more elegant approach, actually has been shown on this slide. So, I'm a little nervous that we signaled that it should in one direction when actually that isn't your intent because that's not where the more elegant approach might be. And I worry that even that – why should we signal something that might actually in itself stifle innovation?

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

Right. And I think we will be careful with the reduction of optionality and stifling of innovation. And after we review Continua, we might be able to make a statement like, we believe that in 2015-16, the notion that a third party can aggregate data and send that data via Direct is appropriate, as opposed to mandating a device speak a certain protocol.

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

Right.

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

We'll see what Continua has to offer us.

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

Well, what's the intention of "should consider?"

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

I mean, so, what of course we know is that interoperability happens more often when optionality is reduced. We give too many choices, what we have is every vendor adopting a different variation and then vendor-to-vendor interoperability doesn't happen. So I think the decision we'll have to make after we review Continua is can we make a statement that reduces optionality, but does not impede innovation or do we need to continue to be vague and allow the market to evolve because this is a pretty early technology at this point in history.

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

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And this is Leslie and I think I'd just add to that that there is considerable discussion about what cycles innovation in a new market because we could use existing and mature standards for new application for patients. Does that cycle innovation when it's already a mature standard? Arien Malec reminds us that, hey, we made beautiful, elegant standards for email for attachments to be interoperable and we still just get more and more and more email and find that that works. So, not to disregard what works for what's elegant and not to stifle innovation, these are ongoing discussions and I think concerns. John points out that when you do give specificity, it can drive more adoption. So, we do have several balance issues to work on.

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

And so I think we'll report back to you next month, after we reviewed Continua, with hopefully an answer to that balancing question.

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

So the challenge we have is the timing we're on, which is to present back to the Policy Committee our final recommendations on February, I believe it's the 4th or 5th. Is there a chance, so we have two more calls, is there a chance that in – by either the 17th or the 28th we could have your final recommendations that we would take into account as we produce our final recommendations for the Policy Committee?

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

And I'm certainly happy to try, so what I would say is, Leslie, light a fire under Chuck.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, we will. But John, do we have a Standards Committee meeting formally this month?

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

We don't, but we could probably do it through a workgroup.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay, great.

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

So, that's – so we'll work on that.

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

Okay, so –

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

Paul, this is George. What answer do we need by the 28th? Do we need to know which standard or do we need to know that it's feasible one way or another by 2016 or 17 or whatever?

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

I think it's more the former. So, it would be nice if we could get rid of these "should considers" and have a more definitive statement like, it's possible that it's not even – it's not feasible in time for Stage 3 and that we would work towards something in Stage 4, for example. I don't know how people would con – how would they take these "should considers."

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

Right. So we will do as much as we possibly can to give you guidance by the end of the month, and Michelle that would mean one of our workgroup calls, certainly, Clinical Operations Workgroup I think does have a call scheduled between now and then.

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

Paul, its Christine. I think it's – you're right that what – the option you're asking for is the ideal, which is to know sooner rather than later. But if we can't, I also think there is a lot of time now between now and 13, so there might be a way that we can do something in between, as I think George is asking about, so that we can have that time to get some clarity, if needed.

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

Hey, but the good news, Paul, is the rest of this slide doesn't have such ambiguity. So when we talk about care team roster, there are no competing standards to the HL7 Care Team Roster standard. It's a very immature standard, it's just been balloted, but it's reasonable and it's real – if you want structured data in a care – of a care team in a message, that's the one to choose.

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

Okay, that's helpful.

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

And then the CCDA for structured –

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

John –

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

Yes, go ahead.

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

John, this is Marc Overhage, just a question about that. One of the things I know the Standards Committee tries to do is place standards on sort of a matrix of maturity, use and so on. And my sense is that the care teamwork, like you say, has been balloted, the use of that is virtually zero today.

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

And that's correct. It's very immature, there – so the decision there is, here you have – it's a standard appropriate for purpose, it's been balloted, it is implementable, it just has not been implemented. And –

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

Well, and that's where I think in the Standards Committee we always had that dialogue about implementable – just because it's been implemented in a pilot somewhere doesn't necessarily – I mean, there's implementation 1-on-1 and then there's implementation at scale and as we've seen with many things, it's not always the same thing.

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

Sure.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, I mean, I would agree with what was just said, the fact that it hasn't been implemented is serious concern. I mean, what we're talking about rolling something out on a national basis and –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I –

Paul Egerman – Businessman/Software Entrepreneur

– then there's something programmed to something that nobody's currently using.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and that's a good caution. And it's also a reminder that we really have not developed anything that supports yet a collaborative model. And one of the things that we were tasked with looking at is what could the future bring us in collaborative care or coordinating care as we look forward to next phases of meaningful use. And before you can get to collaboration, you have to identify the team members, and this was considered a foundational step for any future work. And this has been harmonized across a great deal of HL7 and the research community, so, it is very implementable and it also is early on.

Paul Egerman – Businessman/Software Entrepreneur

John –

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

And so, as we have done before, our challenge will be chicken/egg, and that is, we have a standard, it's immature, not implemented, but is implementable and does the policy goal of having the patient's family engagement with the care team necessitate that we take a leap of faith. And that's – you're right, not an easy answer there, but at least there is some standards ambiguity.

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

If you wouldn't mind including those characteristics, and I'll put that in a general term of feasible, feasibility, from the standards exist to this implementable, to it has or has not been adopted and can be at scale. And any incite you have on why it would – it may not be picked up, that would be helpful, just to have a more informed decision, and just to communicate that information to ONC as we go forward.

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

Well, absolutely. And of course, as Marc Overhage and Paul have said, it may be very implementable, it's just no vendor has done it yet, and therefore it's a barrier because the code doesn't exist to produce it, but at least my review of the standard shows that the lift to produce it isn't so bad.

Paul Egerman – Businessman/Software Entrepreneur

And all I can say is, in my experience, there's a lot of things that look good on paper –

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

– but work out differently when you actually implement them.

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

This is true.

Paul Egerman – Businessman/Software Entrepreneur

Like almost everything works that way.

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

I just don't want to fall into this trap of just because the standards exist that we should – that everybody should do that, because that – I mean, as Paul Egerman was saying, it just isn't always that – there are a lot of other extenuating circumstances.

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

Now on the CCDA, let me give you the goods and the bads here.

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

Right.

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

We know the CCDA has multiple templates for things like problems and meds and allergies and the care plan templates free text, but it's a template. And so what we had asked Leslie to do was, we talk about patient generating data and using the CCDA, it's very, very likely that a patient-facing application could send to an EHR a CCDA that uses one of these existent templates. So that there may be multiple use cases, like medication reconciliation that's assisted by the patient or problem list reconciliation, allergy reporting, those sorts of things. The challenge would be structured and unstructured data that doesn't have a template. So, we all believe that patient reported outcomes are important, but there isn't, at the moment, a CCDA template for a patient reported outcome. And so there is – are – S&I Framework is looking at some other ways to capture structured Q&A that doesn't use CCDA. So I think the issue there is, this standard may be mature and appropriate for purpose if it's something like provide a medication list, but immature or not appropriate for purpose if needed for something like patient reported outcome. And so here we are having Leslie's group give us some specific use cases and then Paul, we would respond to you with appropriate, not appropriate, mature or immature, those same sort of criteria.

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

Right.

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

And used. Because I think we all agree that if a patient could, online, reconcile their medications and provide a canonical list, ahead of a visit, that that certainly would be good and should be incorporatable, just as Meaningful Use Stage 2 does mandate the notion that a CCDA received from an external party can be used for medication reconciliation. So that would probably not be that much of a lift, whereas patient reported outcomes could be a lift.

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

That's very helpful, John. So there are specific templates that already exist and could be reused in the context of patient reporting some of those, like meds. But not to generalize it to use of these templates – existing templates for PROs in the more general sense.

