

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
September 12, 2013**

Presentation

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

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

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

Here.

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

George Hripcsak?

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

Here.

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

Amy Zimmerman? Art Davidson? Charlene Underwood?

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

Here.

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

Christine Bechtel?

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

I'm here.

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

David Bates? David Lansky?

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

Here.

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

Deven McGraw? 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

Marty Fattig?

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital

Here.

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

Neil Calman?

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

Here.

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

Marc Overhage? Mike Zaroukian? Paul Egerman? Greg Pace?

Greg Pace – Senior Advisor – Social Security Administration

Here.

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

Joe Francis? Rob Anthony?

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

Here.

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

Tim Cromwell? Marty Rice? And are there any ONC staff members on the line? Okay, I'll pass it over to you Paul.

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

Great, thank you Michelle. And thank you workgroup members for making the time to participate on these calls. I know there are quite a few of them, but we have actually quite a big agenda to accomplish between now and when we present our final recommendations to the HIT Policy Committee for Stage 3. In this one – next slide please. In this meeting, what we want to do is review for – actually, how many of the people on the call were not listening in or not participating in on the HIT Policy Committee meeting earlier this month?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I was not. This is Leslie.

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

Okay.

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

I was not. This is Marty.

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

Okay.

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

I didn't. This is Charlene.

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

So except for two, everybody else heard it the first time. So, I'll try to whiz through that, but – and focus in on some of the things that we're going to tackle between now and November. So, speaking of which, we'll review the work plan and start working on updating the objectives in the spirit of what was approved, the framework, the goals that were approved at the last Policy Committee meeting. Next slide please. As our – what we've been working towards in the three stages and we're focusing in on Stage 3, and I think pretty much on schedule. We are looking at ways to continuously measure and improve outcomes as the goal for this stage. Next slide please.

And this may build – or I guess it's not going to build. Okay. So the notion is, on the right – so our goal is to – the goal of health and healthcare systems is to improve health outcomes on the part of individuals and communities. The way we arrive at that, certainly the way we measure it – that's how we want to drive the improvement is to measure it basically, to know how we're doing it and how we can continuously improve what works. And those we hope to get through the eCQM or electronic clinical quality measures, and I'll caveat that by the eCQM of the future. So acknowledge that of the hundreds of measures that are currently in existence and approved by NQF, many of them are based on data that was available in the past – that were available in the past, claims-based, administrative data, just because those were accessible. Now with – now that we have 60 percent of providers and 80 percent of hospitals operating with EHRs, a lot thanks to this program, we have a new set of data to work with. And I'm not sure our quality measures have kept up with the available potential for better measures of health outcomes.

So that's the goal, we're going to talk a little bit more about how we're trying to move that ball forward. So on the left side are the tools. And as you know, the EHR and PHR, HIT software are tools for humans to achieve better outcomes, and we're concerning ourselves with that on the left side of the dotted line. If you work backwards, we start with the outcome measures. If those are the outcome measures that we're striving towards, to improve upon, then that – we derive from those a set of meaningful use priorities. So the tools don't change – they're not pills, they don't change the outcomes themselves, but they provide tools for the professionals and the patients and caregivers. So if those are priorities, and we'll speak to those in a moment, then one of the goals, the functional goals that we've set for ourselves in the Meaningful Use Stage 3 that would address the priorities that would help the humans improve health outcomes.

And then working backwards one more time, whether the functional objectives, which is typically where we've been placing a lot of our emphasis in Stage 1 and Stage 2, but we're making sure we connect the dots between the health outcomes of Stage 3 and the functional goals. And then from that, derive the functional objectives that appear in the Meaningful Use Program. Now, one more slide please. And what we did for the Policy Committee was concentrate on the middle two in green, that's what we presented and that's what we got approved, in terms of using these priorities and these functional goals. More importantly, to review what work we've been doing and see if there's anything else that has to be added in order to address those functional goals. I'll pause a moment and say, any questions about that, the process.

Okay, next slide please. Okay, so let's go – we did use Million Hearts, this is part of our connect-the-dots communication. Next slide please. And I went through a series of things to show how the functionality in HIT help you identify population, work on the pre-visit, check-in, the exam room and after visit follow up. So we went through that, I'm not going to go through that here, because I think people on this call understand that. Next slide please. And we also pointed out, next slide please, how it's not surprising that it matches the NQF, because both the NQF and our original formulation of the framework for meaningful use is derived from the NPP, National Priorities Partnership, hosted by NQF. The thing that we did not include initially was efficiency and affordable care. So we've called that out as something we're going to spend more time on, more time and attention, in our later stages, Stage 3 and beyond. We also call out disparities as one of our priority areas for MU3 and beyond.

Next slide please. So we start walking backwards. How do you translate the goals that are derived from the outcomes, the health outcomes, into MU functionality? Next slide please. Starting with category 1, improve quality of care and safety. Now we broke out the reduce disparities until later, you'll see that. So the MU outcome goals or MU priorities would be, it would be nice – it would be – our vision is that patients would receive evidence-based care. They wouldn't be harmed by their care and they wouldn't receive inappropriate care. So those are the goals of the program. Next click please. So what MU Stage 3 functionality goals would align to achieve – to encourage, promote, to facilitate the achievement of the goals on the right?

And here are, they may not be the exact words, but here are some of the functionality goals from an EHR, PHR that all relevant data are accessible through the EHR. We're going to talk about patients next. All – the relevant data you need to make decisions are available through the EHR, seems reasonable. And secondly, that we have the clinical decision support tools that allow the humans to make better decisions, it says timely, effective, safe, efficient and that we prevent – we apply preventive care where appropriate. And also helps us to avoid inappropriate care, inappropriate diagnostic testing, inappropriate treatment, for example. Just as a reminder, on the left side, we're not going to talk about here, these are some of the functional objectives that we've had in Stages 1 and 2, always supporting where we thought we were going to go with the rectangle on the right, we just haven't been as explicit. And what we've done is taken a step back and called that out.

Next slide please. Okay, in what we know as category two, engage patients and families, our goal is that patients understand their disease and their treatment, that they participate in shared decision-making and that their preferences are honored across the care team. And yes, caregivers are there supporting patients in these goals. Next click please. So the MU functionality goals for Stage 3 would be that patients and caregivers have access to the health information, that they contribute information, including patient reported outcomes, to the record, so that can be used in decision making. And they have a way of expressing their preferences and that it's used in both the logistics in terms of let's say communication, as well as a part of shared decision making. Next slide please.

In improving care coordination, it is our hope that all members of the care team, both the professional side and the patient and caregiver side as authorized, participate in implementing a coordinated care plan. So that's our goal. Next click. And so the functionality goals that would support that is that the relevant information is shared across the entire team, which includes the patient, and especially during transitions. Because that's where a lot – I mean, that's where the communication falls through the cracks and that lack of communication causes – I mean almost causes a lack of coordination. And that you're cooperating across the entire team on the goals we have for this patient, the plan and that the interventions are shared and tracked. And that's addressing some of this feedback. Next slide please.

