

**HIT Policy Committee  
Meaningful Use Workgroup  
Transcript  
January 17, 2013**

**Presentation**

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

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

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

Here.

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

George Hripcsak?

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

Here.

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

David Bates? Christine Bechtel?

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

Good morning.

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

Good morning. Neil Calman? Art Davidson?

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

Here.

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

Hi, Art. Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

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

Hi, Paul. Marty Fattig? Leslie Kelly Hall?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Here.

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

Hi, Leslie.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Hi.

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

David Lansky? Deven McGraw? Marc Overhage? Patty Sengstack? Charlene Underwood?

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

Here.

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

Hi, Charlene. Mike Zaroukian?

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

Here.

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

Hi, Mike. Amy Zimmerman?

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

Here.

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

Hi, Amy. Joe Francis? Greg Pace? Marty Rice? Rob Tagalicod? And are there any ONC staff members on the line?

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

Hey Michelle, Elise Anthony.

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

Hi Elise. And with that, I'll turn it back to you Paul.

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

And Marc Overhage joined late.

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

Hi Marc, thank you.

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

Great, thank you very much Michelle and thank you all for participating in this call. We have this call and the next call to sort of finalize our recommendations we're going to be presenting to the HIT Policy Committee on February 4. So, we're going to take these two remaining calls to review all of the recommendations, the draft recommendations we're putting forth. It's a good opportunity to step back, now we've been in the weeds, to step back and make sure overall one, we've gotten the language right I think probably a good percent of the consternation that happens afterwards is because of things where we weren't clear enough and people may have misinterpreted our intent. So that's one of the purposes of going through the final review and George, Michelle and I tried to do some editing to address that issue.

The other is to just look at the overall picture. We are at Stage 3, its 2017, it's really more in the penalty phase, so need to watch our balance in terms of what's pushing the things that need public and infrastructure to be set and sort of backing off and allowing things to – allowing individuals, whether they're vendors or providers, to innovate. And watching out that we keep people in – on the escalator, as David Blumenthal said, and not falling off. So, we're going to go through some slides and part of it is to get some feedback on the way we present it, because that's an important aspect of it as well, so your feedback on that, not to wordsmith, but to give us some individual feedback on does this come across well, would be useful.

Any other points to make up front? George? Michelle?

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

No, good.

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

Okay, why don't we go to the next slide please? So here's how we're building it up, and you recall, we step through the framework and reminding people of what's the problem to solve, what's the outcome goal for the whole program, and then work our way back to functional objective. So we start on the right-hand side and our goal is to measure improve outcomes for Stage 3, and that means that patients receive evidence-based care, they're not harmed by their care and they don't receive inappropriate care. So those are sort of our, for this Stage in this category, we want to address these points.

If you step back and think of, well how can an EHR contribute to those outcomes that means let's get all the relevant data in front of the providers and the patients when they're making decisions. Let's support those decisions so that it is safe, timely, efficient and addresses prevention. And let's use this CDS also to avoid inappropriate care. So those serve the MU outcome goals. If you step back from those functionality goals, then, let's start looking at key critical, not all of them, but key critical functional objectives, and we also listed, and I think it's reasonable, listed Stage 1 and Stage 2 functional objectives for your reference. And this is color-coded red, those are changes and blue, these are newly introduced.

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

I've got some – this is Charlene.

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

Yeah.

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

Yeah, I like that. The only – on that slide though, you know how it's moving advanced directives to care planning, you've got to give them that roadmap somehow.

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

Uhhh, okay. Yeah –

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

Yup, thank you Charlene. We'll have to figure that out.

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

Okay, we'll figure out a way – yup. Thank you, that's the kind of feedback we need.

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

Yeah. It's just – we think in one way and it's like what's this new care planning one, that's new, right? So –

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

Got it. In fact, we might – I mean it could be as simple as putting that in parens, and I can verbally address that.

**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**

Okay, good. Thank you. Okay, the next slide please. We're going to step through each of the key objectives with the functionality goals in mind, on the right-hand side. So one of the very – one of the areas that we've chosen to emphasize in Stage 3 is clinical decision support. It always has been important all along, we've sort of been building up, and so now we are both re-emphasizing it, aligning it, not both, but – emphasizing it, aligning it and being – avoiding being prescriptive. So, what we've said is, we didn't give a number any more, we went from one in Stage 1, five in Stage 2 and we're really – people now know the value of these things and they're working on them, we're just saying align with the National Quality Strategy, and they're things that everybody would believe in.

So we're saying that really the only criteria is really address at least four of the six national priorities, pick four that are most relevant for your organization, and pick them up. And we would recommend, so the word recommend was chosen so it's – we're just really trying to avoid being prescriptive, that these are areas that we suggest you look at strongly, as you build your CDS. And what this turns into, of course, is certification criteria for the products, so that they can address these things, prevention, chronic disease management, appropriateness of orders, medication related decision support and improving the accuracy/completeness of the key list, problems, meds and allergies. So those – so I'll just pause there for comments. I tried to describe the rationale behind the way we presented it, how does that sound?

**Paul Egerman – Businessman/Software entrepreneur**

This is Paul Egerman; I have a question about the appropriateness of radiology orders.

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

Um hmm.

**Paul Egerman – Businessman/Software Entrepreneur**

What is your vision there, is there going to be certification criteria of it?

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

No. So –

**Paul Egerman – Businessman/Software Entrepreneur**

What does that mean, appropriateness of radiology orders?

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

This really addresses affordability and medical appropriate – so that's in the e.g. So appropriateness, let's take high-cost radiology. One, in the ones involving radiation, the appropriateness includes consideration, is this one the most appropriate by guidelines? The ACR has a number of guidelines, for example, and considering the radiation dose exposure to the patient.

**Paul Eggerman – Businessman/Software Entrepreneur**

Yeah but, so that's sort of like my question. Do you expect like a certification criteria –?

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

No –

**Paul Eggerman – Businessman/Software Entrepreneur**

– for orders of radiology to include the guideli – the ACR guidelines?

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

No. So let me explain. That means the C – an EHR vendor has to have, however they deliver clinical decision support, the ability for the organization to program conditions by which a radiology order could be measured as being appropriate to guidelines or not. Most – I would say that most EHR vendors currently already do this, we're just making sure that everybody has the ability to say, oh, this is one of those high cost imaging tests and let me make sure the following indication is present, or something like that. They don't write the indications; they just have the ability in the rule say, point out radiology orders, point out lab orders and some indications. Does that make sense Paul?

**Paul Eggerman – Businessman/Software Entrepreneur**

Yup, I understand.

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

Yeah.

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

Paul, this is Amy, can you just refresh my memory for me. So we say, demonstrate use of multiple CDS interventions –

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

Right.

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

– we're not putting a number here and on the CQM side, is there a number there, like in the past you've had to pick so many out of so many?

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

On this – well actually, that's not CQM, that's measure. And so yes, in the past we did say, in fact, Stage 2 we said five. And at one point in this Stage 3 we said 15, and what we did was back off on numbers and say, people get it, that CDS is important, what we're doing in this is say align with the current national strategy, one. And two, vendors make sure that your customers can write rules that address these things.

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

Okay, so we're – so I guess what I'm questioning is whether the wor – I mean, I don't want to go back and debate it, I'm just – and I'm blanking on the conversations we had around this. I'm just – multiple is sort of vague, and so from an audit perspective or from some other perspective, how are they going to know that they've achieved this – how is someone – how is CMS or the state going to know they've achieved this one.

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

Multiple means greater than one –

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

Okay.

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

– and you have to address four out of six, so we specify four out of six –

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

Four out of six – okay, so four out of six –

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

– national quality strategy priorities.

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

– priorities, but – so minimally you could do four – if you did decision support interventions in four of those areas, yeah, okay, never mind. Yeah, I'm getting – I'm confusing this with the clinical quality measures, so, I think I've answered my own question. Sorry.

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

Okay.

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

So this is Art. Paul, I have a question. You just said that your customers – make sure that your customers can write rules.

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

Right.

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

So it doesn't say write here, it says demonstrate use of multiple CDS. And I just wonder if we really want to – if it is about writing rules or accessing and implementing rules that are written elsewhere.

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

So the functional objective is a behavioral objective for the providers, so that's why it's demonstrating use. Each one of these objectives does turn into certification criteria. And the way that the – that ONC and the Standards Committee would look at this as saying, okay, so they can pick from these, one, two, three, six areas, that means that the vendors have to be able to give providers the tools to "write a rule" in any one of these six areas.

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

So that's a little bit what I'm concerned about is, is everybody writing the same set of rules or can they just use them because they're available and implementable from some external knowledge source?

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

So vendors make available the functionality so that providers can write rules in any one of these six areas. The provider must demonstrate to CMS that they have used multiple, i.e. they have written rules that cover at least – that address at least four of the six national quality strategy priorities.

**Paul Eggerman – Businessman/Software Entrepreneur**

And if I understand Art's question –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

So Paul, this is Leslie, and so that would mean that they're either writing rules for those events themselves or to get to external data sources so that – I just want to make sure that those are an “and” and not an “or.” And then also in the broader sense of clinical decision support, we've been talking about shared decision making with patients and I'd like to see that that would be included as an example in the paren that it's four of the six, but these could also be clinical decision support or shared decision making with patients. We have that other places; I'm not sure where it landed.

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

Umm, it's – let's see here, I'm trying to see where that went –

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

So Mike – this is Mike. Meanwhile, to me I had sort of assumed that that would be inherent in any and all of these where preventive care as an example, is the shared decision making between my patient and I –

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

Correct.

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

– about whether they get a flu shot.

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

Correct.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Yeah, I would hope so, but I think that we probably understand that clinical decision support means also shared decision-making, but it's not well understood in the industry, so I'd love to see it just referenced.