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

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And this is Leslie. Largely we don't yet have a consumer vocabulary that would get to the nuances needed for patient reported outcomes. But, we have about 32, I think, different templates for questionnaires that could be used, including things like medication reconciliation and pre-visit information that could be quite helpful.

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

And we do have some nice vocabularies at the National Library of Medicine, Kaiser's converged medication terminology has been curated by the NLM and that links such things as what I'll call patient friendly terms with SNOMED, RxNorm, LOINC and those sorts of things. So, there are, as Leslie points out, for some of the templates, we might have both content and vocabulary that are suitable for patients, but at the moment, I am unaware of a generalized vocabulary for patient reported outcomes.

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

Other questions for John before he leaves?

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

John, this is Charlene. From the – back to kind of the care team roster, are those – as you looked at those, were those – the use of that tagged with a use case, too. So for instance, under care coordination, we identified three use cases, would that standard be used in support of, for instance, when a patient is discharged and we wanted to send some information about care team members is that the thought? The only reason I'm saying this is we're tending to – we're aiming to get a focus on a couple of key use cases, for instance, med rec is one that is kind of active, so, is there any alignment of the care team roster with use cases?

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

So I would say partially, and that is that I use the Direct protocol to at transition of care, send information to the primary care doc, the referring doc, the folks that the patient has provided upon registration would be likely participants in any follow up care. I can't imagine that if you have a structured care team roster that that could be used by an application as part of transition of care messaging, but, this is something that would be done at an application level, there's nothing specific to the standard that includes the Direct address of recipients for transition of care documents.

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

Okay.

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

And certainly Leslie, if you had use cases like that that you wanted us to review so that the care team roster would be also evaluated as suitability for purpose, we're happy to do that.

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

Yeah, I think that would be really –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Great.

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

I think that would, especially from a standard perspective, start to hone in in terms of where the development would be. I think that's the ambiguity, when you start to talk about just one element out of the context of what you're using it for.

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

I –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

We'd be happy to make sure the use cases are more explicit.

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

Thanks Leslie. So I think the "to do" here, and we're really hoping that it could be done before our call on the 28th is both a follow up of specific use cases for both the care team roster as well as for the struc – for the useful cases that patient-generated data for questionnaires and a review of Continua's named standards so these can help give us better guidance on – or more complete guidance on the device generated patient data.

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

We will do it. And so Michelle, we just – as the keeper of our agenda, you have heard our marching orders. So we will do everything we can to get back to the Meaningful Use Workgroup in a timely way so they can make their final recommendations.

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

Thank you John and thank you for joining today's call.

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

Great. Everybody have a good day.

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

Thanks for joining John and thanks for all their work and help.

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

Certainly.

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

Okay. Thank you. And then next on the agenda is Marjorie Rallins and Danny Rosenthal about medication adherence and some feedback from the Standards Committee Clinical Quality Workgroup.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Well good morning everyone, this is Marjorie. I'm not sure if Danny is on –

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

I'm right here.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Oh, you are there. Hi Danny.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Good morning.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So, our workgroup actually appreciated the opportunity to be able to provide comments on these two issues. We had a very robust discussion on December 19. And if you're looking at the presentation online and if you have the slides, I'll briefly – I don't want to just read them, but I'll try and go through them very briefly. One of the things that starting off that the group felt very strongly about was getting some additional clarification on what the goals were for medication adherence in PDMP for the certification criteria for meaningful use. They felt that as the goals or objectives were currently written, that it wasn't quite clear at this point in time. So – and once you clarify what the goals are, then you should prioritize them; that was one suggestion.

After we had that discussion, then we looked at – when we focused on medication adherence, we felt that the NCPDP standards were at a point where they could be recommended for medication adherence, in particular the NCPDP SCRIPT standards and the Structured and Codified Sig Format standard. And one of the things that we also wanted to note is that both standards had an original intent of being used for administrative analysis and if they were going to be used for clinical purposes, then the data would require additional cleaning. And then we also talked about –

(Indiscernible)

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

– go ahead, was there a question?

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

This is Paul. Yeah, would you mind just expanding a little bit on what you meant by administrative analysis.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So, I think there were – when the NCPDP standards were originally developed, they were for plain-based and transaction type analysis rather than being used for clinical data does that – clinical data analysis. Does that make it clearer?

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

In other words, whether such a medicine was prescribed but not necessarily what's the dose and the sig were.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

I can't tease it out to that level of detail. I think it's – maybe so, but I'm not quite clear on that, I'd have to have some of the other members give clarification. They basically sort of kept it at the administrative and clinical levels for that part of the discussion. But we'd be happy to go back and get clarification if you'd like. Danny, do you have any –

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

We do have Shelly Spiro on; I don't know if she could speak to that at all.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah.

Lynne Gilbertson – Vice President, Standards Development – National Council for Prescription Drug Programs

This is Lynne Gilbertson from NCPDP.

Rachelle “Shelly” Spiro, MD – Executive Director of the Pharmacy e-Health Information Technology Collaborative

Sorry, I’m on. Hello?

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

Is that Shelly?

Rachelle “Shelly” Spiro, MD – Executive Director of the Pharmacy e-Health Information Technology Collaborative

Yes I am.

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

Could either Shelly or Lynne answer the question that was just raised?

Rachelle “Shelly” Spiro, MD – Executive Director of the Pharmacy e-Health Information Technology Collaborative

Lynne, you can go ahead if you’d like or I’ll be glad to.

Lynne Gilbertson – Vice President, Standards Development – National Council for Prescription Drug Programs

Sure. The – it perhaps, since I wasn’t on the discussion, the administrative analysis might be coming from the perspective that yes, a lot of the medication history information is coming from the claim processing. It would contain dose and days supplied, frequencies, those kinds of attributes. It would not contain the sig, as was noted. So perhaps that’s where the focus came from. The transactions were built so that they can be exchanged by any party that has medication information, so it doesn’t have to be from the claims processing, it could be from a request to a pharmacy who might have dispensed, as well as maybe cash-based versus commercial versus coupon-based fillings and dispensings that have taken place. But the predominance right now from the industry appears to be the use of the information coming from the payers, based on the claim filling. Does that help?

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

Yes it does. I mean, the key task for us, when you’re talking about medication adherence, you actually have to understand everything in the sig, so there could be things like p.r.n., there could be multiple pills taken at a specific dose, strength, etcetera, so that’s really important for us to be able to calculate whether there’s med adherence or not. At any rate, so thank you for clarifying that.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

And so, in addition to the NCPDP standards, we also talked about RxNorm and that the EHR should be able to accept RxNorm codes. We also talked somewhat about NDF-RT, but the NDF-RT should be only considered with respect to drug class identification at this point in time. There were some other recommendations that we talked about as it relates to medication adherence and that signals can be identified, but they’re not necessarily computable at this point in time. And the group also felt that actions on signals are out of scope for this particular question.

We also talked about the CCDA medication list and that med rec should be considered in the context of medication reconciliation as a – medication adherence, I'm sorry, and there was a lot of discussion around that. Eric Rose pointed out also that various states accumulate data on controlled substances and those states make that data available to providers that have no data integration with other systems and that in the discussions about the certification criteria, we should consider that. And then it was also important from the group to know that they felt that it was import – to communicate that the alignment of the goals of medication adherence and PDMP should also align with other regulatory activities with other agencies. And one example was some of the initiatives that are coming out of the FDA, is extremely crucial. And then the Meaningful Use Workgroup thought that we should have other standards on the call, other standards experts, such as Lynne Gilbertson and Shelly Spiro, and I believe they've joined the call today to continue your discussion on medication adherence and PDMP.

And then with respect to PDMP, those standards, the group felt that there are many issues that are under consideration, I think some standards are still up for review within HL7, don't quote me exactly on that and maybe Dan, you might have more details. But, we weren't ready to make recommendations of the standards for PDMP at this point. Any other questions?

