

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
November 21, 2013**

Presentation

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

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, this meeting is being transcribed and recorded so please state your name before speaking. Also, if you aren't the one speaking, if you could please mute your line that would be appreciated. I'll now take roll. Paul Tang?

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

Here.

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

George Hripcsak? David Bates?

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

I'm here.

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

Hi David. Christine Bechtel?

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

I'm here.

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

Hi Christine. Neil Calman?

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

Yeah, I'm here.

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

Hi Neil.

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

Hey, good morning.

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

Art Davidson? Paul Egerman? Marty Fattig? Leslie Kelly Hall? David Lansky? Deven McGraw? Marc Overhage?

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

Present.

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

Hi Marc. Charlene Underwood? Mike Zaroukian?

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

Present. Hi.

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

Hi, Mike. Amy Zimmerman? Tim Cromwell? Joe Francis? Marty Rice? Rob Tagalicod?

Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration

Here.

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

Rob Tagalicod? John McGing – for –

John McGing – Health IT Analyst

Here.

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

And do we have any ONC staff members on the line?

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

George here; sorry for the delay.

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

Hi George. Okay, with that, I'll turn it over to you Paul.

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

And this is Art Davidson, Michelle.

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

Hi Art. Thank you.

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

Good morning.

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

And the last two people you called Michelle, didn't – I think there was some cross-talk.

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

Was Marty Rice or Rob Tagalicod on? There was nobody from ONC on, right?

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

Okay.

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

Good. Well thank you everyone for joining. You'll see – in fact, I'll go ahead to the next slide please. You'll see that we have a sprint at the end here to cover the things we need to finish before delivering our final recommendations for Stage 3. So, this is recommendations from the HIT Policy Committee to ONC and CMS, as they deliberate in their rulemaking that would lead to an NPRM where they solicit public comment and then produce their final rule, perh – somewhere on the order of about a year from then, at least that's the timetable from the past.

I want to start out with one discussion about timing, and no, it has nothing to do with timing of Stage 2 or even the timing of Stage 3. I don't know what the Secretary's thinking, but the timing of our recommendations to the Department. Our original schedule calls for us to deliver our recommendations really in two parts, some of this is a result of the two week shutdown, where it's not just you add two weeks to everything. There are complications because that affects a lot of the deliverables from other people that were coming in, and you'll see some of those others still in pending state. So for example, you see that we're not discussing feedback from the Standard's workgroups or imaging until December 10 meeting, which is after the December HIT Policy Committee meeting.

And then the other piece is that the Quality Measures Workgroup, while they'll be talking to us at the December meeting, won't be delivering their final recommendations until January. So we originally sort of split up between some of the objectives recommendations, some of the talk about deeming and the quality measures and some of the input. So instead of having this separate, we thought we'd just shift all of our Meaningful Use Stage 3 recommendations to the January meeting. So that basically gives us a little bit more time in the MU Workgroup to collect all the feedback we're getting from the various groups and to provide a comprehensive set of recommendations in January. Does that make any sense? I don't think people on this call would object to shifting this a month to align it with the quality measure and all the other feedback.

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

Sounds good.

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

Okay. So you see we're going to talk about deeming again. We have asked for, and they've been very diligent in trying to collect the feedback from the EHRA and you'll hear about that shortly. We'll look – we'll start reviewing our recommendations, starting with Category 1 that was led by David Bates on the quality, safety, efficiency. And then we'll – next call we'll be reviewing the recommendations from the Consumer Workgroup on patient-generated health data and continue our review of the recommendations from Categories 2 and 3. And the following call, after the HIT Policy Committee, we're going to be getting – we should be getting our final feedback on imaging, of CDS from the Standards Workgroup, VDT, registries and case reporting. And that feeds in to some of our objectives for Stage 3 recommendations. And the latter part of December, we'll be reviewing recommendations from Category 4, as well as looking at what – how we're dealing with health disparities and affordable care. So some of the other domains in which we're measuring ourselves in terms of meaningful use objectives.

So in January, before the Policy Committee meeting, we'll be reviewing our whole set of recommendations and fine tuning them, before we present them for approval at the January 14 HIT Policy Committee meeting. It's quite a full agenda, so, thank you so much for your participation. Any questions on that? Okay, let's go to the next slide please. And I think instead of going o – and following one more please. Let me just sort of summarize where we are with deeming and get some comments and reflections after you've slept on it since our last talk.

We started out with our original motivation is, wanting to simplify; we're taking advantage – so this is Stage 3. This is a time we announced we'd be shifting more from the process oriented get the EHRs installed, in place and exchanging data to getting data out of it so that we can both measure and improve outcomes in a continuous basis. So that was the motivation, it still stands today for Stage 3. So in – so what we wanted to do is see if we can shift the objectives – the way we measure qualifications for meaningful use over towards outcome oriented measures. At the same time, we wanted to simplify the whole program and reduce the burden of complying with the program, frankly. So we've certainly heard feedback that sometimes it's more burdensome to prove that you've complied with the EHR Incentive Program than to actually do it. And so one of our thoughts was, if we reduce the reporting requirements, for example, and the functionality, the more process oriented measures that would reduce the burden.

And the principles we have for deeming is one, the assumptions are that you obviously by the time Stage 3 rolls around, you've completed Stage 1, you've completed Stage 2 and by our track record, people don't really let up. When they come in with a 90+ – over 90+% of the measure, and they stick with it in the sometimes three years that they've been in the program. That deeming would be an optional program that tried to accomplish the principles, the motivation we had that I just stated, and that it wouldn't deem you out – completely out of the program, it's really only a subset of the functions, which we felt were tied and necessary in producing good outcomes. That the quality measures we would select would be HIT sensitive, that is, it's reasonable that you would think that if you are performing well on these quality measures that we select, you're probably – you not only have the HIT tools available, they're being used by your staff. And that it would really reinforce the notion, the original reason for meaningful use in the first place, of achieving good outcomes from a patient point of view.

So as we've been discussing it, we've had some devil in the details kinds of discussions. One is the kinds of quality measures we're looking for are sort of a different type than we've been used to in the hundreds that are already around. A big reason is because we didn't have EHRs in the past and so most of – many of the quality measures couldn't rely on anything else but the available administrative and claims data. And the sec – another piece that we discovered is if it's going – if we're going to reward high performance or we also added in significant improvement, that requires either benchmark or a track record. And there's a bit of a catch-22 in the sense of, if we think we need better measures, i.e. new measures, then we're going to have less best marks and sort of a less track record. So we got into the predicament of needing to have some sort of a runway where you've already built up experience before we can use this effectively.

So that got us to thinking, we wanted to make sure we preserved the – we want to orient towards outcomes and we want to reduce the burden of the program. Are there other ways? And I'm going to open it up for other thoughts that people have. It's possible that we use measures that already exist or at least in the pipeline, so that they can develop some track record by the time Stage 3 rolls around, versus these de novo measures. It could be that we retire – another way of simplifying the program is to retire some high performance objectives and retain the more outcomes oriented objectives. Or we do some substitution of the actual CQMs that are reported upon to be more of the outcomes oriented. So there are a number of alternatives, we – there's a lot of attractiveness for this deeming approach, but we've run into some challenges and just wanted to hear peoples thoughts on those. Let me pause here and get peoples thoughts after having slept on it.

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

So this is Mike, I'm going to give a really oversimplified approach, but it relates to a meeting I had this morning. And that is, for folks that just in general principles are humming along, as you say Paul, with a high performance against all of the functional measures that they've had that they're doing well against the quality measures. And for Stage 3 can basically focus squarely on clinical quality measures with a high enough bar to be meaningful to kind of the program framers and the HHS, etcetera. And to really be able to say, we already know that you're leveraging Health IT to get all this work done, we don't really have to prove that one more time. And as a result, you can focus squarely on the clinical quality measures, with perhaps as you said earlier, the absolute retirement that those that are HIT sensitive be part and parcel of that, but that also you might even have additional ones that are less easy to prove or as HIT sensitive.

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

Um hmm.

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

So – this is George. I think we – what we don't want to do is start again at seeing if we can figure out deeming, because we've given it a couple of shots. I think that the goal of deeming is to simplify, not to make it more complicated. Every version that we've come up with so far I think increases the burden both on the vendors and the providers, because we're basically creating another program. We're finding it hard not to just accept the quality measures that are there, we want different quality measures, we want a different combination of them and we want to measure it slightly differently by allowing not just performance but improvement to do it. And then on the objective side, we want to take half this measure and half that measure and in the end, we're creating yet another Meaningful Use Program that's going to be much worse.

So my recommendation is we not do deeming, because we can't get it done. The only way I would approve deeming is if we actually accept the current quality – whatever quality measures the Quality Measures Workgroup comes up with, we pick a threshold and that's it. You do the Quality Measure Program and you just have a higher threshold or something. And if you meet the higher threshold than the regular threshold, then you're deemed on the objective, period. And you'll be using a certified EHR still, so you'll have the capability of doing it, and that would be a simplification. But anything where we're picking it apart and creating basically a new program is just not working. It's just going to make it harder and make us – put more pressure on us that we're going in the wrong direction.