So under population public health, just like providers and patients having their dashboard, well it would be nice if at a public health level had a dashboard of knowing what's the status of my community or my population. And actually, I notice this one – this bidirectional was supposed to be moved into the functional goals, because that's not an outcome goal. Next click. So if you consider bidirectional, that's a functionality goal, not an outcome goal, and that the functions we'd work on are ways to get information to and from where it needs to go. So that we can look at it from either a public health point of view or public policy point of view and that that the public health sector can have up-to-date information about what's going on in the field and vice versa. That as we take care of individual patients, that we have the benefit of knowing what's happening in my community. Next slide please.

Affordability is a new area we're calling out to match up with the NQF. And the outcome is that will, by golly, at the very least we should stop doing duplicate things, that just wastes money and causes other complications. That when we make decisions about diagnosis and treatment, that it's a cost-effective one and that we minimize the inappropriate care, whether it's overuse, underuse or misuse. So those are the outcome goals. Next click. So the functionality goals that would address that primarily lie in the CDS. So as we're making decisions they should be shaped by feedback we get from the system that brings to – it to the human at the time they're making these decisions, and that can be on the provider side or the patient side, so that we optimize the outcome goals. Next slide please.

And then under disparities, we want to eliminate those gaps. And next click, so what we'd like to do is have the conditions that we need to consider as we, and by the way, so again, there are some tweaks that I guess didn't make it to this deck. SES was pointed out, I mean, that's not exactly something we're going to be asking patients as an example. So, some of the things that are appropriate for us to include in the EHR that can help shape some of the decisions that are made, in order to reduce disparities. Next slide please.

In the deeming, next click, we reviewed – and go ahead and click through to expand it. The reason for the deeming, it's to promote innovation, to reduce burden and reward good performance and that we were going to somehow decide how to call out high performers or significant improvers. And who have all – and this is an important quality, if you've already met the functional objectives in Stage 1 and Stage 2, we don't have to keep imposing the burden of documenting what you're doing, because that, we've heard, sometimes even outweighs the effort required to actually do it. So once they've at least had experience in one previous stage, we want to reduce the documentation burden of proving that you've done that, and assumes that, as we know from our track record so far, people don't stop doing things, and relieve that burden if they are a high performer or significant improver. And as a caveat, no this does not affect – this is an optional pathway, if you are not qualifying for this pathway, it does not affect your penalty phase. Next click please.

And that the framework is that we look at – we identify these high performers, high improvers, we give them flexibility of picking two measures in two priority areas, for a total of four measures, and that's what we agreed upon last time. And that you'd pick one of those four measures and reduce the disparity gap between where it is in this particular disparity domain and reduce the gap between that and your population, the rest of your population. Next slide please.

Key, as everybody mentioned, is that we have to have the right outcome measure, or at least outcome oriented measure. So we have charged both the Quality Measures Workgroup and a special Tiger Team that's made up of members of both the Quality Measures and the ACO Workgroup to come up in a very short time, like one month, what are the things that would be outcomes oriented and HIT sensitive. That would help us assess whether an organization is already a high performer or a high improver. That's key to making this program work. And the – sort of divided up the group so the QM Workgroup is to look at what's already approved and in programs and pick those that are more outcomes oriented. And the Tiger Team is to look at, well what are the attributes of these HIT sensitive, outcomes oriented measures and look at things that are either in the pipeline or still remain as a gap and try to accelerate the development of those kinds of measures, so we can use them in future stages. Next slide please.

So our work is, and we're not going to do it on this call, but we're scheduled to well, let's go back and look at the high priority categories, like we named – we identified a couple of examples like prevention and chronic disease management for EPs and patient safety and care coordination for EH's. They might be the ones that we'd like to choose. What's the threshold, is it top quartile as we currently say, and reducing the gap by 20 percent? And this is based on a 12-month reporting period, the previous 12 months and then what are areas where – my computer went out – how do we structure the deeming criteria for reducing healthcare disparities? So the special Tiger Team is due to get back to us in early October, so we'll want to consider their recommendations as we – and incorporate those into our deeming recommendations. Next slide please.

So what we've got approved is that green area, the – okay, we get the connection of the dots from health outcomes to how does it affect the meaningful use of HIT program, and those seem like good goals that link there. So our next step is on the far left which is, what are the functional objectives of achieving those goals. And we're going to rely on the special Tiger Team to feed us some ideas about quality measures that would fit this. Let me pause for a moment and see if there are any questions, now most of the group has already seen this, but then we'll talk about working on that left box.

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

Paul, this is Charlene. The only comment that I've heard some feedback back on the deeming pathway is again, one of the challenges of the current program is the audit program. So the question was, as we think it through, I know you're not allowed to define audit criteria or I don't think we are, but we need to recognize that that will then become part of this audit process, and just be sensitive to that.

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

Good point.

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

So, it's – I don't know where you put that in, but you can't forget that piece of it and that would be helpful, because I think people –

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

Yeah, it think that's a good point and it came up in our earlier discussions. We have to remember to include at least the recommendation that the auditing, whatever these contractors are given as guidance, really match up to the measures and the certification criteria, so they don't have yet another version of things to comply with. So that's a good point, so that's good feedback from the field and we want to make sure that we provide recommendations about the tight alignment of that process. So, good point. Next slide please.

Okay, so as we begin our work – and next slide. Here's the approximate agenda for our work. So there's, including this call, there are only five calls, so there are four more calls before the November Policy Committee meeting. So we're going to start looking at the objectives, we're going to use a couple of exemplars that have been particularly challenging for us and see how we apply the feedback we've gotten from the Policy Committee and from Farzad, and work our way through that. An important suggestion that was made at the Policy Committee and accepted at least to present – to consider is to get feedback from the EHR vendors to say, look there's easy important stuff and there's hard important stuff, and there's hard not as important stuff. So tell us the level of effort, in a sense, in some combined way, and that's the trick. So instead of getting feedback from just one vendor, how can the association give us some kind of consolidated feedback to say, this is a really hard project, but – and then so, we're trying to decide what are the high impact functions and we'd like to also have as input, how hard is it? So if you want to – we could pick a strategy of let's get three hard, but extremely important things to do or five things that can be knocked off fairly – so we can go through the permutations, but it's very helpful to understand the level of effort required. That of course also figures into the length of time, the timing discussion, which is on our agenda as well.

Speaking of timing, so that can be somewhere between the 24th, it sort of depends on the pace we go in updating our objectives, and the 7th, when we would focus in on timing, considering what our objectives are and the development time required. We should have input from the virtual hearing on advanced directive, we've been waiting for that for quite a while and we want to incorporate the feedback there as we prepare our Stage 3 objectives. And we should have recommendations from the Tiger Team that I just alluded to. We will either tackle deeming, if we have time, on the 7th or the call on the 24th, to finalize our deeming recommendations. We'll then be looking at the recommendations from the Consumer Workgroups plural that bear on the patient-generated health data and feedback from the Standards Committee on imaging.

And finally, review of our recommendations before our presentation on the 6th, because that's going to be an important meeting where we're going to get more granular. And we've staged our presentation in a sense, to make sure we can socialize what we're trying to do and make sure it's visible the connection between our functional objectives and the outcomes that we're trying to solve for. Next slide please.