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

Okay, any other questions from the group? Thank you Marjorie.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Um hmm.

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

So, the final recommendation with respect to med adherence, and what we're trying to do from the clinician's point of view is to have the computer provide some indication of adherence based on the available information, specifically from PBM, if the standards and the important information are there. The question I guess I have is it is very critical that we understand, in particular the sig. I understand we know the dose, strength, etcetera, but the sig is really important and one easy example is the p.r.n., taken as needed. That would definitely color how you interpret the number of pills dispensed. The other interesting change in workflow these days is the pharmacies now have auto-fill, auto-refill kinds of programs, which are convenient and useful, but actually clutter up the data in terms of can you use the refills as an indicator of med adherence, and in the sense you can't because it's just being doled out automatically anyway.

So, that's a bit of a conundrum, because the convenience method actually interfered with the signal that we're looking for. So I think one of the biggest things we have to consider is whether we have the standards support and the adoption goes back to that discussion of particularly structured and coded – so that the computer can automatically sort of make it count and see if the appropriate amount of tablets dispensed meet the prescription and the way it was intended to be taken. Comments about that or about the suitability of med – automated med adherence for Stage 3?

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

So Paul, this is Mike. I would just resonate with your comments about the difficulty in interpreting the results, assuming they're even available. On average I consider inversely p.r.n. medicine use with clinical control as a primary care physician, so the less they're using it and the better they feel, the happier I am. And to your other point, the dispensing without request for a dispense doesn't tell me much and I'm a little worried about the false assumption in the absence of patient confirmation that dispensing correlates with actual use.

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

Thanks Mike. Other comments?

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

Paul, this is George. I view this, the med adherence, I don't see anything out – I was never aiming for automated here. It's just other evidence to give to the doctor. So even if you don't have the script, the doctor will know why they – for their meds, they'll know why they ordered them. And so what I would be doing just presenting data, that is, patient dispensed – it was dispensed or it wasn't dispensed and expect it – like I'm not expecting to set up a lot of alerts that says, of these five medicines, the patient hasn't taken three of them, because then you really have to figure out what's going on. But if I just knew, as a doctor, that the patient has never filled these prescriptions that would be interesting information to me. So if we get rid of the word automated and it's just a source of information for the doctor, I think that makes it easier.

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

That's helpful George. And so, if I – I look back at the objective; we are calling out only for certification criteria, right?

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

Yes.

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

So this is Mike again. So George's point I think was a really important one and trying to make sure that you're not overwhelming physicians with data that requires so much interpretation that they just sort of bail on it. I think there is a great – this and it was filled is really helpful, simple information as opposed to the calculation of whether once filled it's likely they're taking it as prescribed. So I would certainly argue for a functionality that makes it clear that you can correlate the prescribing of something with the actual dispensing of the medication as a priority.

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

This is Marc. I – this is Marc Overhage, going up one level. We have here the PDMP suggestion, and certainly those are powerful tools. On the other hand, to George's point, if our goal here is actually to be helpful, yes, it's another bit of data that's largely redundant with the data that's available, especially if you say not just PBMs, but pharmacies in the data that we're looking at in the first part. I guess I worry a little bit about is this encouraging information overload in the sense of, you've got stuff that's going to be largely redundant and not helpful, so do you really want the prescription drug monitoring program being listed here. I notice –

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

This is Amy –

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

– that complete overlap.

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

– and I joined late, but from a state perspective I can say the PMPD stuff is very, very high priority and I think that however we can promote integration of that data, even if we have to be duplicated or whatever. In our state, there is a separate PMPD and the Department of Health and the Director, it's a priority for them, but they're very concerned because the providers aren't going and using it. So –

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

And we have the same in our state and it made it very accessible, and part of the challenge is it just becomes very confusing as a provider, especially when you're doing the – you're getting data from Surescripts that is largely redundant. It just becomes a lot of work for minimal value and it's only that very small, select number of patients where you say, this is high value.

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

So I'm trying to think about it and again, I joined a little bit late and got called away, so I've missed part of the conversation, so I apologize. But I think whatever we can do to somehow integrate them, because there's been large investment and a lot of push at the national level to get these up and going and so we have to think about how to tie them together better.

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

The Standards Committee presentation, though, said they weren't ready to make recommendations because of some – because of the standards, that there are many issues with the standards.

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

Yeah. The other interesting thing is I don't know if anyone on the call knows, SAMSHA put out a grant to try to really integrate PMPDs directly with EHRs. I know our Department of Health has one, I don't know what they've done with it yet, I'm trying to catch up on that. So again, I think there's like lots of pockets of things going on with that and I don't want to derail this conversation from that. I just – I think because of the priority and the focus on it overall and nationally, I think we do have – and at a state level, I think we do have to think about how they tie together.

Lynne Gilbertson – Vice President, Standards Development – National Council for Prescription Drug Programs

And this is Lynne Gilbertson. That – the PDMP work is a project of the S&I Framework, so hopefully there could be something from that that's brought forward that would be of use to the committee.

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

So one more note on this – this is Marc is, so the de-duplication of – what's needed to make it useful, but it also slightly increases the complexity and challenge for the implementation because then you get into all these issues about – excuse me – what drug codes are truly duplicative and all those sorts of things. And so I just want to make sure we understand the complexity that we're talking about introducing by having both. It's not a freebie.

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

What ab – this is Amy. What about, one of the things we're talking about here in Rhode Island is trying to do some sort of a, and we haven't explored this yet so I could be way off but, trying to do a single like some sort of single sign-on between the PMPD and, in our case, our HIE since, a single sign-on for that so at least – and then somehow figure out how eventually that could relate to a single sign-on to the EHR. It's not full integration, but it's a step towards it if the standards aren't quite there or –

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

Can you explain what is actually our goal in connecting to the Prescription Drug Monitoring Program, independent – the difference from our goal with med rec and med adherence?

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

Was that to me or to anybody?

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

Well, anybody.

Rachelle “Shelly” Spiro, MD – Executive Director of the Pharmacy e-Health Information Technology Collaborative

This is Shelly Spiro; I might be able to answer that for you. I'm the Executive Director of the Pharmacy HIT Collaborative and the prescription drug monitoring information is originally set up to help hinder controlled substances. And I was involved in the workgroup activity when MITRE actually had the contract and there was a huge amount of discussion over many months, in terms of how we're going to utilize that to help with abuse. And so what – there were a couple of discussions that have taken place in taking that prescription drug monitoring data and adding it to other types of medication information, not just controlled substances. And run it through the workflow of the prescribing process using the SCRIPT standard and medication history. That is the ultimate goal in terms of, especially from the prescriber's side, in moving the information to the prescriber prior to sending the prescription, so that that information is available to the prescriber, not just controlled substance data, but all data prior to prescribing.

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

So there are a couple of things going on. So one is, you're not expecting doctors to confront patients, necessarily, for what they've done in the past, what you're mainly concerned is when they write the new prescription and they already have 10 prescriptions for narcotics, they don't need an 11th one. But that sounds like that's the main goal and then you're saying we should benefit from this because if we tie this all together with all prescriptions, then it could be used, but – so it can be used for clinical care. And on this last part though I wonder, how does everything fit together? How does the PDMP fit in with what we're doing on med reconciliation anyway and HIE? Does this replace that? Is this in addition to that, because that's why the duplication came up?

Like one vision is, it's a very narrow scope, what we want to do is tell doctors this patient has had too many narcotics in the last month and they should watch out and not prescribe another one, and that's a very specific goal. Versus trying to reuse the PDMP infrastructure to solve medication reconciliation, if we're going to pick that one, then maybe we shouldn't be doing the other med rec thing. So that's what I'm thinking.