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

So George, this Mike. Thank you for that comment, because that really is squarely the intent behind what I was describing. I agree completely, you do not want to make this more complicated. You want to stare at what you have already, focus on that, create the threshold necessary for the oversight of the program to say yes, if you can do that, you have actually met the outcome goals of Stage 3 with regard to quality and everything else can fall away, simplifying that and letting you focus. So I think that's spot on.

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

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

Other comments.

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

This is Neil. I would say that I think I agree with you, I just want to make sure that the way that you're reporting quality, in terms of the things we're talking about stratifying by race and ethnicity and other things are also included, because otherwise we really could fall away from some of the important concepts that means incentive to most.

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

I'm getting only part of what Neil is saying.

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

For some reason you're a bit muffled Neil, is there –

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

I'm sorry; I'm in a noisy place. I was just saying that I think that – I would be in favor of that as long as we make sure that you're still requiring things like stratifying measures by race, ethnicity, and stuff, so that you don't lose some of the overarching goals that we have.

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

Okay.

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

And this is Mike that works for me as long as it's not burdensome to be able to do it.

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

Other comments?

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

This is Marc, I guess it's interesting that you make that requirement, which of course is the whole purpose of I think the deeming approach, is to try to find a way to, and Paul or others correct me. But is trying to find a way to make it easier for high performing organizations to meet the program requirements and be not burdens – or less burdensome. So, it's kind of interesting that you make that observation.

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

And this is Mike; I'll just add one more color commentary. Right now, in the real world of the two organizations I live in, they look at the clinical quality measures, we're all interested in quality, but we're also focusing on everything from how do we make sure we can report this measure right and survive an audit and all of those sorts of things. Rather than turning and simply saying, here's where we're doing great on quality measures, here's where we haven't focused. Because we don't have to focus on as many as we might be incited to do, and that if we had the ability to let go some of the energy on the others, because we're already doing well, and focus on those. We'd be working just as hard but we'd be working more towards our connected purpose, which is to get these quality measures all improved. \

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

So, interesting. Let me try to pull together some of these very insightful comments we've been hearing and see where we're headed. I think one of the new thoughts is that – so we were really trying to rush towards getting the outcomes measures that we so desire. And partly that's where it's tripping us up because they are so aspirational that they don't exist and that causes one, the new work and two, the less of a benchmark and track record. So instead of a "yes" or "no" deeming, is there deeming based on some compromise on the trajectory to the more desirable outcomes measure?

Another interesting thought is we talked about stratification from a disparity point of view, but it's interesting that I think stratification by any population of interest and importance to some local organization, is something that isn't being done much at all today. But in theory, you have the tools because we have patient lists as part of the objective, you have the tools, but you're probably not using it in the way we've been thinking about, in terms of stratifying your population and figuring out how to intervene to improve things. So, is it that we basically – in order to reduce the burden, both in development as well the implementation, we use the existing functionality and apply it differently. And much more oriented towards the outcomes, or the things that are important to you locally, as our emphasis for Stage 3, on the way towards much more out – when we get better outcomes measures, better quality measures orienting and measuring the total outcome.

I'm not sure I said it right, but I'm trying to capture the in-between state of saying take the existing functionality and apply it differently in ways that probably most people are not, which is use these reports richly, give them back to the providers in the frontline in a timely way, not in a retrospective way. And let them turn on their improvement juices to achieve better outcomes. Does that capture what George, Mike, and Neil –

M

Paul cou – I'm very sorry. Say it one more time.

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

So let me compare it to where we were – we have been discussing. What we have been discussing is saying, okay, we need some quality measures that are truly outcomes oriented and that give us a really good sense of the patient outcomes of our panel. What we've found is those measures don't exist, so they need to be created, they need to go through this pipeline and hence they have no benchmarks and/or track record for individual providers. The in-between that I'm hearing you all suggest is, take advantage of what we already have, maybe refocus on some of the ones that are more like the ones we are striving for, they're more like the outcomes measures. But one of the new twists is, and apply – and stratify your patient population by your local priorities, which may include disparities. That when exercised, that would use the current functionality, and that's where the less burden comes in, in new ways that are moving towards improving the health status of the population you serve.

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

Right. And this is Mike, so Paul, I think that – again, that's spot on and I think your last point from the first summary was really key, which is, turning on the creative and enthusiasm juices of providers who really can resonate this as being connected to their purpose and can more easily strive in this direction. And their organization leaders can help them with that process better than simply meeting another functional measure that somebody else sees as important, but they haven't yet been able to connect to outcomes.

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

But Paul, be more concrete on what it's – so I'm a provider, I do what? I meet existing quality measures on portions of the population, I mean, that's the dis –

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

So, okay. So, let me try again. So from the set of quality measures that are part of the MU program, we might want to say, well here's this set where they're more outcomes oriented. So let's pretend there's a subset of the quality measures that are already there, hence are already programmed into these systems. We're – one of the emphases, areas of emphasis we could have for Stage 3 is stratify your patient population according to the measure you select and into groups that are important to you.

One of the groups that's important to us is disparity variables, but there are other groups that may be important to you. Let's say you serve a large Hispanic or a large Native American population and diabetes is important to you, then stratify your diabetes populations so that you understand how you're doing with respect to those high risk groups, so that you can design interventions that target those groups.

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

And then –

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

In other words, use the tools.

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

And then if you do that, what happens? You have to achieve what and what do you get back?

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

Umm, that's in lieu of continuing to measure, this is Mike's point, continuing to measure demographics and the percent of CPOE or – I'm just making those up, but drop off some of the things that you just have to do to keep up with the process measures –

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

All right –

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

– to essentially requalify.

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

All right, so then what we're doing is, we're taking – it's better than new ones. If we look at all the quality measures, we take a subset, so I don't like that that much, but okay, so we take a subset –

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

Right.

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

– and obviously will pick a set that are outcome-oriented, then we have to stratify somehow and then perform on the stratification on each of the strata or in one of the strata?

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

Well, we'll figure out how we reward – essentially how do we reward stratifying and acting on –

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

Well –

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

– and I think one of the important – one of the important things –

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

Now we're coming up – and it's getting complicated again. So I'm going to strata and then I have to reach 90% on each of the strata and then I'm going to have improvement towards 90% also counts, but then you start losing me again on deeming.

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

Yeah, okay –

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

It's got to be like, here are the quality objectives that the nation has decided are important, you have to get 90% on them and then you deem either all the objectives or at most complex, a subset, period, done.

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

So let's –

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

Paul, its Christine. This – I think what you're describing sounds like the original proposal we had minus the first reporting bucket, right? We had a set of things you had to report in the first bucket around prevention and outcomes oriented and then – and half of it was safety, and then you had to pick two measures to stratify and report those.

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

Yes, only they're existing me – so one point is they're existing measures. And point two is it's something that Mike said which is, try to remove some of the effort from some of the process measures from Stages 1 and 2, so that you can devote more energy towards this new thing which is stratification. You have the functionality in "patient lists," but maybe not –

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

But isn't that –

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

But you may not have been using –

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

– isn't – I mean that's I thought that what we asked the ACO or Quality Measures Workgroup to tell us was, okay, if there were measures like these then – now I know they may not be going in that direction, but that was where we stopped was, we – you had the list of these functions get deemed and these wouldn't, remember?

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

So this is –

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

Um –

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

– I'm not seeing the difference and I think we got stuck on that one.

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

And this is Mike.

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

Actually – .

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

This is Mike, I was just – go ahead, I'm sorry.

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

All I was saying is, again, conceptually everybody gets on board, and then we get stuck in trying to figure out how to do it because it gets really complex. But I was hoping that the Measures Workgroup was going to help on that.

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

And they – in a sense they're getting, they're facing the same challenges, but the main thing is they would be looking towards new measures that address the needs of ACOs, as an example. And they're facing the same challenge, which is, well, the existing ones really don't cover, let's say, care coordination that well, which is a big need for ACOs. So we're getting stu – so, I hate to use the word stuck because we want them to work in that area because we want those measures to appear in our future.

I think we have a timing problem with Stage 3, that's not future enough for us to both get new measures and to get a track record. So the interim stage is what I'm hearing discussed here, is to use existing things, whether it's existing functionality or existing measures, and try to apply them in new ways.

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

Right and this is –

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

I think that's sort of the –

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

I don't understand, we're redoing the quality measures job though. I don't see why we're doing it a second time. What we should be doing is deeming everybody. The Quality Measures Workgroup should be figuring out what goals everyone has to achieve to achieve meaningful use, period. And they should be worried about whether we're stratifying to take care of disparities and we should be dropping the objectives that we're willing to deem for everybody, and not call it deeming, call it simplification of meaningful use. Drop demographics, if we can drop it now, and don't come into two different things because as soon as you – what I'm saying is, if we were willing to just say the – of the Quality Measures Workgroup we'd set a slightly higher threshold, that's good enough, and then we'll take off some objectives. That's the most complex that I think we should go.