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

Shared decision-making is not some – it's a process, and that's not something that you – it's something – it's hard to measure that process. You can't write a rule; I mean you could, but I don't know how meaningful it would be to write a rule saying, you need to discuss the – you need to discuss with the pa – it's a little hard – you can supply the infrastructure for shared decision making, like the information that's needed in patient terms to help make a more informed decision on their part, along with their professional team. But it's a little hard to understand how to write a CDS, which would –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Well it's sort of like the difference between a clinical decision support algorithm and having a group – with specialists to discuss it. There are electronic tools in shared decision-making and there are also trigger events that cause for future consultation here or promote future consultations. So, I'm not – I'm just stating that I think both – how do we make sure that clinical decision support, which is how we're working on it in the Health eDecisions group and other includes decisions made with patients and tools with patients and not –

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

Right.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

– not –

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

Where we think that applies, Leslie is in the patient-specific educational material. That's probably one of the biggest areas whereas the electronic systems can help support patients as part of their shared decision-making.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Well would we count, then, in the – score of six, if a provider was using a shared decision making with clinical evidence and clinical efficacy with a patient? Would that be counted in this measure?

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

Umm, the bigger question, I think, is how does – can you suggest how a decision rule would support that?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

So today at the Foundation for Informed Medical Decision Making and other places, Group Health and others, there is a trigger event that says, I have – based on this condition, this treatment, this – gender and so forth, the context of the patient, there is a task of the EHR, like referral, there is an opportunity for shared decision making to occur, where a tool from an external source can be then retrieved and used by patients. So that would – that's the same context that you described using an external clinical decision support system for a provider, there's a common context understood and then there's ability to either write rules or to trigger requests from external systems. So it's pretty much the same workflow, I just want to make sure that we're not excluding shared decision making from this particular measure. Because it could be, especially in the example given on radiology, imaging, expensive radiology imaging, there are very good tools available that help a patient and their doctor make shared decision making about that next high-cost radiology –

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

So Leslie, I think the answer to your question is no, there's nothing here that would exclude shared decision making as counting as one of those four categories, because patient engagement, I believe that's the way it's said in the National Quality Strategy, is one of those, patient engagement.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Okay.

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

If somebody has access to that, they can verify that, but – so, if your main concern is that we don't exclude that, and it would count, that is still true here.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

And then I would ask that somehow we either put it as e.g. or a reference, so that it's not lost in the thought, that's all.

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

Okay.

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

So Paul, this is Art. I'd like to return to what I was trying to ask before.

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

Uh huh.

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

So, the vendors could set up a way for people to share information through an exchange, but we decided that there was a standard for that and that CCDA is a standard way to exchange information from one EHR to another.

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

Um hmm.

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

And currently, or prior to meaningful use, you could do that and it would cost you a lot of money to set up an interface. What I'm wondering here is that if we just say you can write, then each EP and EH will be writing, and may rely on their vendors to help them write this versus using the external knowledge source that's standardized to allow you to incorporate it into your EHR and your workflow without having to go to that extent.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, this is Paul. I agree with what you're saying Art, although I would sort of phrase it a little bit differently. I'd say we're being overly prescriptive if we're saying that a vendor must provide the ability for the EH or EP to write their own rules because there could be a lot of ways that this could be implemented. They could write their own rules, they could use a library of rules, the vendor could customize rules for them, there are lots of different ways it can happen and so – and also there might be very different needs, depending on the organization. Some organizations maybe do very little in terms of expensive radiology exams the nature of the practice is they never order them. So I think it's just – I think it's adequate to simply say that we're going to look for the appropriateness, but I don't think there should be certification requirements around saying that the system has to allow the user to write the rules. It's also my observation that a lot of users are not able to use those kinds of tools, they're sometimes very difficult to use.

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

So, I think these are good comments. I'm not – as you know, we don't write or make the recommendations about the certification criteria, that's in the standards area. What we've done is just make sure that these important areas are accommodated. So none of these words will prevent what you're suggesting from being true. If a vendor says, oh the only way, I mean the mark would have to say whether that's acceptable, the only way we can do it is you can pick from this library or something. So anyway, the way this is written is purposely to try to not prescribe what a vendor must do, other than be able to address these areas.

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

This is Michelle, I just want to back up for a minute and clarify. So there was a matrix attaches as well that has a few more details. And so for CDS, there were three items that we had suggested as certification criteria that aren't present on the slides. So I don't want people to think that those got lost, we are just trying to be parsimonious in what was presented, so maybe we need to rethink this slide itself. But I do what to point out that there is –

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

Got it.

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

– an example for using Health eDecisions, which I think is part of Art's concern, in that certification criteria.

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

Right. Okay, so –

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

Thank you Michelle. Thanks.

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

Okay, so that's a really – thank you Michelle. So if you do refer to the word document, which is the matrix, it actually has six certification criteria and –

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

This has three, sorry.

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

– oh –

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

So what are the –

**Paul Egerman – Businessman/Software Entrepreneur**

So where do I find that?

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

– because I just printed it out and it has six.

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

Yes.

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

No, I have three, Paul.

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

There are six items

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

Says from January 17<sup>th</sup>.

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

January 17<sup>th</sup> you're looking at. I mean – from the email, I thought.

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

Hopefully – so there are six items for intervention, the preventative care – drug-drug interaction, but then there's only three items for certification criteria. The first is the ability to track –

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

Okay, maybe you're in the second col – third column, you need to be in the fourth column is the updated objective –

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

You're right. You're right, that's where it was.

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

Thank you George.

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

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

So look at the red, sorry.

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

So, and maybe we need to figure out how to best present this, and that's part of why we're having this conversation, so –

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

Okay.

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

This one is just – there's a lot to it, so, we were afraid of overwhelming.

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

And this is Mike. In the slide for the – in the spirit of parsimoniousness, would it be reasonable to have in the Stage 3 functionality goals off to the right, just the issue that says, CDS helps support patient shared decision making, this is the functionality goal, per se, and that makes it implicit in all the other things that are listed in more detail?

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

Well would that come under the patient one though? There's the engaging patients and families in their care is where that may track back from. It would –

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

The problem is, this thing crosses multiple areas, I mean CDS accomplishes many goals –

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

(Indiscernible)

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

Right, but for safe, effective, efficient, I mean, I understand all that, but I just want to both be sensitive to and resonate with the notion that says, it might be okay in that column since it's not data dense to say that it also will help support shared decision making.

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

So –

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

It's a functionality goal.

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

– Mike, on page 10, well actually on many, it talks about patients participate in shared decision making as the outcome.

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

I understand, but we had a five-minute conversation about making sure that we were calling out shared decision making as part of CDS, so I'm just providing a suggestion for how we might do that on the slide if people are interested, that's all.

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

Okay.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

That sounds like a good plan, its Leslie.

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

So what we would have to do is on the – either the last or second to last column put in parentheses also – CDS crosses many of our areas, and so we just have to say – and we could say shared – e.g. shared decision making. You see what I'm saying, Michelle?

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

Um hmmm.

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

Like just be careful, remember, we got rejected in August because we had – partly because we had – it provoked it a little bit, had too much on our slides, we were trying to be as informative as possible and instead we got rejected. So, that's what Paul's looking to watch out for, is that he wants it to look as simple as possible. I guess you guys didn't like my gray.

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

Honestly George, I didn't even – I was more worried about the words.

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

Because what I did is I made the first, second and third – first, third and fourth column on slide 1 grayer, so you only noticed the second column, which is the message we want to give them, the important thing we want to discuss, and just say it maps to the other without spending an hour explaining how. I mean Paul; it depends on how much time you want to spend claiming that these things meet the goals versus making them look shorter.

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

Okay, so we'll work on this, so this is still in – form, but we'll take –

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

We'll work on it next.

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

– but George does remind us that one of the issues – anything overwhelming, no matter how accurate, good or valuable it is, just becomes overwhelming and it just turns your good intent into an overwhelming situation. So, George is right that we're trying to reduce words, and we don't have it yet, but we're – that's one of the ways we want to simplify it and yet help people understand how this is to accomplish our primary goal. Okay, any other – so these are good comments and we'll take this into account as we do our next iteration on this.

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

Okay, this is Charlene, I have two comments. One, just so that the group understands, like when you look at things like preventative care and those types of things, order sets can do that, so again, the concept of intervention in Stage 2 is much broader, so just – I know we talk rules but it's different.

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

That's correct.

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

And then the other thing is, I chatted with the vendors, because there's a – I was concerned with the breadth and depth of the level of certification criteria around clinical decision support. And again the feedback the vendors are hearing from their customers, and that's why this approach may be forced through a lot is if we can hone it and actually use them, that's where the value is. Because right now, literally we're just checking the box, we're not really using them to improve things. So that's a sensitivity I think we need to have. Some of the certification criteria, for instance like make it so it's actionable – make it that you can actually track it, well that's relevant on things that you can actually track. Like you've got to do something, like maybe a drug-drug interaction or something like that, but not so relevant perhaps on a prevention measure, which could be an order set. So it's just – we – that's the kind of thing that makes the vendors crazy, because we can't track all that. So, what's trackable, basically, so just – ?

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

(Indiscernible)

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

The other piece was when we looked at drug allergy and the requirement to improve drug allergy, it wasn't clear how we would do that, using clinical decision support, so is that really relevant on the page? Should it just be the accuracy of problem list and med list or can you improve the allergy list with data? I don't know that answer, but that was the question that was brought to the table.

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

Okay, so the first question about tracking, we did have that discussion with David Bates –

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

Yeah, that's –

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

– and he was going to update the words here. His intent was – it was closer to what you were saying, but –

**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**

– we needed an edit of the words to say, look, when – some things can't –

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

And I sent some notes in on Paul, so maybe Michelle can look at those and you could use those, because we kind of said –

**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**

– that’s a doable thing, but it’s got to be doable in perfect context, right?

