

# Health IT Joint Committee Collaboration

A Joint Policy and Standards Public Advisory Body on Health Information Technology  
to the National Coordinator for Health IT



## Joint Health IT Policy and Standards Committee Certified Technology Comparison Task Force Transcript January 8, 2015

### Presentation

#### Operator

All lines are now bridged.

#### Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you, good afternoon everyone this is Michelle Consolazio from the Office of the National Coordinator. This is a Joint meeting of the Health IT Policy and Health IT Standards Committee's Certified Technology Comparison Task Force. This is a public call and there will be time at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Christine Kennedy?

#### Christine Kennedy, RN, BSN, MA, CNOR – Nursing Informatics Coordinator - Lawrence and Memorial Hospital

Here.

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

Hi, Christine. Chris Tashjian?

#### Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics

Here.

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

Hi, Chris. David Schlossman?

#### Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics

Good morning.

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

Hi, David.

**David Schlossman, MD, PhD, FACP, MMI, CPHIMS – Missouri Cancer Associates**

Good morning, I'm here.

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

Oh, sorry that was Chris and hi, David.

**David Schlossman, MD, PhD, FACP, MMI, CPHIMS – Missouri Cancer Associates**

Hello.

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

Liz Johnson? Joe Wivoda?

**Joe Wivoda, MS, CHTS-IM – Chief Informatics Officer – National Rural Health Resource Center**

I'm here.

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

Hi, Joe. John Travis? Jorge Ferrer?

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Good morning.

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

Good morning or good afternoon here. Steven Stack?

**Steven J. Stack, MD – President – American Medical Association**

Here.

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

Hi, Steven.

**Steven J. Stack, MD – President – American Medical Association**

Hello.

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

And did we get Anita or Cris? And Dawn Heisey-Grove from ONC?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I'm here.

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

Hi, Dawn. Okay well thank you all for joining, I'm sure Anita and Cris will be joining momentarily they probably are caught up with something but I don't want to take up too...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No, Cris is...

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

Much more of your time.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Cris is here.

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

Yay, Cris is here, perfect.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Can you hear me?

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

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I'm sorry it took me forever to get through the phone triage but I was here for the last couple of minutes anyway.

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

Oh, okay, perfect. Well, we just did roll, you're here and now I'm going to turn it to you, sorry to throw things at you Cris.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No worries. Welcome everybody and thank you for sticking through the hearings yesterday and our follow-up materials on our survey. Again, thanks to Dawn and Michelle and everyone else who was responsible for putting the hearing together yesterday.

So, you've seen the materials that Dawn put together on very short order and I think pretty effectively. We have a little bit of a task ahead of us I think to try to put together the materials or put together a coherent set of recommendations based on a lot of great input yesterday. I think we're going to want, in just a minute, to start walking through the slides as presented by Dawn.

But I think before we go through those slides I'd want to open up and if Anita is here I would open up to her comments first, but if not, if anyone wants to provide any sort of, you know, opening brief comments based on what we heard yesterday? I'm going to take silence to assume that everyone is in a

contemplative and sober mood ready to dive into the discussion here in a few minutes, but, again, thanks to everybody for great questions and great engagement yesterday.

So, unless Anita is on the line and has comments I think we probably want to just turn this over as quickly as we can to Dawn to start to walk us through the slides that you all received. Does that work for everyone and Dawn are you on?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I am, yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, why don't we go to the slide materials the group presented and I don't know if you want to open up about how you want to get feedback as we walk through this Dawn. This is a compact set of slides, do you want to go through the whole thing and then go back for comment? Do you want to have comment as we go? Maybe if you can guide us with that this would be great. So, I'll turn it over to you.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Thanks, Cris. Everybody this is Dawn, good afternoon, good morning, depending on where you are. I think that the best strategy, Cris, is to kind of pause after each set of slides, obviously, not this first one, but going through because I think there are some open questions on each to help us guide and create those recommendations that we need to do. So...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That sounds...

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Part of the...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That sounds...that sounds great and actually I think what we...excuse me for interrupting...