As soon as you start talking about taking a subset or outcomes oriented and then we're going to maybe allow for improvement and not just achievement for the people who are starting at the bottom. And then we're going to pick out which measures we're going to deem and we're going to start doing one-to-one mappings between the objectives that we – that do the deeming – I mean – I'm sorry, the measures that we're willing to use, the outcome measures and how they map exactly back to the objectives that we're willing to get rid of. We're creating a new Meaningful Use Program again. So either we do it en masse and are happy with it, and my sense of the group is no one is happy with that, we're not willing to give this up. Then what we should do is let the Quality Measures Workgroup decide what the quality measures are and we should get rid of objectives that we're willing to deem.

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

So –

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

It sounds like you're proposing essentially the “consolidation approach” and skipping the “deeming approach.”

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

Yeah, well, not – yeah, it's really – don't call it consolidation because it's not a matter of putting two together, it's actually a matter of dropping some.

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

Yeah, okay.

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

Like if we're worried – the group seems to be voting only on deeming things that we probably should be getting rid of anyway. Because everyone has a measure they think is so important that we can't deem it, that's how we ended up reducing the size of that set. If it's that unimportant that no one thinks we should do it, then maybe we should just get rid of it.

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

Well –

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

So, but you mean deeming the functional measure, but – so, sorry, I'm stuttering. Today, all you have to do is report quality measures, you don't have to perform –

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

Okay, so –

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

– so this would add a performance dimension, right?

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

We would add the performance –

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

No –

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

What would we be deeming then?

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

Yeah, yeah. No, no, you're right. You're right.

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

All right, so this –

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

We would have – I was saying that there would be a threshold on it.

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

Yeah, there would have –

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

Yes, I agree.

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

Right. So this is Mike, let me try and see if I can help again.

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

In the sense that – isn't that getting away from what the Meaningful Use Program is about? I mean, we have all these other places where we're held accountable for quality outcomes and it seems to me like all of a sudden we're like moving towards having meaningful use be like setting thresholds for quality. Like that doesn't – I thought – I don't know, that just seems to me like we're sort of getting away from things. The whole issue of whether systems perform at a quality level, it's being dealt with by ACOs, by the Joint Commission, for us by HRSA, I mean, we're all in systems somewhere where that stuff is being looked at. I just can't see that we're going to be in a position to really – to do that. It just seems like we're getting away from the functionality piece. I know we're trying to get to outcomes, but setting thresholds for outcomes, I don't know, it just seems – there seems like there's something wrong with that.

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

So Neil, I don't disagree. So my first vote was that we not do deeming, and just focus on the functional objectives and see if there are some more we can drop for everybody.

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

Right. The other simplification method to me, there's two other things I just wanted to throw on the table before we get too deep into the weeds. One is like, if you're participating in an HCO and you're putting – that in a sense is a framework now for sort of an overarching look at performance. And if you're participating in that, the idea of basically thinking about if you're providing data to an accountable care organization and that is something that CMS knows, because they have all the NPI numbers of everybody that's listed as participating with their Medicare population in an ACO. Then you are, by definition, already submitting those kinds of quality measures and you're already in a quality performance organizational model that really is kind of where we're all headed. So to me if we're going deem, I would deem that people who are in an ACO and the NPI numbers are listed and are participating in those kind of quality places, could be deemed out of a whole lot of stuff or forgiven from a whole lot of other things that we're doing. Because in a sense they're participating. So that's just one example.

And the other sort of just simplification idea is, I will bet that we could make a list of things that if you started doing them in Stage 1 and Stage 2, there's absolutely no way of going backwards on them. So for example, CPOE, right, I mean these are things like nobody that's done this that achieved Stage 1 and 2 are going to stop doing their order entry through the computer. And nobody that's been collecting data in certain elements where they've been – they've built those data elements into their system and they've been collecting data on 80% of their people are all of a sudden going to throw up their hands and say, oh great, now we don't have to do this anymore.

So I think that we should look through the list at – in those things and say, hey, if you've already accomplished this stuff, let's just drop those completely and without substituting them with anything. But just drop them because we believe that anybody that has systems that are doing that and that are already operating and doing that, don't need to continue to prove that they're still doing it. So those are just two other ideas about simplification.

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

So this is Mike. It feels like in some ways we're back to square one, but I mean, remembering that the whole deeming process, at least from my perspective, was to recognize the reality that people are along a continuum. For some measures everybody's doing it so well that we've decided to drop it. In other areas some people are doing better than the threshold, but they're not real high performers in that regard and that if you look at the quality measures they're reporting, they're not very strong and they're relatively low, but it doesn't matter, so they're not doing what it takes, leveraging health IT to get there.

So part of what at least the concept that ACP did when I was working with the Informatics Committee, was to say for people who are proving that in the functional measures in Stage 1 and 2, they used the EHR more or less exactly the way the program intended. And that at least for some of these measures they're doing well and that we could actually try to encourage them to pay less attention to the functional measures, even though we can't drop them for everyone. Because if we drop them for everyone, some people will revert and are barely at thresholds as it is, and really are delegating a lot of tasks, even in their ACOs, to other hidden factories of care in the Six Sigma terms to other people who are getting it done, but they're not really leveraging the HIT.

So the beauty of the quality measures is that they have to be directly reported from the EHR. If the functional measures for Stage 1 and Stage 2 tell us that the combination of the team of the eligible professional and the staff that work with them are getting the job done in way that we're comfortable with teams performing in. And that in Stage 3 all of a sudden it can really, really matter how you perform in the quality measures, which is the biggest conversation in the back room that says, why are we doing all this, the quality measures really don't matter anyway. This is just functional work that people are insisting that we do, that argument can largely go away, that we can – and I really like the simple deeming approach. And the notion that says, you get an A+ for how you've used the technology and functional 1 and 2, you've demonstrated you can do really well with the quality measures, but haven't had to do an awful lot of them yet and haven't had to apply them to a broader population.

And so if you were to ask me, if I were to take my team and go home I would say, we now have to do – we really have to show our outcomes for Stage 3 to get the incentive payments and avoid penalties. And we need to prove at least for some of these measures that we're not leaving out people for whom disparity sensitive, poorer performance matters. So I wouldn't necessarily tear out and focus hard on all the disparity areas, but I'd try to prove that you can take a measure that is sensitive to disparities and show that you're doing just as well with the patients at risk for at least one or more demonstrations of that. And if you choose to do so beyond that, so be it. But that to me would be a simple approach, leaving the measures in place for those who aren't deemed and deeming those who are doing well.

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

So Paul, that sounds pretty much like the approach we originally came up with, that now the quality group has. So, should we just wait and see what they come back with?

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

Well, having sat in some of these meetings, I think they're facing – we sort of delegated this challenging area to another group, but didn't remove the challenge. Okay, so they're facing the same thing. Let me build on the last two comments that Neil and Mike made, because I think it's moving us towards a direction. So one, it was a very – it was one of these "ah ha" moments in terms of Neil saying, you know, we've – CPOE's so precious and so we hang on to it, but there is no one who's going to turn it off. So that is a way to just get rid of something that been there, done that and there's no one going to turn it off, even though it's so precious.

So refocus maybe the word, and spend more of our energy in the thing that we always have believed is really the transformative part, such as clinical decision support. Could we do more with clinical decision support so that you can intervene on the stratified population that's important to you? So, in both ca – we're reducing the burden, reducing the complexity, shifting focus and resources on the things that are – kind of produce more value to the organization. That seems like a more productive path to take, as far as how we reorient Stage 3.

Let me add one more possible suggestion to consider, we're having so many questions on deeming, maybe what we should do is put that out – suggest that that be put into the NPRM so that we can get much more public thought about it. Because one, we might be missing an approach, two, the public may not like it either, after they consider the thing. So, in other words, if we just drop it from discussion right now that may leave us with an opportunity we don't take advantage of, for public comment. If we –

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

So Paul, it's Christine, I'll weigh in on the public comment thing. I think 60 days, and we don't have like an RFI going out, so I think in reality, if you want deeming to be part of this, then we've got to figure out enough detail to get comment on. Because if we just stop the conversation right now and say, here's this concept, we're going to get the same thing we've always had, which is conceptual agreement, no real sense of how to do it and 60 days in which the agency has to figure it out, not us. So I don't think that's a good approach. And then the only thing I'll say is, I led the work around consolidation and that's, I think, essentially what you're describing now. We did do a lot of that work, the challenge that we encountered was people would say, well no, no, no, we can't let go of that objective, because it's different, last time it was CPOE, but now this is CPOE with like more rules or more areas or whatever, and so we can't let that go.

And so I think you have to think more about, because we went through it, and that was hard work to get people to agree that we didn't need to keep asking people to do some of these. But I think we have to agree on how we would approach that, number one. And number two, leaving in certification around some of the new functionalities, so that people will at least have the option of using the EHR in expanded ways. But I think we did more consolidation than we recall.

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

I – you're – actually, you're absolutely right and I think that we did – we were not as aggressive as we collectively. I think you made suggestions that weren't adopted, but I think having gone through this process, we are probably more willing to say, look, by dropping it does not mean it's not important. That's sort of the hurdle, the cognitive hurdle we had before, so I think we have to be more strict with ourselves of saying, is it something that you continue to need to have people sustain the burden of reporting on and is it something that they will stop doing. So CPOE is not something they'll stop doing, why should we put them through the burden of reporting on it, that's sort of the different question asked.