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

Yup, so this is Michelle. So Charlene, I think we did try and take into account the feedback that we got. So originally there were a lot more certification criteria items, and from David’s perspective, he already provided his feedback. At one point there was a piece about structured sig, which we’ve now taken out. So we’ve tried to minimize this a little bit more, but –

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

Okay.

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

– let us know Charlene, if it doesn’t help.

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

And I think what he meant was, for example, if you had an alert and an action you could take that if you did take that action right in context of that alert, that counts. But not that you would track down everything else that happened that could be related to – so, we struggled –

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

Good intervention.

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

– with – he was going to give some edits to try to make that point.

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

Perfect.

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

And I think that’s the same point you made. Now, I didn’t get your – you’re questioning whether you can improve the accuracy of the allergies?

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

Yeah, they weren’t quite sure how conceptually – so is it, can you improve a drug allergy list?

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

Like if there isn’t anything present, for example, that’s an example of improving the list.

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

Okay. All right, that's kind of where we were –

**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**

Okay, so how could we do it? So –

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

Right, right. Okay, that may be a detail that we work out and it could be – there could be more explanatory text in the preamble for the certification criteria.

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

All right.

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

Okay. Other sort of global – this is one of the – spending time, because this is one of the important ones from Category 1 is CDS, so – okay. Very good. Thank you. So we're going through move to the others more quickly. Next slide please. And you see the red is what we've changed. I don't think there's much different here. Next slide please. Tracking mismatches, actually I can see that we – well, I think in our text document we go through a little bit more what we mean by mismatches, or if we don't, we should Michelle. Next slide please.

**Paul Egerman – Businessman/Software Entrepreneur**

Wait, wait, so go back to the mismatches. This is a place where I did have some questions –

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

Paul, we can't hear you very well.

**Paul Egerman – Businessman/Software Entrepreneur**

I said this is an area where I have some questions in the text.

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

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

When we talked – in the text, we're only talk – in the text, this is only mismatches on medications as opposed to mismatches on anything else like radiology, is that right?

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

Correct. It's really in support of eMAR.

**Paul Egerman – Businessman/Software Entrepreneur**

Right, so if somebody orders like 20 milligrams of something as a pill –

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

And instead, two 10 milligrams are administered –

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

Correct.

**Paul Egerman – Businessman/Software Entrepreneur**

– because they don't have 20, does that count as a mismatch?

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

Yes. So how – in other words, if all you do is record it and there's no way to report and say hey, how am I doing? That's not real helpful. So that's the whole purpose of that.

**Paul Egerman – Businessman/Software Entrepreneur**

So I don't understand the value of that, in other words –

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

(Indiscernible)

**Paul Egerman – Businessman/Software Entrepreneur**

– they're out of the 20 and so they administer two 10s to a patient, why do we –

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

I didn't hear that. If you're supposed to administer 20 and you administer 10, that's a mismatch.

**Paul Egerman – Businessman/Software Entrepreneur**

Two – no, no, you're supposed to administer a 20 milligram pill, but you ran out so you administer two 10 milligram pills, is that a mismatch?

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

No, so that's a detail, but just conceptually I'd say no. So the purpose of this is not just to record what was administered, but to be able to generate a report for quality improvement on, okay, so if you're supposed to give it at 10 and you gave it at 12, that's a mismatch, let's investigate whether we should change our policy or that's something, an error that occurred. If you're supposed to give 20 and you gave 10, that's a mismatch. So not all systems apparently even give you that feedback so that you can act on it.

(Multiple speakers speaking over each other)

**Paul Egerman – Businessman/Software Entrepreneur**

– you're supposed to give 20 in a single pill or single dose and you gave two 10s, is that a mismatch?

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

Conceptually, no.

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

The system is either going to do one thing or the other. Remember, we're not asking for these alerts to be sent to providers, it's an ability to produce reports so I can look for potential mismatches. So if it's a – I can engineer things that are too complicated for any system to figure out it's actually a match, even though it looks like not a match. And that's something that's the pharmacologist or the doctor, the provider, might have to look and say, oh no, that one's okay, that one's okay, but I see I made mistakes in all these, why did that happen? So this is just producing a report and we acknowledge that it may not be possible to be perfect in deciding what's a match or a mismatch.

**Paul Egerman – Businessman/Software Entrepreneur**

Well yeah, because the problem is that if you end up too many false positives, the report's useless and actually it's worse than useless, it's like annoying.

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

Agreed. On the other hand, if it's completely infeasible, then we should take out the objective because if MAR can't improve – can't do any process improvement, then we shouldn't be torturing people with it. So, they have to presume that there's some degree of – so, like is that the exception or is that going to be the norm?

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

So this is Mike, I could just tell you I have several examples on my plate right now where that functionality is helpful and if I had technology that didn't require it, I would wish I had it.

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

Does this exist presently? Are people doing this?

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

Unfortunately it does not exist uniformly and that was the motivation for this.

**Paul Egerman – Businessman/Software Entrepreneur**

So, we think it's important, but we're sort of going ahead of what the industry is currently doing.

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

No, it's just not a standard yet that all across the industry is doing, but some are and they're benefiting from it and we'd like to make it a standard that's available in all certified technology.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, I understand.

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

Okay, great. Next slide please. So, I actually have a little question on this, what would it take for the EHR to deliver a friend – it means it has a – there's a place for you to write a description or is the EHR supposed to do this automatically?

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

Hey Paul, what slide are we on? This is Charlene.

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

Slide 5.

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

So this is Mike, maybe I can use an example. So it's with a patient education system that has the ability to give patient education around how to interpret a laboratory report, it would be great if the certified technology was, if you will, required to be able to have the capacity to take a patient education handout or information relating to the laboratory result interpretation and deliver that to the patient in one of several modalities, including a patient portal.

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

And that – I think that’s what – that’s an example of what we meant by patient-specific education materials. This seems – well, this may inappropriately imply something different. It says, deliver – first of all, this is under imaging, deliver a patient friendly description of the result of this particular patient’s results, and remember, this is test from a radiology report. It seems as though that would be pretty hard – unless you’re saying, let me describe for you – well, let me just leave it open, because right now I think it’s a little bit hard to interpret this.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie. Is it tied to the actual test or the order, the CPT, ICD, SNOMED, any of the context that we’re currently using to pull up patient education materials today, chief complaint, problem list, all that? It’s possible to attach an education material to that particular report, just as we have in our discharged patient in a clinical – or in the discharge instructions, we’re pulling out patient friendly information associated with that particular diagnosis of discharge or – so I don’t think this is farfetched.

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

But I think this is – belongs in the patient specific educational material, because then that would trigger off your diagnosis or your med or your test result, for example. I’m a little nervous that this implies something different, because I don’t know that any – there’s any automated process to actually read the result and then translate into a patient friendly description.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, and this is Paul. First of all, when you talk about imaging results, I’m assuming that means the radiologist’s interpretation.

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

Correct.

**Paul Egerman – Businessman/Software Entrepreneur**

That that’s what you mean by an imaging result. And I would also just make the observation that it might be difficult and dangerous for a non-radiologist to try to summarize it, because – by saying, well this means, your chest is normal. I mean, a radiologist would say, well, there’s no such thing as a normal chest and that’s not what the interpretation said.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

And that’s generally – this is Leslie, that’s generally not how the patient education works either. It’s not a – it attaches the information, outlines what the test is for, what the results could mean, when to discuss it with a doctor, what’s – so it takes into account that – what a responsible organization that’s doing that would. So like the question is can you attach it – if the outbound result is a Consolidated CDA, for instance, you can attach patient specific education materials, there’s enough information in that structure to attach. If the question is that it’s not really here, but put in the patient education material section, you can say beyond just patient education at discharge when results are available, patients are given patient specific education materials.

**Paul Egerman – Businessman/Software Entrepreneur**

And the other question I have is anybody using that right now? Is this really an important thing to do?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

It’s used; it’s one of the highest areas where people query patient education from the web to find out what it –

**Paul Egerman – Businessman/Software Entrepreneur**

For radiology?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Yeah, for radiology and labs, it’s high area –

**Paul Egerman – Businessman/Software Entrepreneur**

It's already the case that physicians are putting these patient friendly education materials in radiology –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

No, it's already the case that patients are seeking out that information to find out what that means. So, that's already the case. So if we were to say either here that results include – results to patients include appropriate patient specific education materials, that would be – that that's a good thing to do. If you're asking whether or not each individual report is the infrastructure there, that's emerging. But if we put this in the patient specific education materials section and talk about now any result provided to a patient online also includes education materials, that's – that might get to your issues of how do you translate the radiology report to that education – does that make sense?

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

So let me –

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

Yeah, I think we're going out of scope here. First of all, I don't think we can – I don't think it makes sense to put – this doesn't say patient education materials, I don't remember what was discussed when this was put in, but I don't want to put patient educational materials for each data type that we enter, problems, meds, allergies, we'll have it through the entire – all the objectives. So yes, whatever we do should be in the patient education materials section. I don't want to stipulate that doctors have to include the patient educational material for each kind of result and to attach it, it depends what attached means, because you're not – it depends what it means within the context of VDT. I mean – I don't think – I wouldn't put it here, number one –

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

Let me summarize, because we're having a pretty long discussion. I think all of the comments are consistent with the following action, which is to take this out of this objective. We do have a place for it in the patient specific educational materials, and that seems like the most appropriate place. So, may I take the groups recommendation and just remove this language from this particular objective?

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

Paul, are you going to move it –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

I think as long as we know – this is Leslie, I think as long as we note in the education materials that that includes results, because it is one of the highest areas of use by patients and interest by patients, the labs and radiology.

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

I understand. So, it's just – I think this is probably not what we intended when we have – the way it's written here.