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

That's okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think if you want to do it that way going slide by slide that's great. I also want to make sure that by...that we leave some time at the end to identify some overarching kind of themes or structure, or significant, you know, recommendations that relate to the whole in addition to each of the potential topics.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I think that's a very, very good point and very important to do. So, yes, because I also don't think that the slide deck encompasses everything that folks want to cover. So, while we're going through it also think about what is missing here and what still needs to be discussed.

So, this first slide here is slide three and in orange is just a reminder of where we're supposed to be building our recommendations on the benefits of and resources needed to develop and maintain a certified health IT comparison tool. And then the other, the sub-bullet points under that, are things that we've highlighted in the past but I didn't feel for this particular slide need to be called out immediately. Next slide.

So, in general, I think what I've heard from this group and from the speakers yesterday is that there is a general consensus that some sort of comparison tool is needed or that the existing comparison tools may need to have more information available through them.

Comparison tools...it's considered that they would be available or would be useful for providers who are making their first health IT purchase and we saw, way back in the beginning, that a good number of physicians haven't adopted, depending on the demographics of those physicians, and then we know that there are other providers out there, as we heard yesterday, that have much lower adoption rates. So, there is still a good population of providers who are out there considering what type of health IT to buy for their first time out.

And then with the modularity that's been introduced with 2014 and 2015 CEHRT there may be providers who are looking to add onto their existing health IT and this would be a tool for them.

And then finally, what we heard yesterday, which I thought was pretty interesting, is that it could be used as a part of an ongoing health IT or IT strategy tool so that the IT department in larger practices may be using it to consider what purchases to make in the next 3-5 years for example. I'm going to pause here and see if there's any thought, agreement, consensus or things we need to add?

**David Schlossman, MD, PhD, FACP, MMI, CPHIMS – Missouri Cancer Associates**

Hi, this is David, I think we want to...I'd like to pause for a moment and talk about something we didn't hear yesterday which is Dr. Doug Ashinsky's written testimony where he points out quite correctly that the tools effectiveness is going to be limited by the unusual characteristics of the health IT marketplace because it's not really a free market. It's very expensive and incurs a large regulatory burden to try to change health IT products and this limits consumer's abilities to change to new software developers and it's had the effect of slowing down innovation and improvement in the health IT sector and the same forces are going to have an impact on the tools ability to drive a business case for software developers to accelerate desperately needed innovation and improvement.

So, as Dr. Stack said, at the first meeting, I think one important goal or outcome that most practitioners would like to see associated with this kind of tool and this kind of a process is to drive innovation and improvement in software IT in general and IT software in general and I think, as Dr. Stack said right at the first meeting, I'd like to see if there is some way we could work that concept into one of the benefits for a comparison tool.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I think that's a fantastic point and I'm making a note of it now. Anyone else?

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

No, otherwise it looks very good to me. It's a good approach.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay, great.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Dawn? Dawn I have a comment. On your first bullet, this is Jorge here, making first purchase of health IT products and not just faced with Dr. Schlossman's comment, but I think its first purchase and new purchase of health IT products. There are instances where a lot of clinicians are hospital-based clinicians that will never have any decision making in the tool that's put in front of them to use.

So, there are many instances where they do have the capacity to choice for a multitude of reasons. So, I think it's not just the first purchase of individuals who are looking for the product but also there will be purchasers of products that are not meeting their clinical needs.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay, great, so I'll make sure that's incorporated as well. Any other comments on this one? All right, next slide.

So, then one of the sub-bullet points in the Task Force charge is to identify different health IT needs for providers across the adoption and implementation spectrum and we heard from a lot of those folks yesterday and I think we all pretty clearly heard that the health IT purchasing needs vary dramatically depending on if they're a small practice provider, a large practice provider or part of a hospital system, or not a physician, or there is some other type of provider and so I think what we clearly heard was that any tool should allow the health IT products that you're comparing to be filterable so that you can sort if by some of the demographics that you as the provider are...that you meet.

And one of the things that I heard yesterday, clearly, was that if you just have one category that's not going to be really helpful because you can't select, you know, psychiatry and small practice for example but that might be very different than a psychiatrist in a large practice. So, is there anything else that we need to highlight for this particular bullet that we have not or you want to add or have questions?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

This is Cris, I think to the earlier comment about the competitiveness of the market and so on I think if in fact we have some ability to provide different views by different user types it will help with that visibility and agenda because, you know, how many certified products...how many EHR products did ONC receive as certified, I think the number was in excess of 500.