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

So, this is George. And I'm fine with what Christine just said, it may be that we decide either not even to look or not to drop any more. I'm saying the push – the desire to do deeming should be turned in to more dropping rather than creating another program. Because when we created our candidate deeming program, it was always aimed at getting more out of the providers, not less. It was always aimed at, well if we can do this and this, and this extra thing, then we'll give up this small number of objectives over here. And I know that people have the option of not doing it, but we shouldn't be creating a parallel program that's even harder than the original.

So I think it's not going to work, deeming, the way we're structured, unless it's completely simple, and I don't think we can make – I don't think anyone will agree to the completely simple one, and Neil already brought up an argument against even the simple one. And therefore I think we should stick to the functional objectives.

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

And reduce them?

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

Well, reduce them or not. I mean, we may go through, as Christine said, we did try – we worked really hard on it, so we may be able to reduce more or we may not. I'm saying right now that the deeming is not working. And I guess I agree with –

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

Yes, I would agree.

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

– Christine, and putting it open to this public, it's not a bad – I don't mind putting it open to the public, it would be hard to come up with something really good in that time. But I just don't want to be sitting here picking quality measures, picking algorithms to decide whether you've met it and thinking, which subsets of objectives, and match those. That's where I think we're going to make a mess.

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

So this is Mike, let me just ask the question, what is our plans for having people actually improve the quality for Stage 3 Meaningful Use?

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

Well this is Neil, I don't think we're the quality police. I'm sorry, I don't think that's our goal, I don't think we're the quality police. I think we're trying to improve functionality of systems since from the discussions that we have that drive new requirements on the systems and new capabilities of the systems. I mean, from a policy point of view, we drive things that say, hey these should be – we need standards for these things and these should be in the requirements for electronic health record systems. That's one way that we've been improving quality, by giving people more functionality in systems. And that's a lot come out of our group. And I think we're demonstrating new functional requirements for people to be able to do things like exchange information and share information and do things like that. But I don't think we're the quality police. There are a million other places – not a million, but there are many other places and more emerging all the time, that are looking at systems and providers and other people to achieve quality outcomes, where they can't even be part of those systems without having the electronic health record that we've been sort of promoting and helping to stimulate the development of.

But I don't see the EHR Program, the Meaningful Use Program as being the quality police for healthcare. I just don't – I don't think that's the right objective for us and I think it's taking us into a completely weird realm. How are we going to look at quality measures and how are we going to determine whether somebody's taking – doing outreach programs and taking care of really poor people or taking care of a wealthy population of people that are all doing really, really well. Or – I mean there are so many aspects to quality that we're dealing with in our other venues that make even quality measurement, when that's the very specific objective of a program, difficult to evaluate. I just – I don't think – I mean we're going to set the bar low enough that a lot of people can achieve it, to me – I don't think that's our role. But I know that many – some people disagree with that, but I – I don't think that's our role, I think that's where we've really sort of gotten off track. We've gotten from looking at the quality of people using systems to now looking at the quality of care their delivering and to me that's kind of like a huge leap that's gotten us into a very confusing place.

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

So I'll just –

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

Neil brings up a good point. I hadn't thought of it this way, but if you want to do quality improvement, the whole point is follow through. So we would have to decide to be the ones not only to come up with oh, these measures will deem that, but then track how the public – not the public, how the industry is doing on those measures, modify those measures. There's a whole work that you have to do if you actually want to do quality improvement, it can't be just selecting a couple of quality measures and say, they deemed them. We then have to see the effect of our – like, do those – are those quality measures actually correlating with improved health for the public. That's something that the group that decides the quality measures needs to be measuring and paying attention to. There's a whole kind of industry that needs to occur if we're actually going to get in the quality improvement business. So I agree with Neil.

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

So this is Mike, I'll just take the contrary perspective and maybe try to use an analogy. So I don't think we're the quality police, but I think we are the front and center of a program who's ultimate goal is to improve quality. And using the – maybe the chef or culinary arts analogy, I see the functional measures as being the ingredients. I see the quality measure improvements as evidence that the recipe works, that it yields at least process outcomes that are felt to relate to actual patient outcomes and that I would have been very, very, very surprised going into the Meaningful Use Program to exit it not having any accountability for actually performing well against quality measures.

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

So I think your analogy is perfect, but wrong because basically what you're saying is, here's all the ingredients for the chili, now let's prove that everybody can cook the chili, so we've already cooked that. But what you're asking people to determine is so how does this chili compare to another chili, but one person likes it spicy, another person likes it with a lot of beans, somebody else lives in a place where beans aren't available and so they can't really put the beans in their chili. I mean, we're like into this whole thing where we're just – we're in a world that's so complex, of quality measurement. And the other thing is, remember, so far we only have Stage 3, so what's going to happen after that?

I think we focus on continuing to build these tools and driving the functionality that we think are related quality, and we have a lot of work to do just in that state, a lot of work to do. We've got things about – that we've talked about in terms of getting information out and getting reports back electronically and closing the loop on electronic communication, things that are very complex functions. And if we can drive those kinds of things, we know we're driving improved quality. And I think that that's what we should be focused on.

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

So I'll just take another position again here.

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

Okay.

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

I don't think we're talking about different flavors of chili, I think we're talking about whether people get fed or not. And we're not going to carry the analogy much further here, but –

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

Okay – we can drop it.

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

– but I think the bottom line is I live in a world where there are all sorts of capability to use an EMR in a way that impacts quality, the functionality is there, there's some evidence of use. To Paul's clinical decision support, the tools are sitting there, people dismiss them, people ignore them, but they're there, we get credit for it for meaningful use, but we haven't actually moved the needle necessarily on it. And when we sit with some of those folks and we talk to them about the difference between having a quality measure and them having to perform against it, they'll tell you it's a nice idea, but that that's not what the program is about, that's not what some of the other incentives are about.

And you're right, there will be other forces that affect that over time, but these are all habits and lessons and muscle memories that are built about how to use the system. And when we have people that see that they need to use the system in a certain way that's above and beyond current meaningful use if they actually want the quality measures to improve, they use it differently than they do today.

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

No but wait now, just listen to what was the discussion here. We're talking about deeming. So what you're saying is that we need to be careful that people use the stuff. What we're proposing here is not to help them use the stuff, we're just proposing deeming, which is an alternative. So if our main program is not forcing them to use it, adding an optional deeming program also won't force them to use it.

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

Sure it will.

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

What I'm saying is, people are using it –

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

Sure it will.

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

What's that?

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

Sure it will. My argument is, sure it will –

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

(Indiscernible)

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

In other words, if they don't have to add additional features and functionalities to focus on, another new set of things to learn. If they simply can say, here's the tool we've already trained you on, now we're focusing on using that tool to actually make all of these outcomes improve, then they do indeed turn their focus to that issue, they use the system that's in place better. So it's that issue of consolidating the tool and whether it's good enough to improve quality and actually making sure it improved quality by how it's being used and how it's being optimized –

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

No, but we're offering deeming as an optional program, you don't have to then – what I'm saying is, deeming is not the answer to your – what you're saying is we should be measuring quality, not of the deeming – that we should actually be measuring quality in the Quality Measures Workgroup and make sure that they get there. Doing deeming doesn't get us there, it gives an extra option, so they could either use it or not use it. They already have –

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

(Indiscernible)

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

So actually, I –

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

There's like no construct under which everything would be deemed, so they are going to still have to learn new features and functions and change workflows in certain areas. So I think it's – again, we get really stuck and we agree at the conceptual level, although not in the last 10 minutes, but we can't figure out how to operationalize it.

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

I'd like to build on – actually use Mike's concept, but build on what Neil is suggesting. I think Mike, you're – one of the things you – points you made is, we've got to give people time to use the tool effectively, rather than continue to learn new things and implement new things. And I think one of the things, to Neil's point is, if we have an effective tool actually people will use it and get benefit and do better at. I think a big thing we're missing, for example, is can I walk in and find out how am I doing with my patients today? The answer is no. And would I like to have that and would that meaningfully change my – what I do during that day or in that encounter? I think it would and that's not forcing me to do another check mark or something, it's basically give me the tools to give me relevant information so that I know how I'm doing and use my intrinsic reward system to want to do better.

That's one of the things I think we can contribute to this tool, that's to Neil's point. And to your point Mike is, and instead of spending my time complying with something else, I focus on things that are really important to me. And we had to do all that something else, you had to learn calculus and you had to learn physics before you can tackle the interesting problems. That's sort of the analogy to Stage 1 and Stage 2. In Stage 3 we really want to give them more and more potent tools to appeal to their everyday need to know how they're doing and do better. That's sort of a refocus and shift in giving me powerful tools, and I'm not talking about deeming and I'm not talking about being the quality police either. So it's really – it's more aligned with what Neil's saying, it's get powerful tools in front of people and they'll do better things.

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

You're not going to try banging a nail in with your hands or with the side of a pair of pliers if you have a hammer. We've got to get the right tools in people's hands, and I think that from our perspective, we've been a very powerful force in doing that, since Stage 1. That's what we've been really driving and driving it through the Standards Committee, driving it through the EHR functionality that people have to have put in place. But I think – remember what we're trying to do is accelerate a process that might be likely to happen anyway, but in a much longer period of time. And I think there are still a bunch of tools that we've been talking about as part of meaningful use that are – that we need to really focus on in this issue and if we accomplish that, we will have done a lot, especially the stuff related to exchange and sort of accountability for information going back and forth.

Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration

And this is Marty with HRSA. Especially – this is – what I've heard from a lot of the clinicians in rural and the Safety Net communities is, we want to make the patient's visit better, we'd rather know what the patient needs before they leave the office so we can change something. So if we're actually measuring something, let's measure it so it's a direct alert to say, these are some of the things that – these are measures that you need to do because we value those measures. So if they truly are quality measures, it shouldn't be reported on in a year or a month, it should be known before that patient leaves the office, to do that work. So anything we do to put in to the doctors or the clinicians toolbox would be really helpful.

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

Yeah, I think that's consistent with certainly some of Neil's comments as well.

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

So this is Mike. The only other thing I would say related to the earlier comment was, how much of this is standards and certifications? In other words, if you make the tools available they'll get used, assuming they're usable versus the here's what you must demonstrate that you're using for us to believe we're advancing here, and we're going to assume it relates to quality.

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

That is an interesting question. I think it's been our belief that it's – I mean, that's almost by statute that some of this is a try it, you'll like kind of thing. If people don't know – so right now people might be getting a report that says, here's your average A1c for your panel. What they don't have a clue that they might – they've never had the experience of, here's how your diabetes panel is stratified by SES or soc – or other disparity variables or even by weight or by some activation meas – I mean, there are lots of ways you can stratify to say, oh, let me – here's a problem area, what can I do to ameliorate that problem area? How can I intervene to – does it take more counseling on – or more programs, not even counseling, community based programs on weight loss. I mean, those are tools people don't even have a taste of, so they wouldn't even know they're available, and I think that's one of the things that we think may be very valuable. I think we've all gone through the experience of getting reports that stratify so you can identify problem areas and work on those, rather than just getting an overall grade.

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

So Mike and Paul, this is George. We know that – I mean we know it's our mission to put good tools in front of clinicians, so we're working on that and that's what we pretty much do in most of our meaningful use meetings is how to achieve that. We either do or don't want to start measuring quality, and that is either the Meaningful Use group or the Quality Measures group. Whatever we decide – and there are arguments on both sides, what Mike's saying, what Neil's saying, whatever the answers we should just be doing it as part of our main program. My point right now is that deeming is not the way to do that, not creating a parallel program, that either we're going to do this and push everyone there or we're not going to push everyone there, don't use a parallel program to do it.

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

Right, right. Let me try to bring this part of the discussion to a close so that we can move on to beginning our review and let's see what happens. So point one is, I think a lot of us, or almost all of us are saying, we need to reduce the burden and simplify the existing functional objective component of the program. Christine did a yeoman job putting together a draft, she couldn't get as far as perhaps she wanted because of some of our holding on. And as a result of this discussion, maybe as we go through our final review, we can decide that some of these things could be eliminated from Stage 3, not because they're not important, but because they're not – the benefit of reporting on them is less than the cost of reporting on them.

With regard to deeming, let me throw out one – two possibilities. One is, we say no deeming for Stage 3. The other possibility is we lay out the pros and the cons as we have learned about them, and pose certain questions that need to be addressed as planning either for Stage 3 or future. So really it's more asking for more information from the public so that even if it's not for Stage 3, that it could be implemented in future stages, or, there's some new information that comes up – new ways to deem that we didn't think of that could be brought in in the rulemaking process. So is it a close the door or is it seek more information, whether it's for Stage 3 or beyond? So question one is, should we – benefit – can somebody mute in the car. So, with the benefit of this conversation, as we go through our review of all the categories, can we keep an open mind as far as other functional objectives to eliminate – to drop from Stage 3 program? That's point one. Are people in agreement with that?

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

Paul, I think we can, but I think we have to – having done the work before or helped do the work –

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

Okay.

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

– I think we have to have a pretty tight set of criteria that we're going to look only through that lens because otherwise we are going to reopen every fight that we've ever had on every criteria. I mean, I really just don't want to talk about the same issues –

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

– over and over again. The goal has to be consolidation, and I think you can first look for some low hanging fruit. For example, if it was core in Stage 1 and it was core in Stage 2 and the performance was high, we should look very closely at that. If it was really high – the menu item in Stage 1 that was chosen a lot – by a lot of people and the performance was high, it became core in 2. But see the problem is we won't know about performance in 2, so I think you can, though, look at at least core, core, okay do we really need that, and that might be a starting point. And then the other thing you can do is look at the – I mean we had a set of criteria, and I could probably dig them up, around is this going to be essential for new models of care where man – that are going to cover many, many providers, that kind of a thing.

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

Right. Okay, so let's – I think Christine has both a valid point and good draft criteria to look. We're not going to look at any other thing but saying, look, if this has been high performance and core in Stages 1 and 2, let's strongly consider dropping it, just really dropping it from the burden point of view.

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

Yes.

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

So that's the visor we would take.

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

Yeah, and I'm not sure there are going to be that many of those, because we did this work once.

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

Okay.

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

And this is Mike, it's true that they're truly dropped or are they consolidated into another criteria, which basically means you still have to track them because if you don't meet them, you can't get credit for the consolidated criteria?

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

Well I think we're talking about truly dropping –

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

Okay.

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

– because you don't get removal of burden –

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

– just by sleight of hand.

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

Right. And the other criteria that we used was similar, but not the same. In other words, if you know that this program is going to have quality measures stratified by disparity variables, then that was how we consolidated the early basic demographics and also like the patient list functionality. We might not need to keep asking people to use that because we're going to have to use the function, doesn't mean you have to track it –

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

– but you're going have to use it in order to perform on that other objective.

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

Correct. Okay, are people okay with that, as we go through the final review?

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

Yes.

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

Yeah, but I think we've got to get the criteria kind of listed and in front of us, and it requires us to have Stage 1. So I'm sure as we go through the last – hopefully last round of finalizing the criteria, I think we need to know what was Stage 1 and what the performance rates were.

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

Yeah, hopefully ONC has that.

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

Yeah, we can do that. I would say – I will say though Christine, I think most of the work that was already done already got rid of a lot of the low hanging fruit.

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

Yup. I agree.

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

There may be a few more, but we can – I'll get the information.

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

Okay.

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

Paul, can I just ask a question. Was there any – I know we talked about this a long time ago. But was – is there any way for giving people credit for participation in other activities that require the same data and the same kinds of quality reporting, like, I remember talking about this, I just don't remember why we dropped it all, but other CMS things, PQRI, ACOs and everything.

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

Well you get that, you do get PQRI credit for participating in meaningful use, but you don't get it the other way, because you can –

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

That's what I was talking about though, thinking about the simplification in the other way, because that would just be huge. The ACO thing is – they're all over and people are participating in these and the level of data reporting and quality review and participating in collaborative quality improvement projects and all this stuff is really so deeply built into that process, I'm just wondering whether or not –

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

Then I think we're back to deeming.

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

– we should just take another look at some time. No, well I'm just saying I'm just wondering – yeah, it's just a totally different model than deeming, it's to say, if you're in one of these, we know you're doing this work. We know you can't be in an ACO without having all this reporting functionality, quality reporting functionality and stuff like that. So I'm just – I don't think – I don't want to sidetrack the agenda today, but I think it would be nice to have at least – just to take one more look at that, because it would be huge in the – out in the community, to be able to do it. And it would drive people into these activities, which actually have a lot more power to improve quality than the sort of things that we're asking people to do. So just maybe put that on a future agenda to think of – to talk about again for a few minutes.

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

We could at least compile that. So I believe PQRS is – deems you out of the CQM requirement for meaningful use. Do you know – is that true Michelle?

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

That's true.

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

I believe that's the direction it goes.

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

Right.

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

So yes, there's already movement in that ground and I think ACOs should be another one. I don't know whether that's true yet, or do you know Michelle?

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

It's not true yet.

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

Yeah, so –

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

Wait a second Paul, hold on, I want to – Michelle, I don't think you're right. If you participate in Meaningful Use eCQMs, you get deemed for PQRS, but it's not if you participate in PQRS –

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

Right.

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

– you get deemed for Meaningful Use.

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

Correct. Correct, yes.

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

That's what Paul asked. Okay.

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

Okay. So we can certainly compile that. All right, so, let me ask the second question then, this is on deeming. Are we closing the door on the deeming concept now because we can't figure out all of the details? Or do we want to share what we've learned so far and pose concrete questions to CMS such that they could either decide themselves whether they think it's too complicated, for example, or want to put out a query as part of their NPRM process?

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

I think Paul, I would probably do – you can ask them if that's going to be effective. I don't think it is, I think it's much too difficult to construct an entire second deeming pathway option out of a 60-day comment period, I just don't see it. But, we are – now I still would like to see the feedback from the Quality Measures Workgroup that is working on our questions and perhaps we can throw it out, obviously at the next Policy Committee and maybe somebody has a brilliant idea. I hate to close the door on it entirely because it's something that conceptually is interesting, but it's really fraught with problems and I think people have raised good points about the fact that meaningful se is not yet another quality measurement program.