M

George –

Rachelle “Shelly” Spiro, MD – Executive Director of the Pharmacy e-Health Information Technology Collaborative

Well – and this is Shelly Spiro again, if I can, because I didn't get a chance to talk about this before. But using the Consolidated CDA, we've been working with our pharmacists on the clinical side to work through the – what we call the medication therapy management process. And using the Consolidated CDA with structured documents to, when the pharmacists are doing their comprehensive med review and their medication therapy management targeted reviews, to send that information to the physician so that they have that information prior to the dispensing process also. More of a clinical aspect of making sure that there's information that the patient is adhering to their medications or coming up with what we call a medication action plan that the physician would be able to understand to help that patient better manage their medication, along with the pharmacist.

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

George, this is Marc. I think my take would be, this is a data issue, right? So, the – if I want to look at a patient's adherence, I agree with you, there are sort of fundamental targeted differences, but they overlap tremendously, right, in the sense that if I'm looking at a patient's adherence and if they're “over-adherent” with their narcotics, that's the same as the Prescription Drug Monitoring Program goal. And the thing that the PDMP programs do bring is that because of the state pharmacy board requirements, you get reporting and data from pharmacies that are not participating in PDMs that are not necessarily participating in Surescripts. And so, they are somewhat complimentary in terms of data, but I agree with you, in general it's sort of a 90% or more overlap in the data. And I don't think anybody would suggest reusing the state infrastructure for medication adherence, if for no other reason than the states aren't funded to support that and they would die trying to respond to the numbers of requests and queries they would get.

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

So then –

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

This is Patty Sengstack. I just – I'm feeling like I need some clarification from a clinical perspective. Are we discussing the ordering of a medication in an inpatient setting, an ambulatory setting, a long term care setting or is this addressing all of the above?

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

Let me – that might – this is Paul Tang. Let me use that question as a way to try to summarize what I think I've heard so far. An important point is it sounds like neither the standards nor certainly the use is sufficient to support automated med reconciliation that includes either use of data from PBMs or PDMP. And perha – but what we would like to do is use EHRs to make available data to the human clinician as they process – as they think about med orders in either setting, inpatient or ambulatory. So that perhaps where we are is that we're trying to support essentially medication adherence, making an informed decision in medication prescribing. And as part of that, would like to have EHR be able to accept the bullet point under Medicare – ability to accept data feeds from PBMs related to fill data and find a streamlined way to access the PDMP data. So in a sense having the ability through your EHR, and in the latter case it might be just a hyperlink for PDMP sign-on, having ability to look at med fill data from either of these programs to support making decisions about medication orders. Did I summarize that correctly? Try one more time –

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

Right, and I think – Paul, this is – I think so Paul. And one of the things we should do is get a little more information about the other sites that were funded under the SAMSHA grant because this is exactly what they've been funded to do or just got funded to do, to do some sort of integration between pharmacy, EHRs and PBM – PMPD, rather.

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

So I think –

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

So Paul, this –

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

– work to be done, but before that, was clearly not a Stage 3 thing then.

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

Paul, this is Neil, can I throw in two comments?

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

Yes, please. Please Neil.

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

So one is that we really need to work backwards from the work – from the clinician workflow because this thing, and even the Prescription Drug Monitoring Program like as it exists now in New York, and how it's being contemplated, it really is not consistent with good workflow for clinicians and it really has a very different purpose than what I see in terms of med rec. I mean, if this – if that program, even as it's contemplated, sort of gets – rolls out for all medications, I mean I would just see people basically ignoring the information, it's just not in a way presented that's useful for clinicians. And the second thing is I think that if we're going to contemplate and have solutions for med reconciliation, it's got to have a mechanism for incorporating patient input.

Because the only people that really know what people are taking, I mean, all the rest of this stuff is a way of sort of checking up on what people would tell you, but the only way you really can tell what people are doing is to have the patient have some input into this. And there are some really nice apps that are being developed for patients to be able to interact with some of this data. So I think that we should – I'm just hoping that at some point we can think about sort of like what's the ultimate goal here. And the ultimate goal has to be to be able to incorporate patient input into this, because they're taking things that may not show up in these others and they're not taking things that are going to show up here. And I think without that input, we're going to have a lot of data, but not a lot of information.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, if I could comment. One of the things that we looked at in the patient-generated health data team was to make sure that medication was high on that list, and included in the template recommendations for doing – on the Consolidated CDA. And the other comment for the pharmacy integration that we talked about very early on was the need to provide linkages to get cost information real-time. And so I don't know if it's with this particular effort or discussions we had earlier with PBMs, but that came out of both the care coordination sub-team and the patient sub-team as highly desirable and for integration of prescription information.

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

This is Marc Overhage. George, while I agree that ultimately you want the patient's input, I guess I want to be careful that we don't throw out the baby with the bath water here in the sense that I think there's strong evidence that the – given the caveat that was placed earlier about automated refill program. That medication possession measures of a variety of ilk do correlate with disease control and do correlate with individual patient medication adherence; granted, this is not as good a measure. And so I agree with you want to keep our eye on the goal of having the patient reported things. But I'd hate to see us ignore the opportunity to improve the information the clinicians do have, because I think it does add to what we normally do, are you taking your meds; sure, for the last 24 hours, towards the measures that we have available today. I think there's a balance there of looking forward, but not looking for perfection, either.

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

But – this is Neil; I'll just throw in more. I don't think this is an issue of correlation with good prac – I think this is an issue of finding the bull's eye in the target and working backwards from a workflow that would get us there and from information capture message that will get us there. Because anything short of that is going to produce – yes, it's going to be correlated and yes it's going to be inaccurate and I think that that runs us into dangers of having information that just doesn't reflect what people are actually taking, and passing that information around the system as if it's factual. And I think that that's where – I think that has as much danger as having missing information. But right now we're like in this process of trying to make sure we don't miss a single thing that was ever prescribed for anybody, whether it was through their insurance or whether they paid cash for this or whatever. But meanwhile, the potential error on the other side of that, which is assuming that medications that people bought to have on hand or that other things were there are actually things that people are taking, made it equally as dangerous if not more. So I just think we've got to focus on what the end game is the end game is to get really accurate information in a workflow that works for clinicians and patients. And getting there incrementally may be helpful, from sort of a creating standards kind of process, but I don't think it's going to be what's – what we're going to end up with on the back end of this is a workflow that people are going to use, because it won't be really accurate and it's also going to be very burdensome for providers. And if they don't use it, then it's not going to really help us that much. So, be at least – it would be at least nice to have a vision of the destination so that we can make sure that what we're doing along the way is going to help get us there, that's my only point.

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

So this is Mike Zaroukian, if I could tag on to that as a person who's doing primary care on a routine basis. So the classic examples for the narcotic medication would be, I would like to know in the process of either ordering or renewing a narcotic medication whether the patient has received that medication, or something in that class, from another provider during a specified interval. And if instead of having to go to our MAPS Program in Michigan or whatever to figure that out, that would be great, but it's both for renewals and for new prescribing.

The part for other mediations is I'd love to eliminate all the current alerts and warnings and messages I'm getting from PBMs and others about a patient who is potentially non-compliant with a medication based on the current frequency with which they last renewed it, etcetera, etcetera. That can be helpful information, but too disconnected from the point of care with the patient, you know have to tie a piece of paper or a FAX back to the EMR, assuming you have time to get back to that patient at that time. I think the third point, with regard to medication reconciliation is, doctors have felt quite burdened, and their nursing staff, etcetera, at the work involved in medication reconciliation. So anything that we can do to help the patient electronically indicate, with reasonable options, their current use, partial use or lack of use of medications that are at least chronically prescribed, would be a way of giving back, if you will, workflow convenience to the providers that currently feel that this extra amount of work is necessary. But that the automation – that the process ought to be more automatable and the patients ought to be able to participate more.