Okay, so let's start working on these criteria. You know what, how about if we back up a slide and let me get some comments on the work plan itself. And they may not be exact on timing, but that's sort of some of the work we have to do between now and November. Okay, sounds like it's –

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

Looks good.

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

Oh okay. Good. Thank you.

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

Paul, it's Christine, I just had a question –

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

Sure.

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

– in terms of the work plan, I know we are talking about going back through the criteria according to some objectives that I know you're going to talk about. My question is are we able to do that in one call or do we need to have the Tiger Teams again, or how do you envision that happening?

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

I think, hopefully, there's really pretty good alignment of the objectives we had previously developed, I think we overwhelmed the committee by trying to present all of those details at once. And so I'm not sure there's going to be a whole lot of new stuff, for example. I think we need to talk about what level of detail we should be presenting them in and – because we got feedback on that, fairly strong, as you know. So that's what I wanted to discuss next, but – so, chances are there's not a whole lot of changing or additions, so I'm hoping we can do it at the big group level, and certainly open to your suggestions and reactions as we start working through this.

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

Um, yeah. I mean I think in the patient and family domain, I think there were a couple, and then also in health disparities, there are probably two or three either adaptations or certification only kinds of additions we could make to really make sure that our claims around how – is oriented to outcomes can actually stand up. So I do think on disparities and I do think on consumer device data, there's been a lot of interest in that and I know Leslie's group is working on that, that might come back a little bit later. So I think there are a few that we need to take a re-look at or add to.

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

Okay. So that's fine, so probably –

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

I – and actually was wondering Paul, if since the advance directives, I have a scheduling problem also on the 24th. But if the advanced directive hearing is the 23rd, could we flip the review and update and criteria with the October 7 call and approach it all at once, so we can take account of the advance directives stuff as well. And I know I can make that whole call.

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

Say that again, flip the – I didn't quite catch that suggestion.

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

Oh, I'm sorry. I said the advanced directives hearing is on the 23rd so I was also wondering if we on the 24th Meaningful Use Workgroup call might flip. Instead of the review and update of MU3 objectives, might put the advanced directive piece in there and then do the – keep going with the review and update of the MU3 stuff on the 7th?

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

I think some of my sensitivity is on the 24th we do have two hours scheduled – my concern is that we get cramped for time on the review of the objectives, so that’s why pulling it up early is –

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

Yeah, I agree with that. Well maybe – okay.

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

Let’s see how far we get here. Next slide please. Okay and next slide. And let me make a comment previous to this, because it’s not on this list. All of you who are in attendance certainly at the August meeting, understand probably one of the biggest feedback we got, and it’s not at all surprising, because that’s the feedback we have from the public as well, is that we want to make sure that – this is an overwhelming time, meaning, there’s just a lot of change. And all of us in our organizations feel that it is palpable and if you go back to the escalator metaphor that David Blumenthal used, we have to make sure that it is gradual, like it’s not this rocket elevator, and we’ve got to get everybody on it and keep them on it. And I think we recognize that pushing too hard can cause people to fall off or not engage properly. So that’s probably the biggest feedback we need to consider as we think about adding – certainly adding anything and I think the request really is to start pulling back. Particularly pulling back on specifics, I think we did – the program has done a huge – has had a huge lift and has done a – has made major accomplishment in getting the field to go from 0 to 60 in this – just really two short years.

But now that we’re there, there’s this floor that’s out there, this infrastructure that’s out there and we need to consider that people now that they’re going to – they see and taste and feel this data, they’re going to be motivated to use this in ways that improve their prime objective. Particularly as it’s being pulled in the new payment models. So, that’s a sign and I think asks us to be less prescriptive as a general rule and to allow more flexibility in how things get done to achieve the objectives. So probably keeping in tune with our exemplar approach and not going overboard in terms of adding things is probably, I would say, the strong message from both the Policy Committee and the broader public. So, I just wanted to sort of give that, summarize that overall feedback we got.

More specific feedback is that, Farzad and he said this more than once, is really thresholds don’t matter, we see how people – when they turn things on, it’s just like – it just blows past our “thresholds.” So their advice to us is don’t bother even quantifying the thresholds, that’s something both CMS can do and it’s not as important – it’s not as an important way to spend our time. A comment that Farzad made is, his concern about numbers versus percent is that it encourages more of the check offs. We’re trying to stay on the, this is a good intent that we put forth, people should try to fill it with good spirit and try to not push them into doing workarounds, essentially, or gaming.

And that’s actually the third point as well, the more specific we’re saying and you must do this in this way, the more burden it creates and the more workarounds and gaming it incents. So that’s something we want to pay particular attention to. And beginning with our stage one, you remember Tony Trenkle talking about the Christmas ornaments and Farzad mentioned laundry – so, we need to – I think that’s – it’s consistent with the overarching feedback we got is let’s worry less about being prescriptive with individual things and more capturing the spirit of what’s a good intent. Next slide please.

So, this is just draft, this is just trying to take that feedback and how would we operationalize that, these kinds of filters as we go back and look at our work, which is really very good. But, look at it with different lens. So how would we place more emphasis on achieving measurable outcomes, so put more – as we always intended, wait on good measures at the end, and less on the “how.” That helps with innovation, that helps with decreasing burden and that helps with broader engagement. Second, how would we encourage, and sometimes require, development of enabling functionality while avoiding the prescriptive language, it’s a balance.

Third, focus on the high-impact functionality, use exemplars, not be comprehensive is what we've said from day one, and avoid the over-specification of it must do this in this way. And finally, we certainly are recognizing that yes, there's a floor functionality you want for the entire infrastructure, but there are so many local priorities that we can't possibly know about them, let alone accommodate them, so I think one of the ways to help with that is to accommodate it by the flexibility we give to local priorities. I mean even in our health system or even in our single organization, we have different regions and they just plain have different needs. And we want to encourage them to address those needs most of all. Next slide please.

So how would we put this into action? Here's an example, we're going to cover two examples, and they're not trivial examples. One is clinical decision support and the other is care summary, both of which we spent a lot of time on because it's so important. But can we apply those kind of revised criteria and feedback and counsel we've gotten from the Policy Committee to our look at functionality. So the functional goals we have for clinical decision support is – belongs in this category one area. And what we want to do is we want to have all the data that's relevant to making decisions on an individual be available and have the system provide support, the reminders, bringing the right information at the time you're making decisions to support timely, effective, safe, efficient care, prevention and avoid inappropriate care. So next click please.

You might think that here's an example of the functionality required to achieve goals on the right side. Well, you need – see this interventions presented at the right point in care, and that they cover high priority areas, like prevention, chronic disease management, appropriateness of the lab and radiology orders, partly because that contributes to cost and effectiveness. The medication related decision support, because meds is a big intervention and it's a big source of inadvertent harm for not picking the right med, that we have these high leverage structured information, problems, meds, allergies, in there in its complete form and accurate. And that we avoid common medicat – common harm, which is due to medication errors. So drug-drug and drug allergy interaction checks are a way of addressing that.

So let me pause here and get people's view on, okay here's the functional goals we're shooting for, here's an example of CDS, somewhat high level, but it's less prescriptive than we have been, and the next slides actually what – we'll look at the actual text of our original recommendation. But, how do people feel with this functionality objective listed on that left box?