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

So this is Neil. I'm actually standing outside the meeting of our state HIT group that I'm going to have to into the board meeting, so, I wish you all a happy holiday and I'll catch up with you on the next call. Thanks.

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

Thank you.

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

I was just going to say, the Quality Measures Workgroup has really had a lot of trouble with the deeming concept. On every call they need to go back to, what are the assumptions, where are we starting from and it's been very hard for them to think through and operationalize. So they put together a few exemplars, but at this point I don't think that they're pursuing it much further.

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

I mean Paul, I guess – I hate to say it, but I think if that group can't figure it out and we can't figure it out, it's not looking good.

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

So, do you want to drop the idea now or do you want to open it up and I understand it would still – I mean, the problems don't go away, but we put more heads to it. Well, so that – does –

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

This is Dave Bates. I would favor dropping it now.

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

Okay, other people?

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

Well this is Mike. Just trying to reflect back on my role in trying to represent 160,000 internists who came with a strong statement basically saying it would be nice to find a way to deem them out of functional measures and let them focus on quality. So I liked your idea of maybe even acknowledging we weren't able to come up with something, but asking in public comment what people think about that as a future stage or how they might envision it, even if it's not something for Stage 3.

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

Yeah, I think that's a good idea, I mean, particularly if we can think about how it might work for a future stage where we are going to see penalties coming into play though soon, so, we have to start simplifying anyway. So, it doesn't hurt to ask, I just think we can't count on it.

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

Right, and I would be okay with that, I’m just feeling like for this stage, we’ve spent a lot of time and we haven’t gotten there.

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

I agree.

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

Okay, what do you think about in – as part of our recommendations, if the committee agrees with it, the HIT Policy Committee, is we explain what we’ve discovered along the way and what we view as the challenges and where we would need new ideas from the public or from the agency, in order to keep a promising concept alive. Is that a way to move forward?

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

It would be for me, this is Mike.

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

I mean Paul, I would – I don’t think I’d put this in the recommendation. I think the goal will be if there’s another stage after 3, that the deeming pathway becomes the program, so we don’t have parallel programs. That we just figure out, we do move towards quality measurement, if that’s the decision, or whatever we do and that is the pathway and there’s one pathway and Stage 4 is a little different, and we do start dropping functional measures.

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

I just think the challenge with that is going to be, we still – regardless of what people have to do in the program, we still need to continue the certification process in order to evolve the functionality of EHRs, so we’re still going to have to have some –

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

– yeah, and I agree, we may still have some functional measures and we’ll still have certification, so I’m not saying drop the functional program, I’m saying, deeming was only going to get rid of some of it. Anyway, I do – so we don’t need to have the discussion, I didn’t mean to re-raise the – I’m fine with dropping it for Stage 3 and whatever we want to ask about Stage 4 is okay with me.

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

Great.

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

Okay. Okay, let’s move on the agenda. The EHRA feedback, does that involve objectives that are outside of Category 1?

W

Yes it does.

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

Okay, because I was thinking, could we move to Category 1 and – all right, well why don’t we go with the EHRA feedback. They really worked hard to give this to us in a timely way, so why don’t we move through that and see what they have to say about these – there’s something like four of these, right? Okay, so the first one has to do with medication adherence. Sasha, we’re you prepared to sort of just briefly go over the feedback from the EHRA?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Sure. So this is Sasha TerMaat, I'm the Chair of the EHRA Meaningful Use Workgroup. So thanks for the questions that you posed to us and the opportunity to give some additional information here. You had asked a few more questions on this one about the level of effort, because it hadn't been part of, I guess, the previous matrix that we had used for our first round of larger picture estimates. So we had identified what you're seeing here in the blue box that Michelle put together, some of the open questions about how we would estimate this, which include what standards would be taken and I guess exactly how the functionality that you're describing in the green boxes would work.

And then we put together, I think in a similar format to what you saw in our previous matrix of estimates, kind of the overall estimate which sums up smaller projects. Bullet projects of the large, small and medium projects that we estimated being part of this, and then a summary, which I think kind of lost some formatting in the translation on this slide. But we were trying to, I think, use – in response to your feedback Paul, some of the categorization of why our estimates would fall into the certain pieces. Whether it had to do with standards, workflow or utility concerns or sort of open questions about what was actually being supposed, which happened to be three categories that fell onto this particular objective. So we saw, I guess, a large project for external med fill history, a small project for identifying patients not taking a medication, unless that's identical to functionality that's already a part of patient lists, in which case we weren't sure why it was called out separately. And then medium projects around identifying two kinds of medications, because medication groupings can be more complex than just not taking a specific med. Are there questions about, I guess, the format of what we've put here or –

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

So when you say summary, not well under – the P not well understood and unclear standards, what does that refer to?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Sure, so the "P" is not actually part of it, I think I had put a, I don't know, a checkmark formatting that got lost when we –

W

Yeah, it's formatting, sorry. That's my fault.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

– ignore the "P." What I tried –

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

So not –

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

– okay, what I tried to do, and Paul, this is actually in response to some feedback that was passed along to me from Mickey McGlynn, I think from your conversation at AMIA. But, I had understood, and our workgroup had understood that the committee was very interested in kind of understanding whether there were certain categories of work – or categories of, I don't know, challenges that were particular to certain objectives that you're proposing, whether there was a challenge of the proposal not being very clear or well understood at this time. Whether there was standards work that was necessary for a proposal to become feasible, whether estimates were influenced by there being maybe workflow changes that were happening for providers, whether there would be kind of software usability implications, if there was kind of a new functional area that required a larger quantity of development.

And so what we tried to do was for each of the four questions you asked us is bucket of those kinds of different categories of why an estimate might be large or not, into that summary, we just put whatever labels were applicable to that particular measure.

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

So all three of these are true of this objective, not –

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Yup.

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

– well understood, unclear standards and okay. So the large comes in the external medication fill history because of –

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

I think a lot of that one relates to the unclear standards.

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

For medication fill history?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Are there particular standards that you wanted us to estimate? I guess we're not sure what's envisioned for the functionality that's in the green box.

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

So we currently already are able to import fill history, aren't we? I assume it's using the standards that Surescripts uses, for example.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

I guess that's our question Paul, is there a particular standard that's envisioned for this, in which case we could estimate specific to that standard. But without, I guess, having a clear sense of whether this would be similar to the medication reconciliation functionality that was part of 2014 certification or whether this is going to do something like the fills that Surescripts functionality provides, it's challenging for us to estimate accurately.

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

Okay, but it sounds like that's answerable, right? And answering that question would reduce the –

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

Paul? Paul, this is Marc and part of the confusion here I think might come from there are different functionalities available from Surescripts, there's a medication history functionality, there's the ePrescribing support. They started down the road but abandoned the medication dispensing support a couple of years ago and so if you ask the que – if you want to ask the question today, outside of an ePrescribing episode or outside of a – I want to do a med rec kind of functionality, they don't really support that today.

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

Okay.

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

Could, I mean, they could get there, but it's not something that you can just go do today. Maybe that's part of the difference here because except feeds for medication fill history for adherence, when you do that and those kinds of things, don't necessarily fit in the business models and I suspect that's why it gets complicated.

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

Okay. Anybody else have any additional information about that question? So is this something the HIT Standards Committee's also going to render an opinion on as far as the standards for various aspects of this problem?

W
Yes.

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

Okay. So this is really helpful Sasha. So, we'll hone in on this and see, because this was recommended as a certification criteria only and if there – there are things we can either clarify like, well what would the standard be and what functionality would have to be re-invoked that could reduce the level of effort, meaning reduce the uncertainty and lack of clarity.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

I agree Paul. I think especially if this is – if it's envisioned that some of the functions that are described, for example, identifying patients that are not taking a drug, patient lists in 2014 certification already has the ability to make a list of patients and has medications you want as the criterion. If that functionality already covers what you're envisioning, clarifying that that is the vision and that new functionality is not required would be helpful to us to reduce the estimate. I guess if something new is envisioned, then we're not maybe totally clear on what it is.

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

Is this under Category 3 or Category 1, Michelle?

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

We've moved it back and forth, but as of now it's in Category 1, but it was in 3 at one point.

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

Right. David, do you have anything to say about this in terms of keeping this versus making – and/or clarifying something that would reduce the level of effort?

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

I don't have strong feelings.

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

So maybe we could work on this offline just to try to – if we want to keep this, to try to reduce the burden that's – by improving the clarity.

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

Sounds good.

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

We can work with standards as well. Okay.

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

Paul, should we wait until we get feedback from the standards side?

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

Well, I just want to make sure they have this question in front of them so that they can even weigh in on that specific question.

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

Okay.

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

I guess that was my point.

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

Paul, this is Art, I have a question.

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

Um hmm.

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

So it says here, identify patients not taking medication. Does that mean patients who have not been prescribed the medicine, because how could you determine that if you don't have the external fill information?

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

I think it is asking external fill.

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

So then is it – are these – can you do the small one without doing the large one?

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

Uh no, but I think what Sasha's saying is, the act of making a list of people who are not taking all their meds is small. I mean, that's using existing functionality. Knowing that meds they're taking may be – is uncertain and that's why they marked it large. Did I say that right Sasha?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Yes. So we did also talk about whether the – what the list we're looking at, so that was also an open question for us.