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

This is Paul Tang. Let me try to summarize the discussion that I've heard and see if I can edit this objective you see on the screen. This is only for certification criteria and we're basically looking at the topic of medication adherence. I think in short we've discussed three methods. Method 1 is just make – having the EHR be able to access information that can ma – and present it back to the clinician. Method 1 is bullet 1 under med adherence certification criteria, which is the ability to accept data feed from PBMs about med fill history.

Method 2 would be what's written under certification criteria down below, EHR technology supports streamlined access to PDMP data. It does not say how, and I would eliminate those other bullets because they invoke things that cause more complication and not necessarily help. So basically the second bullet would be that there's a streamlined way to access the PDMP data, which could be simply make it easier for me to sign in with not single sign-on to sign in to the PDMP system. And the third one that was brought up by Neil was to have a way for patients to be able to communicate their own adherence history via presumably some structured questionnaire. Have I captured what people have said and would that be acceptable? Basically, certification criteria only for three ways, one through PBM fill data, two through some streamlined access to PDMP system and third for access to patient reported med adherence.

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

Yeah, Paul, this is Amy. I have one question. I mean I think from a certification criteria only that seems to be getting at what we've been talking about. I'm assuming then if the HIEs wanted to function as a modular component to that and got certified to be able to do that, they could do that on behalf of providers and EHRs in a community. Because a lot of HIEs are trying to do this – do both the complete – not the ordering, but the ability to look up complete integrated med history and some of them are being integrated with PMPDs.

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

So my response to that would be that yes, so an HIE organization could get a modular certification to do this objective.

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

Okay. I think it would be important to just state that because again, I think even as we move ahead, I think there is work in that area by some HIEs in some states.

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

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

Yeah, please.

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

Paul, this is Art. I just wanted to go back to one of the points I thought I heard you mention earlier regarding the absence of a standard for sig and that might be a concern, is that correct?

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

I think that's what they said.

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

Right. We have been doing for 10-15 years using pharmacy data to do adherence monitoring and things – the screens that we present to patients when they come in the HIV and AIDs clinics – and it's a tool that we use to educate patients about what's going on and find out if there's something that needs to be done to help them. We have not had a sig in this process in the last 10-15 years, as I mentioned, and we use what is readily available is a day of dispense. Now I understand and agree with the problems that sometimes happen when you use this data of dispense, the pharmacy fill that regularly and then put stuff back on the shelf. But there is another variable that's been available to us, this is the point-of-sales dispense and rather than just dispensing from the inventory. And we've found that it's been pretty helpful, even though we don't have a sig, that we can just use a day's supply to make a calculation.

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

Thanks Art. Other comments about the edits to this objective? I think the main thing is adding what Neil brought up, is that something appropriate for Stage 3, which is the patient reported adherence?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

From our point of view – this is Leslie, from the patient-generated health data seeing that would be the highest li – highest on our priority list and appropriate for 3.

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

We'd have to dig down and see if we have – presumably that's a CCDA template that would support that.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

We do, that was the first one we worked on.

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

Okay.

Rachelle “Shelly” Spiro, MD – Executive Director of the Pharmacy e-Health Information Technology Collaborative

This is Shelly Spiro, if I could just add one aspect to that. We are working with our pharmacists to create, because they do interview the patient, they do work with the patient for medication reconciliation, would also be a solution to have the pharmacist send a Consolidated CDA with that information to the prescriber, which would include information from the patient. But in a way that the physician would be able to use that information more effectively for med management and med adherence.

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

Okay, very good. Thank you for this discussion. We'll try to edit the words to reflect what we just said and present it right ba – present it back for final review in the subsequent call. Thank you very –

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

Hey Paul, this is Charlene.

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

Yes.

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

The one comment again, a lot of the feedback from the vendors comes, we do lots of certification that's not used and then it's out there for a long period of time and I understand the chicken and the egg problems. If there's any way this group would indicate a priority, I think that would be helpful. There's a lot on our list for Stage 3, so, it may not be possible in this space, given the conversation, but that would be helpful.

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

I think that's a fair request. So Michelle, maybe as we – when we go through our final review, we can sort of mark high priority or not, and then when we sort of – the objectives, maybe we do shed some things that are not quite as high priority. Anyway, that's something we could discuss in our review, but that's a fair statement. All right, well thank you very much for this discussion; move on to the next topic, which is OpenNotes. This is an interesting concept. As you all know, this comes from a project called Open Notes, and this is basically giving patients electronic access to the progress notes. As everyone understands, HIPAA grants people access to their full medical record, with some small exceptions, and this really is making this available electronically.

There has been a project, as I said, called OpenNotes and we actually talked to both the sponsor and the lead for that project. And in a nutshell, while they're very grateful for the support that we've had in terms of actually talking about this in the context of meaningful use, there's some trepidation about is it too early to prescribe a certain method. So when they looked at the OpenNotes implementations that currently exist, they're all different. That may be a good thing because that's people being innovative on how can you make this useful to patients and how – what exceptions do you have, what accommodations do you have for special requests, the whole workflow thing, with which we are very familiar.

And their thought is that we still – this is an emerging “technology,” it's an emerging concept functionality and we still have to work out how to do this in the most informative way for the benefit of patients, and the most efficient way, from the point of view of the providers. And that's not yet done and there's more work to be done. And so their hesitation would be, we wouldn't want to mandate something before its time, sort of like wine, and in the con – and as a result, inadvertently stifle innovation of discovering what is a good way to provide this for patients efficiently and effectively. So they probably would not encourage us to move on this as far as “prescribing it” as part of the Meaningful Use Program at this stage. So let me open that up to discussion.

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

Paul, this is Christine. I agree it's not a good idea to just mandate that everybody open their notes through the meaningful use policy, but my recollection of our agreement coming out of the clinical documentation hearing was that we said we needed to make the functionality there so that those who chose to could do so. And again, I don't have my notes from that hearing in front of me, but my recollection is that what we said was, as long as we were continuing to increase the frequency with which people are recording their notes electronically, which is in the first bucket of quality, safety, efficiency. And then what we said was, we would also make it an optional data element, in other words, like I would imagine sort of certification only that the view, download, transmit function has to be capable of displaying those notes if the physician or hospital chose to do that. So all – my recollection is just setting up the functionality so that it is there for people who want to, but we all agreed that you can't just, surprise, your notes are available to everybody.

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

More than that Christine, what they point out is it's actually the devil in the details within the actual functionality itself. So, it would not be possible, in their minds, to say how would you certify an EHR to be compliant with OpenNotes because the very act of how you implement that functionality is different in every organization that is using this. So they – that – so in a sense, they couldn't see how we could write certification criteria.

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

Well so –

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul. I just wanted to chime in also. It doesn't surprise me that there's a lot of value in putting in optional certification to do the view, download on OpenNotes because if people want to do it, they don't need the optional certification to do it, the optional certification might actually limit their ability to do it, because maybe they want to do it in a way that the optional certification doesn't handle. But I just don't see any benefit of including that in optional certification, even if it were possible to do. If people want to do it, they should do it; it doesn't have to be in certification to make it happen.

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

(Indiscernible)

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So this is Leslie and I think that poss – let's not confuse what – the data input with the data output, right? So if – with the OpenNotes Project, the patients had the ability to view, download or transmit, this is just a new template type called the progress note. So the output of the progress note could be a Consolidated CDA, just like any other view, download and transmit functionality. So this is simply the ability to add a template structure to support a note.

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

So the way I'm thinking about this, but again, I may not understand the technical implementation, is so, I want to make sure the providers who want to can do this. And maybe that doesn't mean a certification criteria or not, but just as providers are choosing – they have some discretion over what they make available to patients in view, download, like family health history, you don't have to display it, but you can if you want to and it is there, that's the process I'm thinking about. So what am I missing?