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

Paul, its Christine. Are you suggesting that we wouldn't have any thresholds whatsoever anymore and that this would – you would just have to do this?

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

It's we would not make our own recommendations on this. As you know, there's the NPRM stage and that's the suggested time when if they – when they come up with measures, that we would comment on those measures, as we have in the past, at the NPRM stage. But at this stage, what we're trying to do is set objectives essentially.

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

Paul, its David. I was going to – go ahead.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie and I wonder if there's opportunity here, often people are talking about clinical decision support more broadly to include shared decision making with patients, and we've mentioned that before. Wondered if that's worth calling out or advanced directives or to talk about preference-sensitive care at all.

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

I think those are good things, I can't remember whether we included them in category two, I'm try – I'm pretty sure they're somewhere, like preference-sensitive care. So I think they're in category two Leslie, if not, let's come back and figure out where to put it.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

All right, thank you.

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

Actually, we did not take on preference-sensitive care in category two.

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

Okay, so we'll have to –

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

There is a small piece of it when you go to the next slides, in the certification criteria.

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

Okay, so we'll – let's go back please. So we'll get – I remember reading it, so it'll be on the next slide. David?

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

Yeah, two things. One is we've talked a year or two ago about this capability being more flexible and the software platform being able to accommodate rules –

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

Right.

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

– from third parties or libraries or whatever, scientific sources and I'm wondering there's nothing in here that makes it – that talks about the platform or the architecture or the code base that would facilitate – the risk I'm frightened of is like we've seen with quality measures. Fifteen rules get hard coded into every product out there and then you have idiosyncrasies about quality of the rule and the flexibility and adaptability of it over time. So, I don't know if there's any way to do that. And the second thought is the – I'm more comfortable moving away from the threshold approach if these elements that are listed here as examples are linked to quality measures. And that in a sense you're saying if you improve the appropriateness of lab and radiology ordering, as measured by a quality measure, you have a capability in the software to support that attainment of that outcome with whatever set of decision rules you decide to implement. That's a local determination based on the practice type and patient mix and everything else. So, it's good in a sense not to dictate what that threshold should be as some uniform standard, but it's important, I think that wherever we end up with this kind of an approach, be tied to the availability of quality measures in those same domains.

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

Good comment. So let me react to both what you and Leslie said. So two placeholders we should in our parking lot is at this functionality objective level, should one, what David mentioned about CDS platform, which we have talked about in the past be at that level, and it seems to me that's actually an important thing you've said and should be at the objective level. And then what Leslie said about CDS support for shared decision making, on the patient side, needs to be captured somewhere. Let me respond to and get people's reaction to David's one-to-one mapping of the CDS to the quality measure. It seems – so yes, we would like the results of CDS to help – it seems like we want appropriate decisions to be made on diagnosis and treatment, and that's something ideally we get to measure. You're suggesting that we in a sense force the use of appropriateness of lab and radiology orders CDS would be one, I think, an example of something where we might want to hold off on being prescriptive. Because if you put that in, then people will find a way to satisfy that, but it won't be for a specific objective, unless we have a good measure. So is it possible that what we really are asking for is good measures to be developed on that side and worried less about whether they use CDS, which almost everybody – I mean, we would mention that most people use that in order to accomplish the former. I'm not s – was that clear and sensible?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Are there exceptions to that, Paul, where a measure would be necessary because we're trying to advance an agenda so new that there really isn't yet a quality measure that indicates it? And simply because quality measures are often very provider-centric whereas new advances we're doing in patient engagement are very patient-centric. How do we have a balance there?

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

Well I think it's the same answer and let me try it again to see if I can make better sense. I think part of the spirit of not being prescriptive on the functionality is that if we do have the measure of results then people will use the functions available to them. So let me give an example, so in most systems, they've come up with ways of having CDS, basically, it could be a rule, it could be a reminder, it could be colors, but they have the machinery to do that. It really is up to the providers using this to decide what rules, what configuration to put in using these CDS tools. So do we really want to force people to do something in categor – I'm asking the question, in categories because that basically invites people to just fulfill the requirement, the regulation. Versus do we want to make obvious what the needs are and that's at the CQM stage and I guess I'm trying to suggest that should we back off on the what you must do, what checks you must do in functionality and use and focus a lot more on measuring what you've accomplished. Because in a sense, the machinery is already there, they can write any rule. Let me just get people's reaction to that. It's – it is a shift in what we did, especially with Stage 1, but that's a question being called, I think.

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

Paul, this is Charlene. I'm in support of the approach. Again, operationalizing it's going to be a bit of a challenge, but I do know, and I don't know if Michelle can add any additional information, I know there's a lot of work that Jacob Reider has been doing in the area that we're talking about under Health eDecisions and potentially the relationship to the measurement. So I do know there's a lot of work in that area that ONC has been driving and involves some of the vendors in, and I think this would put a little bit more attention on that.

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

Yeah, this is Michelle. Thanks Charlene, and to that point, a group, the Clinical Quality Group on the standards side is actually going to start looking at that, so maybe their recommendations can help inform this objective as well.

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

Paul, its Christine. I totally get this sort of conceptual approach here. I am worried, though, that without the detail that you see on the next slide, that it will be harder for public input because people will immediately go...they're used thresholds, measures, lots of specificity and they'll immediately go to, well do I have to do this one, all my patients or only some of them. And how many do I have to do? Is this realistic? Is my – without telling them the certification criteria, I think they're going to wonder, well, is my EHR even going to be capable of doing this? So, we have a very robust process for getting public input early, I almost feel like this is reflective of where we should have started, and in fact, did start early on, but that by this point in the game, I don't know how helpful it is either to the public or ONC, to strip out so much detail. I understand why, but I'm worried about that.

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

Right, right. And, I share that – but remember, we're not talking about the final rule, we're talking about the helpful recommendations from this group to HHS.

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

No, I know. But part of what is helpful to people is that they have multiple opportunities to shape the details. So, what I think this approach does de facto is actually make only one opportunity to influence the details of the program, and that is a 60-day comment period. You know, the RFC – you remember when we did the RFC and we included some objectives without thresholds and measures, all of the comments were, okay, but what do you mean here and give me more detail.

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

Yeah. Umm,

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

On the other hand, we don't want to be stuck in that space forever.

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

Yeah, I don't disagree with that.

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

So and I think that in so many cases, those numbers were just so arbitrary, I mean, like pick them from the sky. It's –

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

Right, but to me it really raises the question of how does CMS want to structure the program going forward? Because if they're going to keep structuring it in the way it has been, where there are going to be thresholds and measures, period, then I think it is less useful for us to be so broad and not give people details so they can begin to prepare, they can think through what's realistic, they can give feedback. You're just compressing their ability to do that into a 60-day comment period. But if they're – it makes me wonder if what we should really do is think about the structure of the program, so that it isn't so based by Stage 3, on these thresholds and measures and counts and all of that stuff and just think about it differently, like we did with deeming. But how do we create something that is more simplified and streamlined for Stage 3, to me that's the larger question. Because otherwise I really worry that we're just asking people to compress their comments into a 60-day period, and that's not – I think that's not fair, number one. I think that – we don't learn as much from the field when we limit their ability to weigh in on those details, again, if those details are going to continue to be part of the program.