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

So Sasha, when you were doing this, were you thinking that this is – they have a medicine on their list, like they're a diabetic, they should have an "ACE" or an "ARB" or something like that, and it's not on their med list or they haven't been taking their "ACE" or "ARB"?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

So we were not sure what to think, we talked about several different options. So one of our questions was could we use current functionality to accomplish this goal, which would probably be based on prescriptions and not actual dispense history, because as we've talked about, a lot of open questions about how the external fill history would happen. There are things that you can do with patient lists or with clinical decision support intervention with drug-drug interactions, and so forth, about the prescription. How applicable those are to adding external med fill history is part of what we'd have to figure out once we got more information about kind of how this happens. It wasn't – we had questions, is this envisioned to be something that you would work off of a list or is it more at the point of ordering you would see this information? Is it updating continuously? Is it updating at the point the patient comes in?

All of those are things that, I guess from our perspective, could very much change the scope of the project. And those are the types of things that when we talk about estimating and try to help you get a sense of is this smaller than a breadbox or bigger than a breadbox, that come up for us. And we try, I guess, to push through those types of questions to say, okay, well what kinds of estimates can we provide for context? But all those things do definitely change how we think about what we would program, how long it would take, how well it would integrate with other features that we already have and so forth.

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

So, let me try to take some of this offline, but what's clear to me is there's a lack of clarity of the intent, because I'm imagining this was not, David correct me if I'm wrong, it was if something has been ordered, is the patient – does the patient have a fill history that's consistent with them taking it as ordered?

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

That's – yeah, that's correct. I mean, and we do some of this stuff now already and don't get very interruptive with it, unless it's clear that, for example, it's on the medication list and it just looks from the fill history like they're not taking it.

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

So chances are there's additional clarity that could help the vendors understand it, but that's something we probably can take offline and I suppose use this feedback to say, well let's use some more words to try to flesh it out a bit. But my guess is from here, outside of this Surescripts abandoned functionality, a lot of it is a lack of clarity of what we intended.

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

I think that's right.

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

So we can help with that, the good news is, we can help with that.

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

This is Michelle. I will say, this actually had originally come from the IE Workgroup, so there's also some lack of clarity –

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

That's right. That's correct. Okay, well thank you that helps. And we have three different ways to deal with it, one of which is the Standards Committee if you can pose that question about the fill history that would be great. Do you want to go on to secure messaging and explain your overall estimate of jumbo?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Sure, so we had – your question had been to try to understand why the estimate was jumbo. So we have here listed out the sort of sum of the projects that all add up to the jumbo project. And the largest portion of it is attempting to track response timeframes including multiple modes of response. I guess the method of responding to a message in the conversation that the EHR developers had, not always recorded in a structured fashion that's available for tracking. And so kind of adding new methods to I guess record how you responded, what the outcome is, if you end up calling the patient multiple times so that you can track more of the timeframes that are part of that, seemed like functionality that had to be added, and that constitutes a large portion of the project.

Then we had some smaller parts of the project there, the patient indications of no response needed, the I guess actual tracking component of having multiple modes of responses and then the updated reporting that now started to account for showing the patient the information, knowing what their average response time, and so forth. We hadn't originally estimated showing the patient the information, which I saw came up in a revision that you folks put together, so we had also thought that that would potentially involve additional work, instead of having, I guess provider facing information, you'd also want to have patient facing information, so both of those would be pieces of it.

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

Okay. I can appreciate the part about the tracking is a problem. It's almost a matter of human sleuthing reading the messages and figuring out what really was responded to and what's related. So I – at least I understand that. Any other questions of Sasha in terms of the estimate for the level of effort?

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

Yeah, it's Christine. I think part of this came, or a large part of this came out of an understanding that we had based on some research that there were a couple of large systems that already did this, like Kaiser, for example. And I want to say Group Health maybe. Does it reduce the burden on you – on other vendors to have information from them about how their systems operate? Could that help in this case?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

So let me make sure I understand your question Christine. You're saying if some vendors have already added functionality that does that, could they educate other vendors on that functionality to –

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

Yeah.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

– help make the project smaller?

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

Yes.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Umm, I guess I have a couple of thoughts, I mean, one perspective is, as vendors, we are of course all competitors, so we have to be sensitive with the types of information we share with each other and be mindful of that. It doesn't rule out education, and we certainly do a lot of sharing, especially around things like standards implementation, but it is something to be mindful of. I guess the other piece is that those lessons are only helpful if you start from the same place, so if your fundamental tracking structures are different or your messaging structures are different and you have a certain format for messaging and the data stores in a particular way. And another vendor has a different format for messaging and the data stores in a different way, then one lesson learned might not be actually particularly valuable to another system.

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

Sure.

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

Well, let me ask the question then in a different way. So I don't know how commonplace this functionality is, but when you say it's like a jumbo, I would – is it safe to assume that you mean that's a jumbo workload for a vendor who doesn't have any of this functionality already built. But it's not going to be that hard for people who are – for vendors who are already offering this? Is that accurate?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

What we've tried to do, and in this particular case we didn't call it out, but generally in our estimates we tried to sort of give an average, which does, I guess, sort of blend together the fact that different vendors are in different starting places with regard to each functionality. I'll point out that actually having more functionality is sometimes not even a timesaver because if you already went down path A, B, C and then certification defines path B, C, D, which is very similar, but just not quite the A, B, C route that you did. Moving from A, B, C to B, C, D is not necessarily actually easier than going down B, C, D in the first place, if you hadn't done that area before.

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

Yeah.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

So, there can be, I think, to meet certification requirements, even if similar features exist sort of changing the features to exactly match what's required can still be a large project. In this particular case, there is a blend, some vendors have similar functions that they would either need to enhance or match to exactly how certification defines it. Some would have to do this completely from scratch, and are estimating sort of a fresh start on doing that type of tracking and feedback. And we've tried to combine the perspective of all those vendors together into admittedly a very short summary.

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

Okay. All right so Paul, I mean my reaction is, I'm not sure how useful it is, like I thought about dropping the large component but keeping the smalls, I don't think that makes sense here thought. I think that really what's important is measuring and reporting response times, and it's not to patients, you're not reporting them to patients, it's really the response times are reported to the clinicians, just to be clear about that. But, we had heard in multiple forums that that would be something that would be really helpful and make sure that secure messaging was really in use well. So I think that's actually the key function here, unfortunately.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Could we revise the bullet at least to clarify that you mean the response time – that the measure and report response time to patients – it's the time to the patient, but the reporting is to the provider?

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

Yes. Yeah, for sure.

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

Okay, thanks for that clarification. Let's move on so we can get through the EHR reports. The next one is summary of care and –

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

So our points are actually on the second page.

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

– yeah, so just go one more – advance the slide one more – yeah, thanks.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

And the question that was asked of us was, you had updated your proposal, so we updated our scope to I guess account for the changes that you had made. We had several questions, which you'll see in the first couple of bullet points there about again, standards, exactly what workflow is envisioned and kind of clarifying those details. The second feedback point is that as we talk about adding components to the CCDA, we're already as EHR developers, many of us receiving feedback that it's too long. So we want to be judicious about that. And then the estimate pieces we updated in response to the new things. Somehow we missed the individual estimates, but the first, adding consult result workflows was a large project. Narrative in CCDA was small and updated reporting was small.

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

Adding the consult request result we – okay, having the results come back –

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Yes, once you've sent a patient off for a consult, having the new workflow for I guess returning the consult to the sending provider using the potentially new standards for the format for that, those influenced a lot of our questions and that was the largest portion of the estimate.

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

Unfortunately, that's the biggest gain for us, that's the biggest benefit for us and it looks like a lot of your – the level of effort has to be defining the standards and the way – the standards associated with that transaction, correct?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

And the workflows.

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

Yes, the workfl – in some sense, I don't know that you – that we – someone could or that you would want someone to predetermine your workflow. I suppose that makes it easier for you guys to decide, but I don't know –

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

I would agree, Paul, I don't mean you deciding the workflow, but I mean, why is it a large project for us? We're going to have to think about our software –

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

Correct.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

– and where it fits into the workflow.

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

And that's probably a good thing.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

But it does take time, so that's why I –

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

It does take time, yeah, yeah. Other people's comments? So I think this is one of those areas of emphasis, if we were to put our finger on some of the things for Stage 3, care coordination and patient engagement are two of the high profile and high value ones. And clearly thank you for recognizing that the workflow is tantamount to making the information come back and be effective. But yes, that'll take work on everybody's part, but it's probably one of those things we haven't worked enough on and could be well worth the effort. But this is very helpful. Other questions about this? Okay, we're going to move on to notifications, and so that would be skipping two slides.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Sure, so this is the one on sending notifications to the care team. And the question that was directed at us was, if the I guess triggers of when the notifications would be sent were narrowed to just ED and admission triggers, would that make the scope of the project more manageable. And so our updated feedback, which is on the second half of the slide here, we talked about it again and we certainly agree that when confronting a new area, reducing the scope is a wise idea. That said, the triggers is really only one portion of the, I don't know, whole handful of bullet points there of development projects that we think would have to be addressed in order to implement this proposal. And so narrowing the scope, while we would support narrowing the scope, it does not reduce it from being overall a jumbo estimated project.