Paul Egerman – Businessman/Software Entrepreneur

Yes, but I just think that the optional certification doesn't help you do that. If a provider wants to do that, depends on whether or not the vendor system has that capability, and whether or not that has the capability may not have anything to do with the optional certification process.

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

So, I –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. I kind – somewhat disagree in that if we say that we start having different types of data for patients to view, download and transmit and some of its proprietary and some of its not, some of its interoperable and some of its not, we end up defeating our purpose. Yet if we say that in the view, download and transmit criteria we allow for a progress note template, that gives us – and we state it, then we have consistent interoperability for anything that's view, download and transmit.

Paul Egerman – Businessman/Software Entrepreneur

And –

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

So this is Mi –

Paul Egerman – Businessman/Software Entrepreneur

– I guess I disagree with that, I think that's being too prescriptive, if that's the right word. I mean, fundamentally a functionality is the capability to view the note and I think we're agreeing that that's not going to be mandatory. And I'm saying, once you agree that it's not going to be mandatory, you don't have to create any optional certification for it, that that doesn't really accomplish anything.

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

But I guess I'm confused by the word –

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

So this is Neil, I would agree with Paul.

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

– optional.

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

So this is Mike Zaroukian, let me try the –

M

Can I just –

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

– primary care approach again if I can. So I have an EMR right now that allows me, if I go through a fairly laborious workflow, to send a patient a copy of any document I want to. I'd like, as an early adopter/innovator, to be able to set my parameters such that every one of my own personally generated progress notes goes to the patient automatically. I don't know how I could do that today.

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

That – so –

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

That's the certification piece that I think is a challenge and wh – this is why we need something, and I don't know whether it's certifying – I wouldn't want to certify how the data is transmitted. Because basically a note is a note and part of what we're talking about here is the ability to take that, even an unstructured progress note that describes what went on in the process of an encounter and say make that be a face sheet. So, anything – if we're talking about certification of like what the components of that have to be, I would be opposed to that. But I think if we're talking about the ability to incorporate that into a transmitted document and to have a way to do that, then that – I think exists already.

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

Well a transmitted document or in the view, download, transmit –

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

Right.

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

– if you have a portal or whatever, just being able to flip that switch to on, and my assumption was that if you wanted everybody to have an EHR that's capable of doing that, if the practice chooses, because Mike wants to. Then he needs some – it – we have an opportunity to make sure that he doesn't have to go through a whole bunch of extra costs with his vendor to create that because it's there, it's just like turning it on. So I don't – maybe I don't understand the – but I don't get the reference to optional certification, I don't think it's optional, I think it's just its certified functionality and whether you use it or not is the discretion.

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

Okay, so let me try to clarify a little bit, Paul Tang. It's not – the challenge that they've had in the existing implementation is that there is no function that you turn on or off. The devil in the details is that function itself, and because of that –

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

Wait – .function, Paul?

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

There is no just turn on or turn off, the challenge they've had is there are conditions about turning on and off, is it for the whole progress note? Well then you automatically go into let's say, mental health. There are some exclusions that are difficult, or there are some opt-in programs that people have designed where it's not just a simple turn on, turn off the entire note or the entire notes. So that's where the cha – the aberrants have arisen in the current implementation, and they haven't discovered a common, good "best practice," that's what they mean by submerging. So it's really the ability to describe the function itself that is in question.

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

Ah ha.

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

So that's the whole point actually.

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

Very helpful.

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

We can't even write the certification criteria without actually – because there's no best practice, and without inadvertently stifling innovation, and so that's also what Paul Eggerman is saying, well then, why write it at – why try to write it at all. I think – and then for what Mike or Neil thin – and we're actually going to experiment with this this year and I'm sure we're going to run into all the things that have already been run into, but that's the whole point. We don't want to be hamstrung or have something prescribed when we're still trying to figure out what's a good workflow. So it's a good idea, it's just it's a head of the curve in terms of how – have we even explored enough to understand what are good baseline pieces of the functionality.

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

So Paul, this is Mike. I'm going to try one more approach, maybe using an EMR we're both familiar with. So you know there's a process, if you will, to automatically send the document of certain things like an H&P, discharge summary, consultation note, etcetera, etcetera, and automatically route that say to a PCP or referring physician or whatever. What I'm actually looking for is the ability to say for my documents, to be able to route my office visit notes to the patient, and that would be a new functionality, but it would be highly analogous to what the vendor already does for other documents to other professionals –

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

Correct.

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

– and that would be a new functionality that I would like to see certified.

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

Correct, but then once you start doing that, there are all kinds of – should the patient be able to opt in, should the patient be able to opt out, there are all other questions that would affect that functionality, unlike the professional-to-professional.

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

Well but isn't that the same with view, download, transmit? The functionality is there and the patient – I mean, this just strikes me that there are a lot of other functions of the EHR where the – where you have to set up the workflow, you have to set up the policies and procedures. Same thing with patient-generated health data, you have to figure out how you're going to do this in collaboration with the patient, but you need – but you want the functionality there so if Mike decides he wants to send the whole note, he can send the whole note, but if he doesn't, then he doesn't send it. But we don't have to, I think, get into prescribing whether – all the workflow details and implementation or the content of the note, but we have a – it's really a sending functionality that I think Mike is describing.

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

Right. And frankly, the whole notion, I can have a patient opt in or out of the portal, but I can't have them opt in or out of receiving their lab results, and they're going to – if I'm – lab results, I'm going to send all of them, I'm not going to selectively, except for those that I have a particular concern about, I want to turn it on and leave it on.

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

And so, I think that's actually a very good analogy because if I have a note that I'm concerned about the patient seeing, then I might hold that back as a matter of workflow, until I can speak with them or whatever, just like in labs. Or I might never send it, who knows, but there's a workflow implementation that we absolutely respect, I mean, that was loud and clear and we should. But to give those who want to the ability, as Mike is describing, is what I'm – what we also heard people wanted. And it may not be –

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

The main difference is that the note is totally unstructured; most of the other things that are going out are structured. So for example, the California law – the disclosure of certain things, certain lab tests. So because they're structured, we can block that. A note has so many things, I mean, it's totally unstructured, as you know, and there are both legal and ethical content that need special handling –

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

Are you guys getting that beeping too, or is it just me?

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

Yeah.

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

Sounds like someone put us on hold.

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

Ah, okay, thank you. I was worried my phone was dying.

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

Paul I think true, but, since we're sending it to the patient, are there any laws or rules that say you can't disclose it to the patient?

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

Actually, California –

(Multiple speakers)

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul; it's not the same thing. View, download and transmit is not necessarily the same thing as sending it to the patient –

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

– that’s a different – those are different concepts.

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

Right, but I think part of what Mike is saying is does it make a difference if you – so, maybe we shouldn’t think about putting it in view, download, transmit because there are too many workflow implications. But if the provider selects, they can send it to most – like a portal that has a document repository or in a secure email, however they want to send, they can send, but at least they have this sort of step 1 of I don’t have state laws that prevent me. I do want to do this, I’ve worked out the implications and so therefore I have a basic sending function that may or may not be displayed in view, download, transmit. Mike I think –

Paul Egerman – Businessman/Software Entrepreneur

And that’s – that’s an interesting discussion. And again, as long as we understand, it’s not the same as including it in the view, download, transmit function, then you might look at some Direct messaging capability or something.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well this is Leslie and Direct message is in view, download and transmit, as is a Consolidated CDA already mentioned in part of view, download and transmit. And so we’re just asking that certification include the ability to have a progress note included in all of those existing functions. So it should be an output function versus a workflow change.

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

Right.

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

So can I – I think we’re – there’s already a group, the group that’s leading this project, who’s already done the work of looking at the implementations and they’re recommendation is its not ready yet because of the tremendous heterogeneity of the way the functions have both been designed and implemented. And I guess I’m relying on their own conclusions to say that we don’t have the ability to prescribe the functionality that would be uniformly either useful or implementable.