**Paul Egerman – Businessman/Software Entrepreneur**

So why don't you say you remove that last bullet that starts with CEHRT?

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

Yes. Correct.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, just want to make sure I understood what you said.

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

And it's going to get moved into the patient engagement area?

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

Well, we'll – not as written, because I think this is not what we intended, but we'll accommodate – we'll address this when we talk about patient specific education.

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

Right. Because when I heard Leslie talking about this, it sounded like it was more about the description of the purpose of the test –

**Paul Eggerman – Businessman/Software Entrepreneur**

Exactly right.

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

– but not the finding on a chest x-ray, which is so big, it's impossible to do that.

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

That's what I meant Art, is as written, this is probably not what we meant anyway, but we can readdress whether there's more we can add to the patient specific educational materials.

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

Good. I agree.

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

Okay. Great. Next slide please. I think – so the only chan – the main change here is, remember we had a whole hearing on clinical documentation. And one of our main recommendations is we wanted to – we proposed the use of track changes, in fact, I think that went out in the RFC and we got some good feedback and I don't think negative feedback on that. And wanted to include that as part of electronic notes. Okay. Next slide please. Nothing new – well, I mean it's new, nothing changed from when we looked at it. This actually was in the care coordination and got – actually, I thought we moved it back to care coordination, but, it has to do with closing the loop of referrals and also some tracking related certification requirements.

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

Hey Paul, just on the last one, on 6, did you – track changes.

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

Yes. Can you go to the previous slide please?

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

Yeah, did you touch on the value to, I don't know if you wanted to touch on – all that noise recently about the GAO and fraud prevention and all that, did you want to – was that relevant to your goals at all or you don't want to touch that?

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

Umm, that's a fair question. When we did go through the presentation, we did use that as one of the goals and we felt that this was helpful both in the clinical val – contributing to clinical care as well as addressing fraud, so I think that's fair. We could add that.

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

Okay. All right.

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

Any objection to that? Okay. I have to say it's driven by making notes more usable in today's world.

**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**

Okay. Next slide please.

**Paul Egerman – Businessman/Software Entrepreneur**

Wait, did we go past that slide?

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

Do you have a comment?

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, I had a comment. If we could just go back. It's about certifica – the CEHRT – it said something about the CEHRT and abnormal lab results. And –

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

On slide 6 now?

**Paul Egerman – Businessman/Software Entrepreneur**

Yes.

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

No, on slide 7 I think, is that what you're looking at Paul?

**Paul Egerman – Businessman/Software Entrepreneur**

Yes.

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

There we go.

**Paul Egerman – Businessman/Software Entrepreneur**

Let me just see – hold on – where it is. The CEHRT provides the ability to identify abnormal tests.

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

If it – I just had a question about that because – use an external lab, the external laboratory identifies they have abnormal results and it might be that's the only source that that can occur from, because –

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– the normal values are dependent upon the type of equipment that is used to –

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

Correct.

**Paul Eggerman – Businessman/Software Entrepreneur**

– produce the lab results. So I didn't know what this one meant.

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

I think this certification just says, if the lab includes an abnormal flag, the EHR shows that abnormal flag.

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

Correct.

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

This is not the EHR deciding whether it's normal or not, it's just if the lab says it's abnormal, be able to show that.

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

So that's what the language, and maybe there's a better way to say it, as indicated the lab result message, that comes from the lab. And this is exactly what George said –

**Paul Eggerman – Businessman/Software Entrepreneur**

I'd say indicate abnormal tests.

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

Okay.

**Paul Eggerman – Businessman/Software Entrepreneur**

Or show abnormal tests. And then I had a question about the next bullet says, indicate a due date for when orders – when entering the order. And what's the purpose of the due date?

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

Here's the rationale, and I'd agree that it's not clear enough in the current text. So if you want somebody to have a test and it's really important and you feel there's a certain time sensitivity to that, it's helpful to say, I'd like you to get this done and I'd like to know if you did not do this, whether it's a referral or a lab, by a certain date. That's what that means, and maybe we can explain it more.

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

It's effectively a request for an alert back to me –

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

Yeah.

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

– if the result doesn't come in in a certain period of time. Like if you're worried about this patient, so this is certification, it's only you would use it voluntarily, but you would just say – because remember, in another – we're linking the orders to the results, this says – this is the data you need in to tell you whether to warn the user that the patient has gotten the test done.

**Paul Eggerman – Businessman/Software Entrepreneur**

And again, is this in operation – people are using this?

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

Yes, definitely. Let's say you want – so you feel a breast lump and you want a mammogram, a diagnostic mammogram, not a screening, you let the patient know, I'd like you to get this in the next couple of weeks, let's say, and you want to know if she hasn't in four weeks.

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

Yeah.

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

Well this is Mike. The only thing I'll comment is one of the potentially unintended consequences of this is that if I want something done by the time I see you or it's overdue if it's not done within one week of your visit in six months. It may also be something the lab cannot do if it's too much in advance of that date, so I think we have to be a little bit careful, or at least mindful of the fact that the date could be confused is also limiting how early a patient or how late a patient could get a test done.

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

– say that? That's the point Mike – that's not – I mean, it's just too – we're just trying to identify gaps, that's all.

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

I mean that one's true, it's a very good idea, I just don't know – we were trying to keep it simple and say, what's the bare minimum we could do and still get somewhere and that was –

**Paul Egerman – Businessman/Software Entrepreneur**

Because a mammogram example –

(several people speaking over each other)

**Paul Egerman – Businessman/Software Entrepreneur**

– I mean the mammogram example is actually very simple, you order a mammogram, you don't have to have an automated alert, you can have a regular process or you run reports on people who have mammogram orders and after some period of time there's no mammogram. It gets a lot harder when you start doing this for laboratory results, because a lot of things happen, the patient gets cold feet because they don't really want to get stuck in the arm, or the laboratory test is performed but somehow it's not matched to the order or you have a situation where the laboratory test is performed, but a slightly different test is performed, you order a CBC and various components are reported back but that doesn't quite complete the order.

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

You know, your laboratory example is a good one. The patient got cold feet and then therefore didn't go. This is like, you just started on Coumadin, on warfarin, and I really want to know the coags, since the patient got cold feet, I've got to do something, because they can't stay on anticoagulants without getting the test. So these are ones I would use only with like the cases where really if it doesn't get done, this is important, I need to follow up on it.

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

So what this is saying, Paul is, the EHR has to provide an ability to one, enter date, if you so choose. Now for the majority of things, I don't put that date, I have this functionality now in our EHR. I don't use that. When it really counts, like George's warfarin example or my mammogram example, I will put that because that's how I help it – use it to help me to coordinate care or to follow up. Its gen – it just needs to be there and the triggering mechanism to provide me notification when it didn't happen.

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

This is Marc. I guess, I agree with that. Two thoughts, one is, I wonder if we would want to add optionally indicate a due date, because this just says indicate, and I know it says provide the ability to, but that might be interpreted as, you have to –

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

Yes.

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

– so an EHR vendor could create something and it would end up saying okay, you've got to put one in.

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

Right.

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

So I think optionally might be helpful. Second, rather than due date, maybe – and I don't know exactly what the right word is, but it's like a back fence date, right, it's the date that you don't want to go past or you want to know if you did.

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

And the other possibility Marc is to just explain why we want this and to indicate –

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

Yeah.

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

– about the notification. And maybe even call it a notification due date.

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

But the third thing, I want to go back to – I didn't catch you with saying it, but this issue about matching things up, it's not a killer, but it's a very real one. Having done this in – if the order ID is returned from the lab with a result saying yeah, you can do it, but when you're working in an environment where patients are going to many different labs and things like that, this is a very challenging thing to do, both to match up the result, because there's nothing that ties it together well. So, I'm a little worried about the feasibility of this generically. And the same is true for imaging. I ordered a diagnostic mammogram, but what comes back is a screening mammogram, because I screwed up.

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

So the – and that's a real – thank you for pointing that out. That's a real challenge, but is it possible – but I think one of the things we're trying to promote, and you can assess whether it's feasible, is to ask people to use that – the order number field in the HL7 message and –

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

Right, which everybody's trying to do, but it's been a very long journey and it's certainly not happening today routinely. And will it happen in five years routinely? I don't know.

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

Or is it worthwhile for us to try to make it happen. Because this is really key to our coordination, right, and the falling through the cracks problem and –

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

Very important, and it gets back to where we have leverage, because it's – what's the lab doing? And what's their incentive to do that extra data entry and whatever.

**Paul Egerman – Businessman/Software Entrepreneur**

My suggestion is to include at least some additional verbiage here, because as I originally read it, I assumed it was like a due date on everything, you're going to track every order. No, with all this explanation, I understand it a lot better.

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

I mean I think the last comments were also very good, I mean, I've been through a little bit of this and it's not always easy to track things back to the order when you have multiple testing locations, multiple imaging environments, they don't always report back the order number when they report back the result. And when that happens, it's a little bit of a mystery as to whether or not it gets – the result gets attached to the order, so that reduces the usefulness of the capability. At a minimum, what we ought to do is we ought to explain a little bit more about what we're trying to accomplish here.

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

At one point in time, we actually – so this is hitting us head on.

**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**

One, it is critical from an information point of view, clinically. Two, it isn't always happening and three, it does touch people who are not covered, although EHR vendors are not "covered" either, but they do this because they have customers who are covered; same for the labs. At one point, and maybe this is something we return to, we, as a part of care coordination we had an objective that people include the order ID – return the order ID that the source performing the whatever, the referral, the test, return the order ID back to the ordering system. That applies, I think as Marc said, its referral, its imaging, its tests, it's anything that – an order that crosses system boundary. Maybe that is a critical thing that we should be working on, and it would produce enormous benefit.