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

Well do we have any sense that CMS is prepared to move in this direction, because I hear what you're saying and I think it's a very valid point. Like if, in fact, there are going to be thresholds at the end of this, we should weigh in on what they should be. But I think we should – do we have any sense from CMS as to whether people would be onboard with moving in this direction Paul?

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

I think actually –

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

This is Rob Anthony from CMS, if you want me to jump in, I'll be happy to.

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

Ah, Rob – perfect opening, Rob, thank you.

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

Good timing.

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

I'm not sure that I can necessarily directly comment on the idea of particular thresholds, but I do think that to the earlier point of looking at an alternative here, an alternative structure that follows something that is closer to deeming as what Stage 3 is, is certainly something that we'd be interested in hearing more about and seeing what something like that might look like. I think we are asking ourselves here at CMS, as we move forward, what type of a sustainable outcomes oriented structure that is both useful for measurement of outcomes. But also, how do I put this, but also simple enough for people to be able to grasp and manage over a long period of time, as the program continues to go on. What would that look like? So, we would certainly be interested in seeing something along those lines.

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

And I think that –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and to that end, I think that if there is a focus on this more broader use, these systems still have to be able to be certified to meet the broader use. And so there's that further reconciliation because if we offer something very broadly to be done with a quality measure associated with it, it perhaps can be met with CDS. But we don't necessarily have the standards associated or a way to certify an HIT system to do it outlined as a companion to that effort, then we really haven't advanced, we've just given people an idea of something to do without the tools to actually affect it. So I think there is this triad of outcomes and some degree of measurement or some degree of specificity and then the ability to certify HIT to meet those objectives.

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

So I think that's a good entre to – go to the next slide please. So I think this would tie back to what David Lansky said about the mapping. And one possibility is we focus our attention on the quality measure side and not do – not worry as much about the mapping, but that we give clear direction on the specifics of the functionality that must be in the products, which is what Les – what I heard Leslie saying. So that products can be certified so that providers have the ability to implement clinical decision support in these five priority cases without prescribing how many and in what categories. So that, I think, is consistent with the original intent. So let me talk that through a little bit more and see if that makes sense.

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

Wait Paul, can I just ask a quick question?

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

Yeah.

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

Are you saying, because this would make a big difference, are you saying that we could shift to a place where we have in essence both the last slide and this one, where this one has more detail, but it starts with the bigger picture saying and then there's details under it. Or are you proposing that the subgroup 113 slide that we're currently showing goes away, we don't operate at that level of detail at all? That's the part that I'm more concerned about, but maybe you're saying no, it's both.

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

Okay, it's a little bit in between. So, the objective would be on the slide we saw. The way that the text would read, and I'm just making this up, this hypothesis. So instead of saying, 15 rules and two in each, get rid of that specificity which, as you can understand, just invites – I mean, anybody can do that, but are they using that, and that's the objective of this program. So, we want to – if you look at the certification criteria, let's pretend, without going into details right now, there are certification criteria that do have to have specificity, do have to have testability and you want the things that we put into provider's hands to be able to do whatever they want to in the top A, B, C, D, E. Do you see what I'm saying?

So in a sense, it is really saying we would like you to be able to use it and we recommend that you look at these five areas, but how you do that is up to you, provider. That implicitly or explicitly says to the vendors, they need to have tools, certified tools that would allow a provider to do any of the above, A through E. But now we've got mostly a certification program that is specific and it is standards space, Leslie said, but is not prescriptive in how you execute it according to your local needs and where you're vulnerabilities or opportunities are in your organization.

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

So are you saying that they – all they would have to do is have the EHR be capable, but there would be no use requirement, they don't have to actually implement any of the rules, it's just their system has to be capable of doing it? Because it sounds like what you're describing mostly is a certification only program.

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

No. They would have to use clinical decision support and then the exercise to the reader, the exercise to CMS is how would they want to measure that. But it's not our job to – our job is to stay at the policy level and not to say and how do you prove that you're do – using clinical decision support in EHRs to affect a better outcome. What that does is it – so we're getting pretty specific and as I say, these kinds of requirements are easy to fulfill without complying with the spirit. And we want to make it as easy to comply with the spirit to address their local priorities as possible, and CMS would figure out how do you make sure they're using the CDS in the EHRs.

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

So I guess that should – yeah – feature –

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

– pick two out of 15 in each of these five categories.

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

Right, but CMS is probably going to say, well, let's see – should – they're going to put in the NPRM you've got to pick two out of 15 or something like that, so –

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

Or they might just say pick – show me that you're using CDS and addressing one of these – I mean, it could be a lot less burdensome.

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

Right, or they might – right, they might just say turn the functionality on or whatever – so, but I guess – so my – the concern I have is back to what Neil said. If CMS is going to use measures and thresholds and specifics, then it is helpful to them for us to weigh in on what those could be in different approaches and they've specifically asked us to do that in the past, they have said, the more specific you can be, the more helpful it is to us. So, I worry that, and I don't have any sense, maybe you guys have had conversations with CMS, where they want to take on that work, because it takes us all year to figure it out and go through a public comment process. And get feedback from the field and do hearings, and then we're asking them to take that burden on, but to do it alone and to do it in a very compressed timeline. I don't know that that's helpful to them, at all.

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

Is there – are we completely out of the realm where attestation could be used by people for some of these things?

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

I guess that's going through my mind as well. And maybe invite Rob –

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

Rob, would you be willing to weigh in on that?

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

Yeah. No, I don't think we're out of the realm where attestation could be used for some of those things; but let me also weigh in on what Christine was saying. I think that if we – if you go down a path where you are talking about a meeting of meaningful use for Stage 3 that would require thresholds for particular quality measures, it is useful for us to have a suggestion. Because obviously, for exactly the reasons that Christine cites, you go through a public comment period, there is some debate behind that and you arrive at a particular threshold recommendation that we can then use as a floor as we go through and make decisions about how to proceed. So it is useful for us to get down to that level of specificity, if you're going to go down that track of producing something that focuses around that.

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

Now you used the word thresholds for re – for quality measures, would you say the same thing about thresholds for functional objectives?

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

Well you do provide the recommendations for thresholds on – or you have previously, on functional objectives, so I assumed that you would still go down the same path.

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

And Paul, just stepping up a level, because thresholds I know, that's sort of the last level of micro-detail for us, but even the level above that which is – so even if we didn't advise on whether you have to implement reminders for 10 percent of your patients or 80 percent of your patients. The idea of the level in between where you go from reminders to – is it – what kind of reminders, appointments and follow up and what kinds of patients, I think that is essential. I don't know that we need to get into the weeds on the details of thresholds, since the program has a lot of history behind it for most of these things. That's something that is much easier done in a shorter period of time, and in fact, we haven't spent that much time on it, because as Farzad said, thresholds largely sort of don't matter, particularly when you're talking about 5, 10, 20 percent differentials. But the level above that I think really does matter and there's the level that we would lose, which I think is not helpful to CMS.