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

So but Paul, my – I don’t – maybe you’ve had more recent discussions with them, but when – we did hear from them at the hearing and I had a number of discussions with them early on, probably a year ago, where they said, don’t mandate that everybody do it. But my impression was, if the functionality is there so people can elect to do it, they have a lot of workflow to figure out or whatever, but they – it would be good to be able to do it, but not mandate that it be done. So I’m wondering if we could go back and check with them on this idea of this sort of sending function or inclusion function and so they understand it’s not – we do not just mandate that everybody open their notes, we just said, the EHRs have to be capable of a certain type of functionality if they choose to. If we could double check with them on that, I would –

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

But Christine, we have had a recent discussion like about two weeks ago and since the time they presented, like you say it was probably a year ago, they have had this discussion with the people who are cooperating. And they’ve come up with the findings and conclusions and their recommendation now is that it’s too early to describe the function, because there isn’t a “function” that is out there.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I think there is no consistent way to say how do I configure this progress note on the workflow of the doctor that is not consistent. However, to output a new document type, which is the assembly of the progress note, into a Consolidated CDA, making it view, downloadable and transmit is very much a certifiable functionality. So we have to kind of separate those two, and it's not likely that you can mandate how people configure the creation of a progress note or the creation of their workflow, but the output is much more easily configured.

Paul Egerman – Businessman/Software Entrepreneur

Isn't it already there, in the CCDA?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Is the progress note already there in the Consolidated CDA?

Paul Egerman – Businessman/Software Entrepreneur

Yeah –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I can look at that, I don't know off the top of my head.

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

I don't – yeah, even if it were as a progress note, it doesn't mean – it doesn't include the – what parts – are there any parts, and as you know, there are sensitive parts, there are legal parts –

Paul Egerman – Businessman/Software Entrepreneur

I understand the issues, but I still – what happens is, when you sort of get into the weeds to try to figure out what you're going to do, I don't see that we necessarily are accomplishing anything. I mean, we've already taken a step back from view, download and transmit, saying well maybe there's a way to transmit some progress notes, and I'm sort of shrugging my shoulders and I think that some of that stuff may already be there. But it doesn't really accomplish what people are talking about, because it's very hard to get the workflow right so the progress notes that you want to get transmitted to where you want it to go. We've altered our course, we're no longer talking about view, download, transmit.

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

So this is Mike. I'm going to just get really, really simple again one more time. To me this is a view, download, transmit. I would like to deliver to the front door of the patient's portal, every progress note that I've done on them and I'd like my EMR to support that. And it doesn't have to be structured; it doesn't have to be anything other than a copy of that document, just like a copy of any other result I might send them. So that's what I'd be advocating for and it may or may not be time to be able to do that, but that's the goal for me.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. I agree and I think there is time.

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

You want to be able to select which patients to do that on or do you want that automatically to happen every time you see a patient?

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

I would like it to be automatic with the ability to withhold some, based on any particular issues that, for example, Christine mentioned I need to talk to this patient first before I release to them some additional things I may not have mentioned while they were there.

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

So once you start uncovering – I'm just – all I'm doing is reporting, so once you start uncovering the oh, except, that's where you get into trouble and the field is trying to discover how, what kinds of functions you need to build into this. So I think, first of all, Mike you can in your EHR, our EHR already do what you want it to do, it's getting to the nuances that both affect that usefulness and the acceptability of this that they're trying to work out, they meaning the people involved in this project. I think to Paul Egerman's point, just for – not mandating it through meaningful use does not stop anyone from doing it, as people are already doing it. And the counter, which is mandating it, can actually inadvertently put some barriers into a project that's emerging.

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

Right, so I understand all that, all I would say is that the barrier to patients getting a copy of my notes today is the fact that it doesn't automatically happen.

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

But it can be, in your EHR. It can be made to do that in your EHR and possibly others as well. So, not having it as a meaningful use requirement does not prevent you from doing what you wanted to do. You may discover, in the process of what seems like an easy task, and this happens all the time, that you'll have some exceptions or nuances and then will want that, too. And that's what the current people who are piloting this have run into, and that's the caution that they're making us aware of.

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

Understood.

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

So let's try to figure out an approach here. Let me start with one bifurcation, which is to express our interest in this, as we have already, and can even state sort of what I stated before which is, it's still an emerging functionality and there's active work going on, but it isn't yet ready for incorporation into Stage 3, but we'd like to consider it in future stages. The other branch point, and there may have to be finer branches, is that we move ahead and make it an objective or certification criteria for MU3.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, could there be another branch point where you look at categories of notes so, you look at like op notes or pathology notes and there are some categories that perhaps get treated –

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

Well, that would be a branch point of option 2, and we could delve into that if we choose option 2.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I just wonder if that simplifies it and gets us started and gets some things that are automatically in the view, download, transmit function.

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

So what's the sense of the group in terms of path 1 versus path 2?

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

Can you clarify them both again, I'm sorry Paul, I'm having trouble here?

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

Path 1 is to explain in our description about our interest in exposing progress notes and our interest in the project called OpenNotes, and further work to be done on that with the intent that we do include it in future stages, but not Stage 3. Path 2 is to find a certification criteria that would be consistent with OpenNotes, and we have to further describe that. So, can I hear some comments on path 1 versus path 2?

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

Well, it's Christine, I think path 1 I wonder if – I mean, I lean towards path 2 if we could – if we can do some additional homework or work, maybe with the standards folks and double checking it with OpenNotes, and if that's a possibility that we pursue that. And if it's not and it doesn't make sense, then okay, we divert to path 1. But I also wonder if since Stage 3 is being pushed out a bit, whether our sort of placeholder could say we support this concept, we think – in an ideal state we would want to include it as a certification criteria, but that that is dependent on a certain type of progress being made in, for example, the OpenNotes Project. And so really ONC should and CMS should monitor so that we don't rule out potential inclusion in Stage 3 if, in a couple of years, we're actually ready for it, but we don't necessarily rule it in if it's unclear, for Stage 3 is what I mean. My hesitation on the future stages thing is that this is changing so rapidly, I'm not sure if there will be future stages or what will be happening, but that nonetheless, to try to go the certification route is our preferred approach, but if it cannot be done or it's not wise, then okay, we understand that.

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

Any other comments?

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Yeah Paul, this is Marty. I just – there on the inpatient side, a hospital's side, there are EMRs that allow this today, for patients to view and download notes. So I think regardless of which one we choose, I think the industry is moving in that direction and it will definitely be a competitive advantage for a vendor to be able to do this. So, I think regardless of which one we choose, I think the industry is moving in that direction.

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

And that's an interesting comment because remember we're not – regulatory kinds of things interfere when the market is already going in a direction, so –

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Exactly.

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

And I think that's where your point, Paul, about sort of the delay in Stage 3 makes it much more likely that this is going to be standard functionality by the time we get around to putting it in as a requirement. I think that some of the comments that were made before about not just whether to put it in, but exactly what the functionality needs to look like is much more the point, but probably premature to have a discussion about that now, because there's not a lot of experience with it.

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

Other comments? All right, let's try to vote on this then, and this is a pathway 1 versus pathway 2. So pathway 1 explain the current state, explain our interest and definitely – and our support actually, of making notes available and the current state of affairs as reported from the OpenNotes group. And our interest in either observing the market to overtake events as Marty described, or consider it for future stage, but not Stage 3 versus taking it for Stage 3. Those in favor of pathway 1?

Paul Egerman – Businessman/Software Entrepreneur

Yes.

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

This is Charlene, yes.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, I said yes.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

This is Marty, I said yes.

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

Marc, yes.

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

Okay.

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

Marc Overhage, yes.

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

Amy, yes.

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

Patty, yes.

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

Neil, yes.

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

George.

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

Okay, so for pathway 2?