**Paul Egerman – Businessman/Software Entrepreneur**

It might be a critical thing to work on, and I think it would produce significant benefit. The problem is some of the entities are outside of our reach.

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

But so like I said, EHR vendors –

**Paul Egerman – Businessman/Software Entrepreneur**

Independent laboratory, we don't have a public policy lever to require them to do something.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

However – this is Leslie, maybe we could use the fact that the CLIA rules now require that the lab results be able to go directly to a patient, that somehow we can leverage that to make sure that the order number is referenced. Is there a way to triangulate some of these regulations to benefit this?

**Paul Egerman – Businessman/Software Entrepreneur**

So you said the magic word when you said CLIA, but the issue is, the independent laboratories have their own their regulatory activities and its separate and so I think ONC's reach there is limited. But, again, maybe we're just too far in the weeds on this issue, I mean, I asked some questions about it, we had this nice discussion. And the main thing that I would like to suggest that we need to do is to simply clarify this, to write it a little bit differently, because I understood it a little bit differently.

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

And to understand that this is useful in some settings, that it could be problematic in other settings for eligible professionals.

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

So let's take that on. We will edit the verbiage here so that it's clearer and people won't have to ask the questions that Paul did to help us clarify. And maybe what our posture is to point out the need for returning – this matching issue and this goes out as part of the NPRM. I mean, CMS and ONC can decide whether they want to include that and get public comment on that. It's definitely the stand we're taking in the sense of this is really important to care and care coordination, and it's hard.

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

It may on this one warrant a sort of a footnote Paul, so that as ON – like you said, I think it's a good point that this will get further comment, just so that these things fit together and that it'll be an important part of making that successful. Because what I don't want to see is docs get really frustrated at getting a bunch of false alarms.

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

Right. Let me ask the question then is how do you want to handle that? Assuming this is the way we want to recommend, do we call it out as a separate objective and cover all orders, or do we just have it embedded with the asterisk in each one of these orders?

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

This is Marc. My two cents worth is it's worth calling out because as you point out, it's a ubiquitous issue and surfacing it at that level in the applicability across these many domains seems like it makes it clearer why it's important and worth doing.

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

I'd agree with that and maybe put it under the care coordination and just say, hey, here's a critical technology-oriented functionality that can help with care coordination.

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

Yeah, I'm – that was Charlene; this is great because I think this was derived from my group anyway and we passed it over. So, we can put it –

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

Okay. Wonderful.

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

Wait a minute. This is George. So, you're saying the second bullet, pull that out as a separate thing.

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

No, we'll keep the functionality here, because it makes sense, but as a separate functional objective under care coordination, we make the case and make it clear, to Marc's point, that the vehicle we're proposing, here's the reason we're proposing it and here are the affected areas, tests, imaging, referrals.

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

So Paul –

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

Okay and that was originally our objective, which then got put in here as part of consolidation, right? That's what happened.

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

Right. Right.

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

Yeah. Well so Paul, here's another thought. If you're going to do that, and I think this would be huge value, you know how I merged that patient summary into one –

**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**

– I would – if we could break this out and include all the referral tracking stuff under one concept, I'm trying to minimize your objectives, I don't know if we can do that, if it'll work, but that might be a way to keep the number of objectives down, but even make that whole concept menu. Because we're really trying to create the platform for closing the loop, right?

**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**

– with the ability to order, to be able to – and send over with that order the information about the request as well as get the result back. So, that might –

**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**

So just as we – we add it, we should think that through, that's all.

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

I'd like to take you up on that offer of trying to find a way to make it clearer and yet –

**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, I agree. Thank you.

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

And then we could cons – it still might merge into one, I don't know how we make it menu, but anyway, we can –

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

So let's try to work on that.

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

Okay.

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

Next slide please. This just has to do with the UID, we've discussed that. Next slide please. I think – so we discussed this thoroughly last time and this is the resulting text, which I think is clearer. Yeah, I think it's pretty clear, actually.

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

Paul, back on the UID, is that menu or core?

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

Umm –

**Paul Egerman – Businessman/Software Entrepreneur**

It's a certification criteria – here.

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

It's menu.

**Paul Egerman – Businessman/Software Entrepreneur**

Well no, it doesn't say that, as I read this, nobody has to do this for meaningful use; the software has to be written that way.

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

Certification. Certification?

**Paul Egerman – Businessman/Software Entrepreneur**

It just says certification –

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

Charlene you asked about UDI, correct.

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

Yeah, UDI. I just couldn't tell from what it said.

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

Yeah, so it would be menu, because it's new.

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

No but, the question is certification?

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

Well the wrong slide is –

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

You're looking at the wrong slide, UDI, it's this one.

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

I went back to 8.

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

Shouldn't this be certification only?

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

No, there was a lot of discussion that this would be a functional objective.

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

Okay. So, just add menu, is that it?

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

Yup.

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

Does that work? Okay, next slide please. Next slide please. Wait –

**Paul Egerman – Businessman/Software Entrepreneur**

Is slide number 9 the one we're on right now?

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

That's one where also I had the question, is this menu or just certification only?

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

It says certification only, I think.

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

It looks like certification.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

But I think the bottom one is patient-generated health data as a menu item, is it not Michelle?

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

The bottom one aligns with PGHD. That's what we were trying to reference using the structured questionnaire that's part of PGHD.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Okay.

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

You're point out that you can also – one of the uses for PGHD is to report on medication adherence. Maybe it's confusing, actually, I mean we tried to give examples and maybe we can use – give the example in PGHD rather than appearing to look like it's a new functionality here.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Well, this is Leslie, didn't we talk about medication adherence questionnaires with patients as being one of the most high value –

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

Yes.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

– areas, but – so that wasn't in a menu, it was just as an example, is that where we landed?

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

Yeah, I think that's –

**Paul Egerman – Businessman/Software Entrepreneur**

On the medication adherence part of this, if I remember this correctly, when you order a medication is actually a standard for the pharmacy to let you know whether or not the medication is filled and whether or not there are any refills. The only problem is it's like almost nobody follows that, but that would be better compliance information if you found out from a pharmacy whether or not the patient is really refilling the prescriptions.

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

Well actually, Paul, we also talked about the fact that these pharmacies now are on auto-refill, so it's – the informa – the value of the information is ironically decreased, but –

**Paul Egerman – Businessman/Software Entrepreneur**

But still, if they're on auto-refill, whenever it's refilled, they could be sending compliance information saying that the prescription was refilled.

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

But that doesn't mean they're taking it.

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

I – Paul, there's no evidence that the auto-refill programs change the estimates of medication availability. I mean, in other words, if the patient doesn't pick it up, for example, then the transaction actually gets backed out. But if they're sending it by mail and the patient is just accepting, maybe, but nobody has looked at that that I know of, so I think you've got to be careful about asserting that it's messed up the value.

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

Well tech –

**Paul Egerman – Businessman/Software Entrepreneur**

Most of the time there's some co-pay on it, but that's again, perhaps too far into the weeds. Let me get back to the first three bullets that are certification only, why are we putting them in as certification only and not putting the menu choice, a menu option for these?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie. I thought the menu option was the PGHD menu option, is that someplace else, not under medication adherence. Is it just a different item?

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

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

Okay, so let me – the PGHD – so medication adherence is just an example of the use of structured questionnaire, which appears under PGHD. I think this is a reason why we should take this bullet out because it's really confused the issue when we're just trying to make it clear that that's an example use. From Paul's question, certification only partly for we're making these things available, we want to make sure that the EHR makes this information available to the provider. It's a little unclear how the provider should use it, so you don't want to force providers to do something, and the worst thing would be a check the box, to use this information. And there are two kinds; one is the refill information from the PBM, which has its limitations. And then the other, the PDMP is not quite universal throughout the country; we wanted to make it a streamlined way to access it. So again, that's a functionality from the EHR, but not a use requirement. Does that help?

**Paul Egerman – Businessman/Software Entrepreneur**

It does. I'm just wondering because one of the things I hear from the vendors is a lot of complaints about our certification process and among the complaints is that they're having to program things that their users never use.

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

Yeah, so that's a separate issue and we actually already committed, from a Policy Committee point of view, to look into that and make recommendations about that. And ONC also understands that there are improvements that can be made. So I think – that's a separate issue.

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

Yes.

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

Okay?

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

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

So leave this as a certification requirement, take out that last bullet and reuse it as an example under PGHD. Okay, next slide please. We're moving into Category 2 and we're referencing our – the outcome goals, we want patients to understand their disease and treatment. We want them to participate in shared decision making, so it's there and we want to honor their preferences, amongst all people touching them. So that's the outcome we'd like to achieve. In order to serve those outcomes, we have functionality goals. Enable them to – enable active participation; I would say that's part of shared decision-making. Provide ability to contribute information, that's the PGHD. And have the patients preferences recorded and used, that's the functionality goals. The way we translated that into functional objectives is the VDT, and we've enhanced that. The ability to submit amendments and patient-generated health data and enhanced the patient specific educational resources. Next slide please.

Okay, so for VDT, our main thing is to add family history, and I think we can cut down on the words here, because it's pretty overwhelming. Next slide please. – and fill it out please. Okay, so that's the main thing we have on VDT here. Actually, I don't think that last bullet is there, we were going to put that into the preamble, because we just got that. We don't want to turn it into a certification criteria, which is the temptation there. Okay, next slide please. Under amendments we worked with new words, one of the objections we heard from the RFC was they didn't understand what obvious meant, so the new substitution we had was easy way, which we thought was clearer, easier to understand. Next slide please.