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

Yeah, other – I mean, we all see both sides. Trying to be responsive to the feedback we get and to be fair, they're not always consistent either, but –

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

Right, and I – but I think Paul that some of the feedback we get is really about – it's really about the structure of the program. So I think there's a – it's a different question, I think it's not the Policy Committee weighs in with too much detail, I don't think that's the feedback. I think the feedback is, the program tends to micro-manage workflows. And should we re-look at a more detailed way that the program could be structured, so that it gives people and Congress some confidence that the money is being used wisely, that there is, in fact, meaningful use of EHRs, but start to move away by the third stage from such as sort of micromanaging workflow approach. That's a totally different issue than the Policy Committee's giving too detailed feedback.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and if we move to more of an approach where it's the outcome or the end in mind, as you've reflected, then that is really the intake to all of the committees, so that the intake is what's the end in mind, what is the measure of quality or – that we are trying to achieve. And then you back into that, the policy and standards associated with it. Otherwise we have some misalignment overall. So I do think it's a programmatic question.

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

Well I think as Rob was suggesting, and I think this group is also in agreement of we would like to both have the successful deeming pathway and to move much more in that direction, because that was the hope from the beginning, and be less in the business of prescribing functions. So, that I think, I mean, we're pretty aligned there. Let me get other people's reaction to this whole discussion about the level of detail in our recommendations on a functional objective. George, are you still in the tube? I thought he might, he was going to – we were going to lose him while he was in the subway, and so it looks like he's in that stage of his trip – his transit. Other people?

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

Well, this is Neil. I'm going to have to jump off, but I – just my last comment would be, I think if we can get some – hearing what Christine said, and I think if we can get some more significant recommendation from CMS as to what they might do in this area, it would help us tremendously. Because I do think if we're going to end up with these kinds of measures, we should make them as specific – we should make our recommendations as specific as possible. But I think if we can convince people that this is a direction to move away from, I think that would be more important in terms of our overall, long-term strategy.

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

And this is Charlene. I think a benefit maybe of decoupling the detail from the – what the Policy Committee and the certification process is as always another issue with the program is there's always confusion between what is certified versus what's required for meaningful use. So the more you start to make the recommendations policy-driven and decouple the certification requirements from it, I think that will clarify that issue, so it's not as overlapping. Because we get stuck with that one today.

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

I'm not sure that clarifies the threshold issue though.

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

Yeah, yeah, I know, I know it doesn't solve the whole thing, but it does start to decouple those two items.

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

Well, let me ask –

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

This is George, I'm back on.

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

Oh great, thanks. So let me ask the question that Neil just posed – well, the topic he posed and ask it as a question so that we can get concrete. So on this slide 34, we said there will be 15 CDS interventions and there will be two in at least – at least two in each of these five categories. Let's hear people's opinion on if we remove those two requirements, those two prescriptive things, that there have to be – the number 15 and there have to be two in each of these. Let's weigh the pros and cons of that. I guess the pro would be, you don't have people chasing these detailed requirements.

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

Paul, I think this is a hard one and I think we need more than one to apply this approach to, but, for this one, I get the point that 15 is perhaps arbitrary, I wasn't part of the group that created them. But maybe you could just say – maybe there's a middle ground that says implement clinical decision support interventions or guidance related to five or more quality measures, and they are able to pick what they are and it doesn't say 15, but it says it's related to quality measures. And if they want to choose five that are in preventive care, then fine, they get – but the system is capable of doing all of it.

M

Now that's just –

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

But there's still a number, there's still some sort of detail around it, there's still a set of certification criteria. I think it would be, and I have to hang up so I'll just say this one last thing, I think it would be different if we were looking at patient reminders, right, that criteria's just structured completely different. So I think we have to try to do more work on other ones and see if we can get this approach where there's enough detail for people to react to and get the point, but we're not being so prescriptive of workflow and micro-management, things like that.

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

That's a good suggestion, let me get others – David Lansky, how does Christine's proposal sound to you, since it is linked?

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

I think it sounds like the right direction.

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

Okay. Others?

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

One other thing I was going to say, Paul, to your last question is that personally I am comfortable with moving the program as a whole toward a model which is less prescriptive at the specific site of care and the specific practice model, because we're ultimately trying to get these tools used in collaborative modes.

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

Um hmm.

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

And we keep struggling with care coordination, for example, as a domain because the program is so practice-specific, at least on the EP side, and even on the EH side. And to the extent we want to focus on health outcomes and not be tied to a computer sitting in an office as a paradigm, I think this discussion is a way of getting us out of that trap. And it may be a little uncomfortable for some users, but ultimately that's what everything else in the system is trying to push us toward.

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

Other folks comment on that specific proposal, that instead of 15 with two in each of the following, saying, here are some recommended areas for clinical decision support, pick – show that you've used clinical decision support in five areas related to five quality measures of your choosing.

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

Paul, this is Marty. I think that makes a lot of sense, especially when you look at it from the point of view of a specialist that some of these things may not apply. I think one thing to keep in mind with this whole thing is that we're looking at Stage 3. And by – if we have folks who have been meaningful users of Stage 1 and Stage 2 for at least two years each at those stages, by the time they get to 3, we ought to be focusing on outcomes and be much less proscriptive about how they got there.

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

Right.

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

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

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The only thing – this is Leslie – that I struggle with is, in areas where we are introducing or advancing concepts in patient engagement and things that haven't been there before. So I'm not quite sure how we – how do we introduce any kind of new advancement in process and care?

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

Someone else was trying to speak.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Paul, why the five instead of multiple?

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
But five is going to trigger a reaction from ONC –

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
– that's to say, see, they're still stuck on the threshold thing.

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
It's going to undo what we're trying to do, so I would say multiple and maybe the answer's ten or maybe it's three, but it's years from now anyway. So if you say multiple, it won't immediately trigger a negative reaction on the other side.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, that's a modification of Christine's proposal.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare
And, umm, this is Charlene. The only other comment I would have is in the current requirements for meaningful use, we have to do – this is on the quality measure side, we have to report out of those six domains that are part of the MAT program. So as we're thinking this through, do we pay any attention to those six domains as we think about the clinical decision support relevant to that? So, and I don't have them in front of me right now, but again, they were the ones that we're doing for Stage 2 in the quality measurement space, and I think one was patient engagement, the other was care coordination, so they kind of are the overarching ones.

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

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

So does that play in here or does this – should this target to their kind of sub-domains of that. So, it's just another place to maybe align – think about aligning the program.

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

Um hmm. Other reactions to any of this. Okay, so the latest – let me repeat the edited version and see if people actually agree with that. Relate to – so, here are five recommended CDS areas, and what that translates into and there are going to be certification requirements to support all these five areas. But for the provider point of view, they need to demonstrate use of multiple CDS interventions that apply to quality measures in each of the six domains. So that's an aggregate of all of the variants that have been proposed and how do people feel with that?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That makes sense.

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

Okay, so we'll just put that down as the draft that we'll come back and review. But that's backing off on these numbers, it keeps the functionality required to do – address these things and that's the value to the providers. It is specific enough for the vendors to understand what it is they have to get certified again, but it's allowing people to do more and more addressing whatever is important to them, yet maintaining the six domains that the NQF.

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

Um hmm.