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

Christine.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Leslie.

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

Mike.

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

Okay, I think by my tentative count that we do have a clear majority favoring pathway 1. So that'll be the way we go and we'll try to include as many – as much comments to make it informative, in terms of our thinking.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, the comments should include the thought process of the people voting for the path, too.

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

Exactly. So, I think all of us are voting in support of the concept, and it's only a question of whether it's ready for meaningful use – for certification criteria for Stage 3 versus future or market. Great, thank you. The next two topics are a little bit more for your informa – let's see, for your information. There are two topics we wanted to include, this is remember we went back to the outcomes we're trying to achieve, and one of course is affordable care. It's an update to say that we have in the past included functional objectives like formulary checks and generics, and in Stage 3 we talked about the use of CDS to support efficiency like not ordering duplicate tests or meds or unnecessary care. So that's where we are with that, any comments specific to this? Okay. The next one was health disparities –

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

Actually Paul, this is Joe Francis, sorry I was slow on the mute button.

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

Go ahead.

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

Just one comment, we're struggling with this actually within VA to sort of capture, through decision support, the choosing wisely recommendations. And one of the things that really gets to be kind of a challenge here is how one incorporates issues of patient preference, because many of the areas where you have the most opportunity to reduce inappropriate use are preference sensitive and require that discussion. And so many of the things that you want to capture that are nuances like whether or not imaging tests are appropriate for a headache, are generally in unstructured fields and so, it's really a much tougher challenge than we thought it would be when we started the process. So I just leave that as a comment. Certainly things like duplicate testing, there may be some opportunities there, but I believe that again, the context sensitivity about why one would need a repeat lab test within a certain window of time, there may be again the issues of reminder overload and lack of flexibility that will become barriers. At least that's based on our own experience.

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

Actually I'm not sure I got exactly your point. You're saying – so you're speaking to – could you sort of try different – you're speaking against the duplicate tests or nuances related to that or –

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

Yeah, what I'm saying is that it is difficult to capture some of the nuances within a clinical decision support system or knowledge-based systems for that, because many of the nuances are based on clinical factors that are in unstructured data or might be related to preference-sensitive care. So I just say, it's a great goal, it is hard – I think it's going to be harder in practice to achieve this.

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

Okay.

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

We're struggling in our system to try to build this in.

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

That's fair, recognizing of course, decision support, you do try to tweak it so you don't have a whole bunch of false positives, but they're still just guidance, right?

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

Correct.

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

Okay. Any other comments? Next, health disparities. One of the ways we had incorporated health disparities, and this was Christine's idea, was in our former deeming program and it doesn't – and the way we were going to do that is to report on one of the CQMs stratified by a disparity variable that's important to your organization. If – the fact that we're not going forward with that recommendation per se, we're going to go forward with language about what we discussed and where we are. It doesn't mean we can't still incorporate that kind of approach with the CQM Program that exists, deeming or not deeming. So that's up for discussion.

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

This is Neil. I still think that that's a good approach. I think allowing people to do this in a way that's meaningful but requiring some form of quality reporting based on a disparity variable is an important process. And so I would consider that we should move forward and I do think it can be separated from deeming.

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

I agree it's Christine. And actually we've been talking about this since the first stage and it's just important to remind people in doing so that their performance on the indicator is not relevant, it's really their ability and their actual reporting of the quality data that is stratified. But they're not going to get dinged if their performance isn't good.

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

Okay. So let me try to restate that as a strawman for further discussion, that is that we use the same language and sense that we had for the deeming program. To say, out of the whatever CQM requirements there would be for Stage 3, that one of the requirements is that for some CQM of the organization's choosing, and a disparity variable of the organization's choosing, would be used to stratify the performance on that particular variable, not for meeting some thresholds, but just reporting.

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

This is Art. I agree with that.

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

Christine, have I captured that correctly?

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

Yup.

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

Okay.

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

Yes, but – and I guess I would say, to be very clear, that it should be a core requirement that they have to do that reporting.

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

Right. Okay, are people in favor of that then?

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

Yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yup.

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

Yup.

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

Okay. Good. Well, I think that tidies up some of our loose ends we've had on our parking lot up to this point. And as I mentioned at the front of the call, so we're going to have a writing session, George, Michelle and I, and we're going to try to incorporate all the feedback we get during these conversations into the words. Because it's the words that end up either leaving people still confused or cause different interpretations, all of which cause re-work and gnashing, either on the part of during the rulemaking process or during the interpretation by provider process. So we're trying to work on clarifying that language and that's the language we'll put back before this group over the next couple of calls, before we go in front of the Policy Committee. Any further comments from anyone and I really do appreciate the very robust discussion and we'll definitely incorporate the discussion points from the discussion in, for example, this last vote on the OpenNotes and just explain where we are and our complete support of that – of including progress notes at some point.

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

Paul, this is Amy. So when you talk about rewriting it, the next time we – or when we get something back from you, will it be sort of all the recommendations sort of all packaged together as one?

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

Yes. So, I –

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

Okay, that would be – I know that would be very helpful because the conversations we start and stop and at least for me –

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

That's right.

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

– it's very hard to sort of keep it all together in one framework in my mind. I'll speak for myself.

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

So that's the reason we're having a final review and so we will prepare, I think, it's going to be a lot of work to prepare both the revised word document that has the matrix and a revised high-level PowerPoint so that we can go through them. But that's the work we have to do before the next call on the 17th.

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

Great. Thank you.

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

Other comments before –

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

Hey Paul, this is Charlene.

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

Yes.

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

The end results of do a lot of gnashing of teeth when we interpret, but if you would want any support in terms of like doing an edit for interpretation or something in the process, I'm sure I can get a couple of folks to look at it and give their feedback to it. Not to change it, but to add clarity.

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

That would be great and I'll ask Michelle, but I think, hopefully the leads for each category have been asked – so we're going to do our best to do some editing, and then we were going to call in each one of you during that day, which is the 13th, to both to check our work. But, if you can get anything to us before the 13th –

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

Okay.

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

– that's where we can start from.

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

Right.

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

So, anything that would help get us a better start, as close a start as we can to our final, that would be very useful. That applies to any of the leads of the subgroups. So we'll work from that final draft and try to make sure that – and one of the benefits, I should have said this up front, there's actually an AHRQ set of projects going on to look at, I forget exactly how it's phrased, but to look at the interpretation of our current draft. And I'm not exactly – it's the current draft that we have on print, and give feedback and we've already received some preliminary – they're not going to deliver that to ONC until, I don't know, a few months from now, which is obviously late for us.

But I've asked to see if, and they've been kind to consider, giving us some early feedback on areas of confusion and some of the feedback we've gotten already it's like, oh my gosh, that's not what we meant and for these three options – the option 3. So that would be stuff that we'd want to incorporate in this editing process to try to make it clear so that some of the misinterpretation isn't there. Because we're really trying to avoid the rework and the gnashing of teeth there. So anything that you can do to help us would be great, would be greatly appreciated. Okay, any other comments before we open it up to the public? Okay, could we open it up please Michelle? And Michelle, did you have any other comments about the editing process or –

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

No, I think we're all set. All of the leads have – we have a time with all the leads that afternoon so I think –

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

Great.

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

– everybody should be good to go. Operator, can you please open the lines?

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.

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

All righty. Well thanks again for this vigorous participation and we're going to need to continue this for the home stretch, as we prepare for the February Policy Committee presentation. Thank you everyone for your time and effort and getting together.

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

Thanks Paul.

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

Thank you Paul.

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

Thank you Paul.

Public Comment Received During the Meeting

1. I like the notion of using the .XDR extensions. This should be spelled out in the slides, having a more SOAP based transport venue.
2. OpenNotes can be a venue to Patient Engagement. Having the patients more involved is good. OpenNotes may be one more tool available (e.g Blue Button Plus).