Umm, this is PGHD and the change here, and hopefully – so we've tried to rewrite this, we worked with Christine on rewriting this to make it clear what our intent was. Our intent was to, in this iteration, Stage 3 versus future iterations, we are focused on structured or semi-structured questionnaires or secure messaging as ways of patients contributing information back to their record. What we didn't want to do was to prevent someone who's already – the reason we didn't move on to remote devices is because of the standards issues and the adoption – the lack of adoption of any. But we didn't want to penalize someone who's already, despite the lack of industry standards; they did go ahead and interface with a device that does count as PGHD. And so that note there says, if you already do this, by golly, that's going to contribute, that's going to be in your numerator for patient-generated health information. Hopefully that was a step closer to where – and that was our intent and when we had the "or," it just didn't – it made it so that all vendors had to accommodate all devices. So hopefully we're capturing the intent. Christine, how did I do?

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

I think it's good. I think the only piece that gives me a little pause is sort of its – is the structure, like it's a "this" or "that" period and then like separately. And it shouldn't be completely separate, you know what I mean? So, I was thinking maybe we should say have – I don't know if it's a semi-colon, I don't know, but some way to connect those two. And I could be overly worried about it, because the language you have is right, but having it sort of separate and aside is what's not sitting well with me.

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

So you want to say instead, what if we say, providers accept electronically submitted patient-generated data through structured or semi-structured questionnaires, comma, secure messaging, comma or interfaces to remote devices that may co – or interfaces to remote devices.

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

Well that's –

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

Yeah or just and accept patient-generated information – way. Yeah, I think that would be great.

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

Yeah. See the way you ha – the way you said it George is what we have and the problem –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
(Indiscernible)

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

– is, that turns into a certification criteria that all vendors have to –

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

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

– all devices.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
Ahh, yeah, yeah, yeah, yeah.

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

That's what we're trying to avoid yet we want –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
Now I understand, now I understand. I'm sorry.

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

– to get – so the original “or” was to give all of those things would credit you in the numerator, but it had the inadvertent, when we put it all in one sentence, it put the inadvertent side effect of creating this undoable certification.

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

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**  
Paul this is –

**Christine Bechtel, MA – Vice President – National Partnership for Women & Families**  
– saying at a minimum at least removing the parentheses and just saying – just starting the next sent – making it a standalone sentence that says and organization may also count that.

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

**Christine Bechtel, MA – Vice President – National Partnership for Women & Families**  
Remove parentheses and be – and say –

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

We could, I just didn't – I'm tr – maybe we just have to add more words, but just trying to avoid it looking like essentially another “or.”

**Christine Bechtel, MA – Vice President – National Partnership for Women & Families**  
Well, why don't – the other option would be to just be explicit about that and –

**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**  
– say or an organization can do this; however, we do not expect this to turn into a certification criteria.

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

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
Right, right.

**Christine Bechtel, MA – Vice President – National Partnership for Women & Families**  
Really be explicit about it.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie and we're still doing some work, we have a meeting with the Clinical Operations work team about the use of devices and questionnaires and structured standards, so we have two more – one more meeting I guess, one in Clinical Ops on the 24<sup>th</sup> and then one back with this group on the 28<sup>th</sup>. But I think as –

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

No –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

– written, we definitely can accommodate this with standards.

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul and I just have a couple of questions about this. Is this core or menu?

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

Menu.

**Paul Egerman – Businessman/Software Entrepreneur**

And the other question I have is does this mean a patient could produce like a 100-page document and say, that's part of my record now?

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

So –

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

No, because it's not unsolicited, so if the provider's practice provided a 100-page structured questionnaire, then sure, but that would be their choosing, not the patient's choosing.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, because I just – in one place it says that you can simply use secure messaging. And so – and I just wondered if I could use a secure message to say, here's my detailed analysis of the outcome of my appendectomy, and they put in a 100-page diary of what my life has been like for the last 3 months.

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

So Paul Tang, actually thinking about the other Paul's comment, we have always said, and I'm not sure if we have language from – on this previously is that this is provider-driven, that the providers are selecting the type of health information they want to receive. But I could see how Paul could interpret it to be –

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

Right.

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

– anything –

**Paul Egerman – Businessman/Software Entrepreneur**

It's just that, I see that second bullet on the right, provide ability to contribute information in the record, including patient reported outcomes. Maybe I read this wrong, I thought that was like I could do secure messaging and say to the physician, here's some information I want you to know about.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie, even in secure messaging if the patient sent you that, you have no obligation to – into the record. So, it's –

**Paul Egerman – Businessman/Software Entrepreneur**

I think we do, don't you?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

You don't –

**Paul Eggerman – Businessman/Software Entrepreneur**

This is an amendment to my record, here's what I want you to have.

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

Amend –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

The ability – HIPAA allows you to say, no, as well as if it's not material to care; you're under no obligation to include it in the record. In the event that the patient says, I'd like this amendment to my record, and you say no, it's not material. The patient can then ask you to reflect in the chart that you had said, I'm not going to include this in the record and why. But you're not obligated to take that information in, just as you're not obligated when they present a piece of paper to you, if you don't find it relevant.

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

So Paul, your comment is legitimate, in other words, people can send whatever they want through secure messaging. From a practical point of view, the way a lot of the organizations deal with that is to limit the number of words, because of the probl – I mean, it would be unwieldy for people to turn in a 10-page document. So typically there is a word or character count that limits the amount of secure messaging – the content of secure messaging.

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

So I think Paul, coming back to my original point, we do need something in here that tells people it's not unsolicited, anything goes.

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

Uh huh.

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

So, I think there does need to be something in the very first sentence that says, it's not just – it can't start with providers accept electron – it's providers select a type of patient-generated health data that would be high value to them and their patients, and they figure out how to accept it electronically. There's –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

I think Christine we called it provider initiated requests, so provider initiated request for patient-generated health data.

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

Okay, that's a good –

**Paul Eggerman – Businessman/Software Entrepreneur**

That makes me mo – appreciate that clarification, that sort of –

**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**

Yeah...so Paul Tang, maybe we can work on something offline and not wordsmith it, but that concept definitely needs to get in here.

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

Good point. Thank you. Very good. Each one of these things improves it so that when we present to the committee, we don't have this –

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

Same conversation.

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

– all these questions come up. So that's good, thank you. And that does address the actual point. Okay, next slide please. So this is on the visit summary, and the problem we're trying to solve was that some either vendors or providers ended up doing a data dump as a visit summary, which made it really long and not relevant to the visit, which was not our intent. And so we're trying to use the words that make it relevant to that particular visit and give providers, the users, the ability to generally systematically choose what to include in that visit summary, rather than the world, so that was the problem that got created by some vendors or customers. So that's what our challenge was with this and you can read how we tried to address that in the red.

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

Paul?

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

Yes.

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

The word – in terms of relevant information, do we need to include actionable on there, because often these are just presented to the patient on a piece of paper and says, okay, make sure that you do these activities. But making it actionable implies it's online, so –

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

You're talking about with relevant and actionable information –

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

– environment.

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

So the reason we chose the word actionable was to make it related to this visit versus just doing a data dump. So you think that was confusing or?

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

It's just to me, it's actionable, I can actually interact with it or...

**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**

– I translated it the other way when I read it.

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

But Charlene, it says actionable, is that – are you saying take that out or put that in?

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

No, I'm just saying – if we could use a – I get what you're trying to do, it's just I got a – because actionable to me means like for instance in clinical decision support, I – up and I can make a decision right then and there. And – on a piece of paper and it's going to say, okay, you're going to go home and you're going to exercise three times a week and you're going to decrease the salt out of your diet and all those kinds of things, right?

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

So we called that actionable.

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

Well that was my – the word action – I'm with you, but, a technical person would interpret it maybe differently, that's all.

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

We orgi – I don't know if this gets are your point Charlene, but originally we talked about that the purpose of this is patient's know what happened in the visit and what they need to do next.

**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**

Yeah, I know. I'm trying to –

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

– what you're getting at, maybe what we could do is just say, is put that phrase in here somewhere.

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

Next step? Maybe next step?

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

Maybe its foll – this is Amy. Maybe it's follow up, patient follow up actions or something like that.

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

Well there's also provider follow up actions, so –

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

Yeah, okay, so then maybe just follow up actions or something that sort of implies what needs to happen.

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

Well is it possible we're reading a little bit too much into it, because I think – I'm just trying to think what do people who don't spend half their time with this –

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

(Indiscernible)

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

– what do they think? It says; provide summaries to patients with relevant, actionable information and instructions pertaining to the visit. Do you think that would make sense to the majority of the population?

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

I know it's not with technical people, right?

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

I think that's a good verb – I mean adjective.

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

This is Mike, I like it that way. I would know as a PCP or whatever, what does that mean and it includes making the appointment, but also, here's the information on who and what's the phone number and all that.

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

So why don't we maybe make a note for the narrative, where we can –

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

Yes.

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

– just have a sentence about that.

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

Okay. All right –

**Paul Egerman – Businessman/Software Entrepreneur**

We're near the end of our time, what is our schedule here?

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

I think we go until 10 my time, 1 your time.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

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

Okay, so what we'll try to do is if this wording is okay, to talk off of, then we'll try to add some additional clarification in the preamble or the associated text. All right. Next slide please. Okay, often times these things are hard to word, so here's the attempt. So our goals are patient specific educational material in the language they prefer, though the certification criteria's not all languages, you need to be able to pick a language that's important to you and implement that. And in the preferred form or medium, maybe we can make it media – it seems a little awkward here. And what we mean is, if you want it online, it's that way. If you would rather have it in your hands, we can print it out. That was the background to this.

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

Paul the only –

**Paul Egerman – Businessman/Software Entrepreneur**

I think it's –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie and I think the new language in there that I've not seen before is that the non-English education material for based upon patient preference, because it – that means all languages.

