Wow! What a great discussion. If I understand correctly, discussants generally agree that much of clinical care is inherently nonlinear, dependent on multiple inputs, variable between clinicians, and too complex to be well represented by the algorithms in current health IT. Most clinicians are simultaneously managing multiple patients under significant time constraints, constantly integrating new data, rethinking problems, and reformulating intermediate goals as they interact with patients, other caregivers, and clinical circumstances. Often tasks and decisions must necessarily be deferred to the future, pending additional data, consultations, and patient interactions.

In contrast, current EHRs inherently assume an idealized, linear, inflexible (no immediate adaptability), one-size-fits-all model of healthcare delivery. Clinicians are required to follow templated pathways whose content and ordering are not a good fit to the patient currently under care or to respond to clinical decision support alerts which reflect incomplete knowledge of the medical literature, of the patient’s specific clinical situation, or both. The disconnect between the reality of clinical care and the way care is represented in the EHR causes clinicians to perceive their electronic systems as disruptive and inefficient. Data from the *Annals* paper that started this discussion and from many other sources confirms that there is an objective basis for this perception.

So how do we solve the problem of making EHRs more workflow centric (Dr. Carter) and more flexible and adaptable (Dr. Patrick)? An editorial by Rudin, Bates, and MacRae titled Accelerating Innovation in Health IT published in the September 1 *New England Journal of Medicine* (<http://www.nejm.org/doi/pdf/10.1056/NEJMp1606884>) argues that an important part of the solution will involve overcoming the other great disconnect in health IT, the barrier between software developers and clinician end-users. It will require multidisciplinary teams of software engineers, clinician users, cognitive psychologists, and human factors experts to envision and develop new EHRs. It will require IT firms to focus on user needs and allow expedited user input into product design and development. It will require clinicians to better document and communicate their workflows and to embrace redesign and improvement of care processes in parallel with the development of new IT.

Clearly this will require a tremendous amount of work. Dr. Fochtmann and Dr. Valdes have called out the key barrier to doing that work. Our policy makers and regulators are so intent on accelerating the evolution to value based payment models (a laudable goal) that they have lost sight of the fact that our current EHRs don’t provide the tools clinicians need to improve quality and lower costs. They are consuming clinician time and brainpower with MACRA, MIPS, MU, and RAC audits based on archaic E&M coding bullet points, none of which will bring us any closer to the much-publicized triple aim. Really accomplishing those goals will require simplified refocused regulatory programs which provide time and incentives for clinicians, researchers, and software engineers to do the very complex work leading to disruptive innovation and development of the novel IT tools we need.

In an editorial accompanying the *Annals* paper (<http://annals.org/article.aspx?articleid=2546705>) Dr. Susan Hingle wrote, “Now is the time to go beyond complaining about EHRs and other practice hassles and to make needed changes to the healthcare system that will redirect our focus from the computer screen to our patients…” Is AMIA joining with the AMA, ACP, and other partners in vigorous advocacy efforts to work with our colleagues at ONC, CMS, and Congressional staff to bring about desperately needed regulatory reform? Are we doing everything we can? Dr. Payne and Dr. Fridsma, what say you?