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

That seems reasonable. Okay, let's go to the next slide, so we just pra – these are sort of practice, although I think we made progress on this one. The next one is, and thank goodness Charlene's still on, is the functional – we really need to move data around so that people can – all the people participating in the care, which includes patients and caregiver, know what's going on and are working off of shared goals and plans. Advance the slide – advance the clicks. And so that would turn into a desire to have the summary of care, electronic is preferred, that covers whatever you all think, you all meaning the provider, thinks is useful, but here are some things, it's a little bit broaching new ground like Leslie was talking about, that we believe should be required. So it does require these things, a narrative, overarching goals, patient instructions and who's on the care team. So next slide please.

So if we thought that was the way – a revised version of how you'd present this objective, and compare it to where we are, it's possible it is just – so, we could – for clarification we could enumerate what do we mean by transition, that's the three bullets. We might actually take away this table, because this is micromanaging, in Christine's words –

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

Um hmm.

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

– and we would take away the 50 percent and 10 percent and CMS would have to decide, and Rob, feel free to comment, whether they want us to say 50 and 10 or whether they'll figure out, how do I – so CMS worries about how to I prove compliance with this. And accompanying this, how would I audit and make sure somebody's compliant. Our objective from a policy level is to say, care coordination is a gap in this country and it's high impact, so we believe that EHRs should support it and here's examples of where you support, transfer of care, consult, consult note. But – and that we have these four things that we think are starter sets. So again, it's the floor, not a comprehensive, and that's where we end up...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie and when we had done this in the team, we had talked about a couple of things, and maybe you have them included. One was, we talked about the care team, it was like a care team roster that included the patient, their home caregivers and other roles. And we've been working hard in the Standards Committee to make sure that that care team roster is ready for primetime, so I don't know if that needs to be more specifically called out, because it's not just the provider, the professional.

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

Right. Back up the slide please. It's on there.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay, and then on the transfers of care, we also talked about – or the transitions, a transition home also has huge opportunity. And so the care team is notified perhaps what the activities are at home, it's an opportunity for patient-generated health data to come back into the record to say the status of the patient, and help to avoid readmission by providing information to the patient. So if we can just expand this a little bit more to include the patient's team as part of the care team and the transitions to also be into self-care.

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

So that's a good question to pose to the group. So one, as you see now on the green, the care team members include the patient, so that's one point. But the second part of your question is a good example of where we need to figure out where we need to draw the line. So do we need to add these new things, you were saying what's going on in the home, as being part – do we need to add – is that part of my – does that fall in the group of micromanaged?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I sure would hope not because it's where the – if we're going to avoid readmission, it's what's happening after the care and in the home and in the maybe the follow up care back to the primary care physician, which the patient actually might be the one coordinating. So, I sure would hate to miss that, we spent a good deal of time with that in the committee – in the subgroup.

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

Yeah, this is Charlene. We do have under the measures, if we look at the second – the detailed slide including home.

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

So advance the slides please.

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

So we have that there, but it's under the measurement. It may not be as called out in my e.g. example, we do have the home health agency, but we might want to just call that out to support self-care. But Paul, what strikes me in terms of I thought the more powerful policy statement was on the previous slide, was really around the gap in terms of transitions and these are the transitions that we want to address. So I would question may be less the data but may be more the kinds of transitions that we want to capture, because that puts the standards in place. So that kind of...so back to your – so back, let's see –

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

Let's go back a slide please.

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

Yeah.

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

So what would you add here?

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

Well you say – you've got certainly the data fields that we want on that slide, but maybe – you talk about – you include in that, from a policy level, that we want to – the kinds of transitions we want to fill in the gaps for, transfer – we call them like –

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

Is that the three bullets?

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

– yeah.

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

Yeah.

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

Because I think that was a very powerful statement you made, we're trying to reduce the gaps and we want to focus on these three areas, and here's the kind of data we think should be shared or something. So it's a little bit more, but not too prescriptive.

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

Okay, so advance the slide to 36 again please. Thanks Altarum. So the proposal here, as a draft listening, would be keep the – so do the following to this slide, take out the matrix and take out the 50 percent and 10 percent. And that in a sense would be – oh, and instead of the matrix, it would be what you saw on the green slide, it's basically the left column. Okay, sorry, let me just try to make it a little – so the change here would be to remove columns 2, 3 and 4 from your blue matrix.

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

Yeah, put the words in more similar to what you had included –

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

So, the words are there, but we're not saying – we're not creating the burden of – okay, this kind of transition it has to – you see, that's where the burden comes in, when – and that's where the micromanagement comes in, it seems to me.

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 if we, as you said, if we advance the – see what I'm saying, where are the hot areas that we're trying to address, it's really those three bullets. And what's the kind of information, as a floor, so Leslie, we're not going to – we can't be comprehensive, and it doesn't say things that are not on the floor are not important, but we've come to some consensus process, we already did enumerate these four things, and if we kept those four, it's the starter. Now you, thankfully, in standards are working on the container to make sure there's lots of room to enter structured stuff, that's good and nobody's saying that's not good. It's like let's just get this container going and populate it with these four that somehow – the group actually came up with these four.

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

Right. Yes.

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

And I see where, let's see – yeah, well actually it's five because they broke up provider and patient – which is fine. How are people feeling about that?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Um – this is Les. I think that sounds good. Back to the not being prescriptive and trying to promote innovation. The transitions of care and care coordination, I think are some of the areas that we're going to see market innovation. And we don't – do we want to say the floor is a document that does a summary of care type of document, but encourage – or how would we encourage more of the collaborative platform of care or collaborative care record that's really being – starting to be discussed? Do we need to be a little bit more gray or say this is – definitely the floor is the summary of care document doing these things, but we do want to encourage future opportunities. Is that where standards can help? What are your thoughts on that?

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

I think I see where you're going. First, I do see that it was omitted the home as part of bullet one, so we can add that. But I think you pose an interesting future, which – so you're right. This is now a document and that's pretty constraining if you think of it as one of our traditional documents. And what you're suggesting, I think Leslie, is, can't this be a workspace to encourage both the sharing and the collaborative contributions. And that's an interesting both metaphor and potentially a technical solution that we go in the next – in future stages.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So I look at the work that's coming out of the Blue Button work, and we're looking at a potential API approach where patients can register their applications – their apps at home, to receive data from an EHR. It's not a document at all, but it's a standard that promotes interoperability. So perhaps that's something we should consider, if we are looking at the new roles is, is there a high level goal attained and then are there both standards that can promote the use of that goal in a current floor, which would be document structure. And an opportunity to direct standards for advancement and motivation towards advancement. I think this is such a critical area that creates opportunity for technology to think of things differently and collaborative care is beyond just better management of transactions of coordination. And although today, just having great coordination of transactions would improve our situations dramatically. In the future, a more collaborative environment could be very powerful.

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

Might be a good use of our column where it says future stages, so that one, it's a placeholder so we don't forget but two, it's a signal that says we would like to get beyond a document, a transactional document. That's a good point.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That would be a great place to put it.

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

George, did you have something to say on this?