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

Yeah, so maybe we need to clarify that, what we meant was, if you speak both English and Spanish, you choose what you want it in, and you may need to know that not every educational material may be in Spanish, for example. But you're right Leslie, it's not clear there and we need to clarify that that it's not all.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Right and –

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul. I also had that same concern, because I'm involved with an organization in that patients speak 40 different languages, and so you can't quite get all your educational material in all the different languages.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

And sometimes – additionally the preferred media also provides a little bit of concern there, too. I think the way you described it Paul is right on, but for instance a preferred media not only might not be available, but might not be relevant to the best learning for that – education for that particular instance. So we know that – what studies tell us when a patient is able to take on video or when they're able to take on print and what the length of something is and the user interface should be. So I think that it's difficult to say, boy I'd like that, but I'd like that on video, and gee I'd like this, but I'd like it in print.

**Paul Egerman – Businessman/Software Entrepreneur**

Right so –

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

May I add a phrase then to address these comments? So, in the preferred media, as available and for the certification criteria, based on patient preference, where available. In other words, use that as a way of modifying –

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

Well Paul, its Christine. On – I think it's fine to say form or form/media as available that makes sense. It's very much sort of like HIPAA, I can ask for it, but it has to be federally producible. But I think my – I'm wondering if with respect to non-English language per the patient's preference, I wonder if we're overthinking that and we just need to say one non-English language, period. Because it's hard to imagine you can't fine one patient in your entire panel who's going –

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

Right.

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

– to prefer a non-English language.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise'**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

That's the question I had though also, because I read what it says for the threshold, at least one patient receives non-educational – non-English educational material. I mean if that's the entire threshold, it seems like this is one of these things that's like check the box, you've just got to fine one patient and give them something in Spanish and you're done.

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

Well it is, and that was the big debate that we had early on, because I think there were a number of folks who wanted a little more robustness, but the idea of saying some percentage or whatever was where we got into trouble. But we thought, well, but you could have a Spanish-speaking person who is actually going to give the material to somebody who's primary language is English and read it back to them, and so that's how we ended up on the one. I would love to be more robust in that, even if it's five or ten, I don't know. But –

**Paul Egerman – Businessman/Software Entrepreneur**

I mean I certainly understand the goals here, what's intended here, which is certainly noble. But it just feels to me like we've given so much wiggle-room here, where available, if you can do it and then you only have to do it once. It almost seems like it doesn't say anything, you just –

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

But –

**Paul Egerman – Businessman/Software Entrepreneur**

– it's like a check the box, okay –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie, we –

**Paul Egerman – Businessman/Software Entrepreneur**

– here's something in Spanish, I'm all set.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

We had started at one point saying everything in Spanish. And then we had thought, well maybe the top five languages nationally. And then, well, there are regional issues and so it became, what's the most prescripti – how do we do this being mindful of trying not to be prescriptive. This is an example of when you're not prescriptive; you can be so vague that we've lost the meaning of it.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and so if we've lost the meaning of it, maybe the thing to do is to skip it? It doesn't make sense to put in something here that people are just going to check the box; it's not going to accomplish anything.

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

Paul – and what if we think about using the same approach we've used everywhere else, where we don't use a number, where we say that the threshold for this is low and could likely be a number and not a percent?

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

Yeah, and Christine, you had some verbiage in terms of this for how do we just say the one non-English language. What was your verbiage, I wanted to write that one down?

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

Well that was just simply to say, in at least one non-English language and remove the reference per patient preference, because it just simplifies it and I think the per patient preference is going to happen organically out of the conversation and context between the provider and the patient. I mean, if you tried to give me something in Spanish, even though I have some degree of fluency, I'm going to say, no, no, no, I don't want that. What, are you kidding me? So let that happen and just say you've got to do it in one non-English language for some number of patients.

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

Okay.

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

And so this is –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

I agree, just put a per – this is Leslie, put a period after language in the red and then on threshold put low.

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

Well I don't think you can put a period in the red part because you don't want to eliminate the preferred form/media, because we got a lot of people saying that they're interpretation of this in Stage 1 and 2 was that they had to do it in print. And we're –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Yeah, but if you say an “and” the preferred media, then you've got everything in every media potentially.

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

Right, well I think what Paul is saying in language and preferred media where available.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Okay. And then just put the – under the black, you'd stop at educational materials, period.

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

Yeah.

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

Yes.

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

Yeah, this is Amy and this minor but I think the non-English in that first red language needs to go before the patient. So, the educational material in the non-English speaking patient's preferred language. Otherwise it makes it – you know what I'm saying?

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

You're not allowed to give them materials in English anymore.

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

I mean, I'm being nitpicky, but it's sort of – it just reads funny to me.

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

Well, so this is Mike, if – I'm not sure from my perspective it does, but let me just – because it's a patient and if they have a preferred non-English language we use it. But let me make a statement another way, what I really want the EHR to do, if I can, is to record what preference a patient has for language. And then if I have a series of patient education handouts I can give, that it will default to providing it in that preferred language because it's supported by the either third-party vendor or other certified EHR technology I have. So it's a no-brainer for me, I can do it easily, you don't need to count, etcetera, etcetera, and if it's not available in that language, then it defaults to the languages that are available and I choose from them. So that makes it easy for me to do, right?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

That's correct, that's how it exists today. Perfect –

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

So likewise, if they say, I prefer to get my stuff as video hyperlinks, and you have the capacity to support that, then that goes into either your clinical visit summary, whatever it is, or out to the portal or whatever, so that they have a way to do that, or even in the office. So I'd like to turn it into something that doesn't require active management and which defaults to the eligible professional or the staff supporting them, a reflection of an awareness of the patient's preferences and where those can be supported, to take action on them.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

And that's included in the standards, so that helps, that we've already named in meaningful use, too, as one of the standards necessary.

**Paul Egerman – Businessman/Software Entrepreneur**

So let me make another suggestion about how to do this, I was thinking about a local organization I know where something like 40-50% of the population speaks Portuguese. And of course they have all their material in Portuguese – it's such a big percentage of the population. And so the comment I give is, rather than focus on the non-English part, we simply say well we're going raise the threshold and we want some percentage of the patients to receive educational material in their language, and you just leave it at that.

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

But that's only if they prefer it in that language. So I understand they may speak it, but I just want to have a good correlation between they ask for it in Portuguese, I had it available in Portuguese and then I delivered it in Portuguese. But if whatever the language preference is, if I have it, I'd like to demonstrate that I'm giving it to them in that category. But I think our earlier conversation was the reason this is such a low threshold is that if we've made it easy to do this right, nobody's going to actively switch away from the patient's declared, preferred language for a handout they have in that language and do something different. That would take more work and potentially more discussion.

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

So, this is Amy.

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

Once you can do it – go ahead.

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

I'm sorry, no; I was just going to say, why don't we just say educational material in the patient's preferred language? We don't need to put non-English –

**Paul Egerman – Businessman/Software Entrepreneur**

That's what I'm saying.

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

– if – and preferred form or media as available or as available – if available in the language and if available in the media, because I think the “if available” applies to both and I think we can take the non-English out if we're saying their preferred language, if available.

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

But the problem is, if we're trying to set a threshold –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

If it's English, if that's your preferred language.

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

– yeah, but the concern I think I heard earlier – this is Mike – was that there was a concern that you could otherwise easily meet the threshold by ignoring everybody whose preferred language is non-English, unless you make some threshold for the non-English ones.

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

Right, but I'm going back to what the previous person was saying which was, if you take out the threshold. So I agree, I think if we're going to leave in threshold around non-English, then we have to sort of just reword the red a little bit. But if we're going to say, in the preferred language –

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

Well, hold on, it's Christine. So, we went round and round this tree and Mike is right, it was too easy to game the system. But, I think what Paul Egerman is saying is interesting. The chal – the problem I have with this slide, which we hadn't actually gotten to yet, is that we lost the second threshold. There was a second threshold that was what used to be 10% in Stage 2, where patient education materials are being delivered to 10% of patients, so that needs to come back in somewhere on this slide. So I think what I'm hearing Paul say is, if we said, deliver patient education materials to 10 or 15 – I'm going to use a number, percent of patients, including some number, and we're not specifying what that is, that are delivered in the patient's preferred non-English language. Paul, is that what you're saying?

**Paul Egerman – Businessman/Software Entrepreneur**

No, it wasn't. Because the part that's really hard here is simply to figure out a way to do this for one-size-fits-all.

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

I mean, it's just that some practices, I mean, as I say, there's a noble goal behind it, but there are some that have a non-English language that's just overwhelmingly there, but then they're automatically providing educational material in that language because there's really no choice. There are other practices where, it's pretty much 100% of the practice is in English, wealthy, suburb of the city and everybody speaks English. I mean, that's the issue, so then like how do you – then I think about Boston Medical Center where I mean English is probably the dominant language, but there's no second dominant language and there are like 40 different languages that are spoken. And so it's like, how do you do this in all of these things and I just worry that we're putting a lot of words on the page and you end up with such a low threshold that it becomes meaningless. And so maybe the question to think about is, well if what we're trying to do in Stage 3 is all about outcomes, why don't we just assume that the eligible providers are doing the right thing with their educational material, depending on the population, that they're doing their best, and stop trying to find a one-size-fits-all for this and just drop it.

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

So maybe – what we're trying to do is make the tool available so that providers can dispense patient specific educational materials in the preferred language where they can. And so, I'm just supporting Paul's proposal – or just offering the alternative proposal, make it certification requirement so that one, you can accommodate an alternative library of patient educational material in at least one other language and two, you can act on that because you can trigger it by the patient's preference. Is that simple and makes available the tool and as Paul says, people are going to want to do the right thing if they have the capability to do this. It's really hard to write one-size-fits-all.

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

But I –

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

Can you say that – say again your suggestion?

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

– can make that argument about any objective in here, that we should just turn the whole program into certification criteria, and that's not meaningful use. It's not meaningful ability to if you choose to, it's supposed to be meaningful use so I would be very, very concerned about dropping this as an objective and turning it just into a certification criteria. That's not what we've agreed to in the years that we've been talking about this, whether it's non-English or just English.