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

And you're saying that it involves a lot of processing power?

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

That was a comment that some vendors made in our discussion. They were concerned that doing the tracking of I guess all of the trigger points that would then send the message and the saving of all the data that would be sent, could have hardware implications, so we added that to our comments for your consideration.

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

Comments on this or – is this Category 1 or 3 Michelle? It may be 3.

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

This is 3.

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

Yeah, and unfortunately Charlene's not here. This is another one of these, it's all part of care coordination. Yes it's stuff that we don't have now, but out of sight, out of mind – I mean, we can't know what we don't know. I think there's some work that's been done in the field, David, I don't know whether you know about it, but, so I'm a little questioning whether this is truly that much of a processing power issue. I understand the concept that this triggers, but I think the triggers would be fairly well defined, so that shouldn't really cause a lot of processing.

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

Well what – Paul, this is George. What I'm hearing is that any new objective is a pretty big hurdle for all the vendors, they're all kind of jumbo, no matter what we think is small. And that what we need to do is prioritize them by the clinical importance and less on the workload. In other words, if they're all jumbo, they're all jumbo and we need to prioritize the things that we think are important to accomplish and not so much on how hard it is to do, since most of them are probably equally hard, they're equally jumbo.

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

Well, and I would just modify that to say, some of the – what they qualified as large is just the uncertainty, the vagueness, and some of those things could be reduced just by better define – either better clarity and/or anointing certain standards. And those are things that could be taken – those are actions that could be taken as policy actions that would reduce the overall level of effort and speed, presumably, of development.

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

Yeah, I think this one is important –

(Indiscernible)

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

– this is Dave. I think this one is important and I'm a little surprised, too that it's considered that hard. But I would still like to see it.

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

Yeah.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Are there components to our estimate, when we go through the bullets of what's necessary, in terms of we'd have to have the triggers, we'd have to send the notification in a particular standard format. You'd have to capture who to send notifications to, the privacy concerns with admittedly various policies in different states. Capturing consent and restrictions for sending, the tracking and auditing of what was sent, having a directory of recipients for who you send to and then reporting on it, are those – I mean –

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

Yeah.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

– are we not capturing with our assessment of what the project would involve what's intended?

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

Yeah. Um, it almost seems like there should be a workgroup that talks with these – so, if there are policy priorities, so care coordination's one of them, and there are EHR functions that can support better care coordination, but obviously the fact that we have this big problem is because they don't exist. Then there's – is there a forum where users and vendors can get together and answer some of these questions in the private sector? And yes, I presume every vendor has their user group, but is there a better forum where vendors and users together can help nail the search space, can help work out some of the better workflows, even though there's not one exact standard? Do you see what I'm saying?

Sasha TerMaat - Legislative Analyst - Epic Systems Corporation

I guess Paul, my thought is maybe slightly different, which is that I don't – certainly it can be helpful to try to narrow the scope of new projects that are priorities, that sort of helps them make easier to invest in. I guess in my mind there are two questions, right? Each individual thing that we invest in, the question is how much does it cost and how much does it gain us? Each, I guess, as a whole the question is, how many things can we invest in? I kind of agree with the earlier commenters that some of these new priority areas are adding net new workflows, new functionality, they're going to have high demand and they're going to be high cost.

It might still be the highest priority, not necessarily opposed to doing large projects for priority areas. I think the challenge is that if we pick three large projects for these key three priority areas that we've just talked about, we have to really be judicious about not picking 10 other small projects in other areas by making tweaks to other things that aren't deemed to be quite as critical. Because those other small changes, while small independently, take away from the effort that we can spend investing on these larger key areas. But, I think the question is not only can we reduce the estimates of some of the individual projects, some of the key things that the big things we always want to bite off, are probably always going to be jumbo. But the question is, how many jumbo things do we take on at any one point?

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

I think that was very well said, Sasha and it fits into our previous discussion today about the – how do we refocus our efforts? I mean, we have to think of this as just a collec – collective pool of resources and where do we want to spend our effort? I think this is a good stimulus to this discussion in the sense that we've always said care coordination is one of the things we really are sorely lacking and that HIT technology is one of the things that can really help us, but it doesn't exist, which is the point of this program.

So as we go through, and I'm talking to our group, as we go through the next phase, which is to review our comprehensive list of functional objectives, both keeping in mind what we talked about. Do we really need to keep the burden of reporting going, and two, don't we need to free up some resources so we can concentrate on things that have always been important to us. This is the kind of thing, summary of care, notifications, to some extent reconciliation, are things that we want to have better tools and we're – it's helpless without the support of the tools. So I think this has been a really good discussion, really appreciate EHRA putting together both the classification, but probably more importantly, what you did which is to drill down on what makes it hard or what involves the effort. And I think workgroup members have said, hey, we want – there are some things that are a lot of effort, not necessarily technically hard, but, are really important, they are well worth it. And we've got to judiciously pick those battles to fight and let go of some of the things that either tweaks that don't need or things that we don't need the people to continue to report on. Other comments from the group?

Well, thank you Sasha and thanks to the EHRA in helping give us this information, because I think it's very important and I think it does raise, and I think you stated well, the trade-offs that we all have to make, and we have to keep that whole – the total balance in view.

Sasha TerMaat – Legislative Analyst – Epic Systems Corporation

Well, you're welcome Paul and thank you for posing the questions to us and considering our input. We're very happy to participate.

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

Thanks. Um, so we only have 10 minutes. David, will you be able to join us next call?

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

Yes.

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

Okay. Great.

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

I think so, anyhow.

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

Paul, can I actually ask a question about the next call?

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

Yeah.

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

I'm getting concerned because I've received a number of emails of people that won't be able to attend because of the week of Thanksgiving. And I know we have a lot to do, but I'm worried that we won't have enough people on the call to have a robust discussion. So if I follow up with the group, I'm going to send an email to see who will be on the call and maybe we can decide if we should still keep it. We'll have to figure something else out, but –

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

Could you both poll who's going to be on, but also poll for alternatives?

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

Okay.

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

Because I'm afraid we're going to have to keep this pace.

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

Yes, I know.

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

So appreciate the discussion today, because I think in raising the question of “deeming,” we really talked a lot about the program itself, the goals of the program and how we achieve those goals, so that was very helpful. And I think part of our bottom line is, we have to preserve – the eye on the prize thing, we have to preserve the things that are most important, not that there’s not – there are many things that are very important, but the things that are going to make the biggest difference as a start. We don’t have to finish the whole deal, but if we can’t get notification, if we don’t know what’s happening to our patients, if we can’t share our summary of care, then things just don’t happen, we don’t have a chance of coordinating. But – so what are the critical few and I hope we have a different bias towards letting go some of the things that are now in place and will continue to be in place so that we can reduce the burden, simplify the program.

So I imagine what we’ll do is next time start going through Category – well, we have two more reports. We’ll have to relook at the agenda and see how to arrange it, do you want to take advantage of David being on the call so we can start going through Category 1. We may sequence it so that we then hear from the patient-generated data group and then go into Category 2, for example. But we’re going to go through – not to review the whole – resurrect the whole discussion for each and every objective again, but to go through with the view towards, what are the critical few and what can we let go. And then where there’s new input, we’ll take those into consideration, such as from the EHRA. Does that sounds like an approach that will – that makes sense? I think I’ll take that as a yes. Or, any better – other suggestions?

Okay, so that’s what we have on the agenda for next time. Any other comments or summaries people want to make, takeaways from today’s discussion before we open up for public comment? Okay, could we open it up for public comment please?

Public Comment

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

Operator, can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have one public comment.

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

Okay, go ahead please.

Ashley Griffin – Management Assistant – Altarum Institute

Oh, my apologies, they’ve decided not to comment. So we have no public comment at this time.

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

Okay, very good. Well thank you all for the vigorous discussion and hopefully we’ll take this into our next call and I do appreciate people participating on these calls, because we have a lot of work to do between now and our final recommendations in January and would love to have all your feedback and comments. So thank you all and talk to you next time.

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

Thanks Paul.

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

Please fill out the survey.

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

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

Thank you.

Public Comment Received During the Meeting

1. Getting Stage 3 will be hard enough. Having Deeming will likely make the process more complicated. Stakeholders have limited bandwidth.
2. Suggestion for "Deeming": 1) instead of optionally "dropping" functional MU measures, make them "implicit" for Stage 3, meaning "not necessary to report, but still subject to audit verification" , and 2) add well-defined minimum performance on certain CQMs as Menu measures for Stage 3, including any nationwide "stratification" requirements.
3. Comment on the PQRS / CQM deeming discussion: I believe the first person was correct that currently one can be "deemed" for MU via PQRS EHR reporting, not the other way around. This "deeming" is flawed for 2014 since PQRS requires full-year reporting, less feasible than the 2014 single-quarter phase-in for MU / CQMs.
4. Regarding Medication Adherence, there are two confounders which need to be addressed: Over the Counter Medications and Samples. The patient may be taking Over the Counter Medication and the patient may be obtaining Samples and the PBM (Pharmacy Benefits Manager) will not likely have these two sources (Over the Counter and Samples) in their database, and thus not on the PBM reports.