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

Actually, the future stages is a good solution. All I was going to say was that as we move to a higher level objective, it gives us the opportunity to give these kinds of choices, the document or more. On the other hand, if we say things like the document or more, people may come back and say you guys aren't really telling us anything, because it's too ambiguous. So I like the idea of being specific in this Stage 3 about the document and then putting future stage the collaborative workspace.

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

In the certification criteria we listed three, do we even need to say those three because isn't – aren't what we doing basically we set the objectives and then the Standards Committee says, well what certification criteria would we need to give people the ability to do the following. So is there any reason why we need to call out these three? I don't know that I remember why we decided to call out these three, but –

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

Paul, we're you asking the three use cases or –

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

No, the certification criteria down at the bottom.

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

Oh, okay. Oh, umm –

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

Yeah, I don't know why we needed to call them out because in the past what we do is we say, here's the objective, now Standards Committee will figure out what's the certification criteria to make sure EHRs can do these.

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

Yeah, I'm okay dropping them. This is Charlene. I think we – maybe we started at the bottom and worked up as we thought it through.

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

Right.

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

Right, that's probably what happened.

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

Well, we were being specific and we were moving some things from objectives into here, but now that we've moved to this new mode, I think, this is exactly the kind of thing they want a little flexibility over the next four years or three years, whatever it is, to define. This is like defining the details of the field, which is one of the things they said –

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

Don't want to do.

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

– we didn't need to do at this point, yeah.

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

Okay. Well, let me do a check here then. So we've done two examples, they happen to be very meaty examples and I think we came to a conclusion on this one, which is, we would delete the certification criteria and we would delete the columns two through four on that middle blue section, but otherwise, it would be the same. We would add home as an example for the transfer of care, from one site to another. But we would give sort of the preamble of here's – of the green slide, which says, here are the outcomes goal and here's the functionality goals we have, and here's how we've reduced it into a recommendation, objective and measure for summary of care document.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So are we consolidating two through four or I'm missing something. I guess I miss-heard you.

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

Okay. So what I meant by two through four is, see that blue matrix –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

So we would keep column one, but we would not have columns two, three and four.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Perfect. I thought you said rows, and you meant columns –

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

No, right –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

– I heard – thank you.

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

And we take out the percentages. So let me – if people are in agreement with this, I'm going to turn to Rob and say, hey, if this came across your desk, how would this look? Okay, Rob, hey, if this came across your desk, how would this look?

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

Yeah, I was fumbling slowly with the mute button here as I try to figure out how to say this. Um, traditionally when you guys have made recommendations, it has come with percentages. I do think that if we have functional objectives that come without percentages we are obviously leaning very much on what we have in Stage 2 as the floor. So, if there's a different thought behind how you're putting these together, and certainly when we saw Stage 2 recommendations versus Stage 1, there was obvious, where we were stepping up importance of particular goals. I think that's where the percentage is really important. I absolutely understand the – you're very much in the same mind space as we are in, I think, as we approach all of these. In that we are trying the best way as we look at these different objectives and what the structure of meaningful use will look like and what the requirements will be, to walk that fine line between providing functionality and requirements that will directly impact what are the real redline areas versus not wanting to overprescribe workflow.

And we, I think, have always been very careful when we've talked in regulations and publically about wanting to stay out of the business of telling doctors how to be doctors. We want to look at ways to enable HIT to assist care, rather than dictate how care should be done. So we certainly understand the tightrope that you're walking as well, I think. Where there are things that – where there are areas where we need more specificity, I think sometimes revolve more around very high level objectives, so certainly as we get further down into individual details, that's probably less useful as a structure. So I think the level of detail that you're talking about here is probably fairly close to what we would expect. How about that?

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

Well, it's very helpful Rob. In fact, it's very helpful for you to have been on this call, so I appreciate your taking the time.

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

Absolutely. I – where we can try and feed into it, I think we're very cognizant of not wanting to impede the progress that you're making as you pull together these recommendations, because obviously the workgroup and the Policy Committee as a Federal Advisory Committee is very important to us and the process and we want to not impede that work. So where we can feed in and let you know what is useful and what is not, we're happy to do.

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

Well that's exactly what we need, we're out to be useful. So let me try to summarize some of this discussion and please, invite your feedback. So one preamble is that I think the group is sensing, and it seems like CMS is also both thinking in that direction and receptive to it, is as we move from the earlier stages where we're trying to get stuff – get the software and these systems in place, and capturing the data and making that available where necessary. We're moving towards one as we predicted, we're going to instead of push, we'll be in a pull state. So really it's the payment model reforms, it's the new delivery systems that are going to need some capabilities to serve their goals.

So we are – the deeming program's actually a signal, and a pretty strong signal, that we are trying to move more towards both reporting and achieving higher performance in helping consumers and patients raise the level of their health. And to the extent that we can get all the way to that goal, we're playing less of a role of prescribing functions in software, in EHRs and PHRs. So the deeming program is sort of a leading edge of that kind of thought. As we transition the meaningful – the traditional Meaningful Use Program, we're also moving more towards getting better measures, so that you can assess your outcomes in ways that are meaningful to consumers and patients, and offering more flexibility in the ways you are measured in your achievement of functional objectives.

And through these two examples we've worked through today, both in CDS and in summary of care document, we're describing the – in a sense we're describing the intent and the policy intent and backing off on the prescriptive nature of the functional requirement – the use of the functionalities. We're keeping the certification capability, so that providers have this at their disposal, but measuring less in the burdensome way, of how people choose to use the functionality, in order to achieve the outcomes goals. How did I do at summarizing a bit of the spirit of what I think our discussion has been?

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

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

I think you did a great job, Paul.

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

So, are people in agreement of that spirit, because I think there's a bit of – somewhat – quite a bit of a shift, an appropriate one, and it would cause us to look at how we spell out the details in a different way. And I think we did a pretty good job with these two. Do other people agree? Does it feel – is it something we can replicate with the other – as we review the other objectives we previously had drafted?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, it's Leslie. I think it's a really good approach. I'd love to also see then how we reconcile that with the quality measures in the future, so that we do have that direct connection.

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

I think we all would, too. And unfortunately, a lot of that is work to be done –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

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

– we do, fortunately, have a group that's working diligently to try to at least point in that direction. So, does it seem reasonable that we can apply, and we purposely chose some rather difficult ones, which is a good sign that we could get through some of these difficult ones. And we would one, map – we'd map our existing draft objectives to the approved goals that we had from the Policy Committee, we'll do that behind the scenes. And then do exactly this process of measuring our formerly recommended objectives, detailed objectives to the functionality goals and seeing where we can fall into this new model, which as you can see, did not take all that much and yet it may be responsive and relax the burden side.

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

Paul, this is Michelle. I'm sorry, we're way over time.

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

Oh, I thought we – I thought –

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

We only had until 1:30.

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

I'm sorry.

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

Oh no, it's been a good conversation so I didn't want to speak up, but, I do think that we have to wrap up.

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

Yup, I totally apologize. Let's open to public comment. And we'll continue this conversation at the next call. I'm sorry.

Public Comment

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

Thank you. Operator, can you please open the lines?

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 comments at this time.

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

Thank you everyone.

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

Thank you everyone and sorry about going over time, I thought it was two hours, and we'll continue next time. Thanks.