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

May – this is Amy. Maybe we can go –

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

I have –

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

– I'm sorry, maybe we can go back to just suggesting that material – like you capture the preferred language and that materials have to be available in two or three additional languages that patients in that practice speak.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

– so many languages.

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

This is Charlene – and I

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

I vote that we leave it – I'm sorry.

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

Can I just say one more – ?

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

Yeah, go ahead, and then I'd like to talk.

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

– one more concept to the table. From the perspective, I do not have this information, we tried to research it, but, I do know that aren't providers required to provide bills in appropriate languages, from the billing perspective, isn't that a requirement? And why can't we be the same? The feedback I'm getting –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

No, that's not the same.

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

– when program – well what languages do they have to provide them in and why would it be different?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Well because a bill you can translate a SNOMED code, one code and what that means to every single language, because it's not education, it's a fact, it's a code. And it's not –

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

But – they require something like that? I mean –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

No, it's – would we want to –

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

Okay, this s Michelle, can I just ask we're everyone's talking over each other and my apologies. I know there are a number of people in the queue, if we could just have one person talking at a time. So I know Charlene, you had a question and George wanted to make a comment and then Leslie.

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

Okay, so my point was, can't we use the same concept as we would for the financial systems, and I guess Leslie was saying why not. But, it's just, I'm in support of that we need to do this, but if there is a consistent framework that providers could use in doing this, it just simplifies things.

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

Okay, George.

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

I think that based on the conversation, we should leave it as is, verbatim. Christine I think it'll work because they're going to keep the same low threshold and they're going to add a threshold for non-English, which is just one, which may be stupid, but it forces us to do just one. And I haven't heard any other suggestions that actually work, so I would just leave it verbatim as is, which we already spent time arriving at. And I think it will achieve most of what you want, and I don't think five instead of one really gets around the fact that you can get around this thing. So I think just leaving it verbatim is our best bet right now.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

And this is Leslie with the following qualification on that, as available.

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

Okay, so let me try to read what I have – as what I heard as the edit to be and let's see if George agrees with that, an improvement of our word set. So in the first bullet it would be exactly the same with the addition of "as available." In the second bullet, the certification criteria would read, EHRs are capable of providing patient specific educational materials in at least one non-English language.

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

Paul, that's correct, in my opinion, that's Christine. But the thing that's missing is there needs to be a second threshold, it's been in every other version, we just lost it in this one for some reason, which is the low percent of all patients that receive patient education material, period, having nothing to do with language.

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

Right.

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

Okay. Great, independent of language – well; unfortunately, this is all about language, so it's a little –

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

Well then you have to add back in the patient education 10%, what used to be 10% in Stage 2, on a second slide. But that's always been in here and it just fell out in the translation, it was in – it's in the Word document that we looked at as well.

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

Okay, so we'll try to – we'll find a way to accommodate continuing that.

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

Well, uhh, all right. I don't know, I think it's okay to give CMS the flexibility. I'm assuming they're going to keep the 10%, but if they decide that we've already gone through the other stage or stages is it stage or stages, I forget where this started?

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

It was menu – oh no, actually I think this was core in Stage 1, wasn't it? But –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

It was menu Stage 1, core Stage 2.

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

So – CM – like Christine, I don't mind if they decide okay, we don't need to keep measuring that, but we do want to do the one non-English. I'm not telling them not to do it, I'm just saying by leaving it open, they're going to decide do they want to continue to measure patient education at the same rate or not measure it. I don't see why not give them that flexibility since we've done it for two stages, and at least one of them as core.

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

Yeah George, I agree they should have flexibility, but it looks like we have intended to take it out because in fact we took it out. So all we're – we're not saying 10% anymore, we're saying it could be a low threshold for doing this, and I don't want to lose that because that has not been our agreement this whole time.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie, I agree.

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

Okay, so maybe we'll find some language that says, oh, we're going to – we recommend continuing the low threshold and add the following –

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

Yup.

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

So we'll find a way to –

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

Well actually what we're recommending is not asking to take it out, we're not recommending to continue the low threshold. See, if they continue it, it should be low, we're not telling them they have to continue it, we just want to warn them that we're not telling them to take it out; they should decide what they want to do.

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

Well no, I think we're just going back to the language we've already agreed on and they get to decide what they want to do for every single criteria in here. So I don't know why we would need to waste word space saying we're not saying take this out, but you need to figure it out when our language the whole time has always said, there's a low percent threshold of patients who receive education materials identified by the CEHRT. That's it.

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

Well that's – just because it follows along with our goal – original goal in the first round on this, to get rid of things that we thought was sufficiently achieved, that people wouldn't back off of it.

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

Right, but that's what we have not agreed to, George, that's what I'm saying.

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

Right. This is Mike, and we haven't gotten so good at providing patient education materials that we could either retire it or not hold people to at least some threshold is my view as well.

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

Yeah, yeah.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

I agree.

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

In some sense the data might help us – so you saw how everybody's 90% for everything else, if Stage 2 was 90% we probably would think differently, but the hunch is that it's probably not going to be 90%.

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

Right.

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

Okay.

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

Okay. So, this finishes Categories 1 and 2. Since we only have 9 minutes left, I think what I propose doing in the next, care coordination, has quite a bit. Why don't we save care coordination and population and public health for the next call, which is a 2-hour call on January 28<sup>th</sup>. It is our last call before the final presentation to the Policy Committee. I think we made good progress and we still have some edits to do based on this call, and really appreciate your feedback on that. Anything else before we open it to the public?

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

Well Paul, why don't we go to affordable care?

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

Uhh – where's that, what page, what slide is that?

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

24.

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

24 –

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

Otherwise we have to do four categories still.

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

Yeah, I'm not actually sure that this is – we actually – affordable care is – we did that with CDS.

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

Then done. Good. So we can strike another off.

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

Yeah. I don't really propose that we add more categories to our work. We did call it out as a way to make sure that we cover it, and I think we covered it under CDS.

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

And did you say we'll do disparities later or it's done?

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

Disparities is part of CQM. Let me see how it's written here.

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

26.

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

There are the additional certification criteria.

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

Okay.

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

Slide 26 is the last one.

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

Why don't we go ahead with slide 26, and let's see if we can approve that. It's basically a certification criteria and we talked about preferred mode of communication. We talked about occupation and industry codes. The two things I think we are adding as optional fields are the sexual orientation, gender identity and disability status. Any additions or clarifications of those two points?

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

Aren't they all optional because they're certification. I mean, is disability status not optional?

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

I think what I meant there is you're not going to force people to say – I mean, they're not mandatory in that sense. But I guess you're right, that everything is optional. So I guess I'm not – Michelle, is there any further clarification on why that has an optional?

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

No, there probably was some discussion during a meeting –

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

Okay.

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

– but I will take that out. Thank you.

**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**

So Paul, this is just a general question from Charlene. Are there standards for these different data fields?

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

I was just going to ask that. I think –

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

The feedback I get is, for this particular area, data quality is such an issue relative – and each of the vendors will therefore implement to some extent differently. And, if we want to get to where we want to go, we can't do that. So we need some normalized data set around which people can at least start from, and even going deeper, for an implementation approach.

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

So Michelle, do you know the answer? Have we – did we – I think we got some feedback from Standards Committee on all of these, is that correct?

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

I thought so. Michelle?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

This is Leslie –

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

Yeah, and we'll have to go back –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

I think that there is discussion on vocabulary about this right now.

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

Yeah, because this is really – I wouldn't – this is important stuff, but to do it – to roll all this out, it's going to be complex to roll out anyway, and to have variation there, that's not going to get us to what we – that's a lot of work for not the return we're looking for.

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

And the way we intended to use it was in stratifying CQMs, so they obviously have to be standardized and coded. So Michelle, maybe for the next one, could you remind us what Standards Committee has signed off for standards for these, please?

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

Sure.

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

Okay. So where standards exist – so I think you want to capture these. What, I mean, we've sort of done sometimes, we've done this in – so, you want to capture these, even if it's only human readable, and we certainly as quickly as possible want to go to standardized codes.

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

You know the other context here, the IOM is going to issue a report in March saying, here are the – here's the evidence for social determinants of health, and I don't know – I don't think they go into standards yet, but they go into evidence, and so that will modify – and that will be sent to CMS. And that may modify anything we suggest so it would be probably not a bad thing to have this as a placeholder, which would then be infor – it will too late for us to inform them, except at the NPRM stage. But for now this would be a placeholder that would allow pieces of that report to inform CMS at least, even if it missed us.

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

Okay. So we'll do some homework on what's available and then we can say whether we want to keep this, if it's not standardized, some of the caveats – basically what George said. Okay. Good. Thank you. Why don't we open it up for public comment then please?

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

Paul, before we open it up, can I ask – I'm concerned because we only have a 2-hour call left and knowing how much time we spent on some things during this call.

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

Uh huh.

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

If people have any language concerns that they notice prior to the next call, if they could share them with me, I think that would be helpful.

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

Great idea, so please submit some adjusted – particularly I think Charlene and Art, in your related areas.

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

Yes.

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

Okay. Thank you.

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

Thank you.

## **Public Comment**

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

And operator can you please open the lines?

**Rebecca Armendariz – Project Coordinator, Altarum Institute**

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press \*1. Or if you're listening via your telephone, you may press \*1 at this time to be entered into the queue. We have no comment at this time.

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

Okay, well thank you very much for the hearty discussion. Please get your comments in so we can incorporate those ahead of the call. Thanks for helping us make it clearer and more to our intent, because that – we want to get the substantive discussion at the Policy Committee, not the misunderstandings. So that it's been very helpful, appreciate it and hopefully everybody can make it to the next call on January 28<sup>th</sup>. Thank you all.

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

Thank you Paul.