So, you'd have to argue sort of...at least in some segments market there is a high degree of competitiveness, you know, 500 vendors is a pretty remarkable number, but other segments like large hospitals the number of viable vendors is much smaller.

So, if that's an inadvertent or if that's an ancillary effect of this comparison tool is to lay out what the demographics or what the characteristics of the market are that might be an additional advantage.

**Steven J. Stack, MD – President – American Medical Association**

So, Cris?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah?

**Steven J. Stack, MD – President – American Medical Association**

This is Steve Stack, to that point I really want to punctuate that and underline it. So, I'll try to use examples in the real world. So, if you look at Amazon on the left-hand side there's a whole series of filters that can be checked for any number of things. I think that if we don't have that functionality for this tool I think it's utility is markedly diminished and so I don't code things, I don't write software, I don't even write, you know, diagrams to help coders in this so I don't know how all this is done but I would say that as a first cut even if the vendor...if we come up with criteria, so you say inpatient, outpatient, specialty, primary care, you can say modular, you know, complete EHR, there's a whole slew of things, you know, practice size less than, greater than, a range.

There should be a certain number of domains we could come up with that we ask vendors, who are going to be...have products in this tool to self-identify which boxes are your target audience and then...and they're going to not want to put down people that are clearly outside their target audience in general because they're not likely to succeed and they don't want to service them.

So, let them self-identify and then at least someone who wants to come to the tool should be able, on first cut, to take what could be thousands of different projects or products as we go forward with more and more modularity we hope and APIs that help a robust marketplace develop, we hope for that, and then go through and check and take this universe of whatever a couple of thousand or a few thousands things there could potentially be and winnow it down to something more usable and they can keep filtering down to the level or the precision they feel they can go to get to a narrower field and then they can do deeper dives on the rest of the content we'll discuss but I think that functionality is really important.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Steven J. Stack, MD – President – American Medical Association**

And I think it's something that if we come up with the descriptors the self-reporting by vendors should be a reasonable first cut at that.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, Steve, I think that point is excellent. I guess the one question or without taking away anything from what you just said, you were presenting that as if we're designing this product and that's I think a useful kind of framework to think about it.

I believe one of the big questions we're needing to address, by the time we get to the end of this conversation and next week, is what is our recommendation? Should ONC develop something? Should ONC create specifications that are desirable? Should there be some sort of effort to incent people to create the kinds of tools we're talking about?

So, I think it's really fair to keep in mind what would the tool look like if we could design the perfect tool but then we'll have to step away from that at the end to make a decision about what recommendations do we want to make about who should actually do this?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

And can I jump in this is Dawn?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Why...

**Steven J. Stack, MD – President – American Medical Association**

Yeah.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Oh, yeah, I completely agree with everything that both of you have just said. I would add that regardless of who you think should be creating the tool we need to figure out how this data would be collected. So, the idea of the vendor...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Agreed.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Reporting the data that's...I think that's a great suggestion. How would they do that? Would they do that through some certification process? Would there be a third-party that they reported to? Some of the things I think that, in addition to coming up with that list, we might want to think through.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right, plus we...

**Steven J. Stack, MD – President – American Medical Association**

Also...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Think about...

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

So, this is...

**Steven J. Stack, MD – President – American Medical Association**

Go?

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

This is Chris Tashjian, I had one other thing I wanted to comment on that as I was thinking about this I agree with that and that's a good starting point but what really this made me think of was the App Store, you know, the App Store has the vendor tell what this does and give their viewpoint but then there are comments but the comments are metered or, you know, they're not just people can't just write them. They go through a process of being vetted to make sure they're legitimate. To me that seems like a good framework.

**Steven J. Stack, MD – President – American Medical Association**

Well and Cris said...

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

So you need both the vendor and the consumer's view.

**Steven J. Stack, MD – President – American Medical Association**

Right, so this is Steve Stack to that point again I'm breaking this...I'm not giving a whole vision for the whole thing I'm just responding to the specific pieces but this would be like a first cut and then, you know, in other layers or other functionalities of the tool I absolutely agree there is a need for a functionality for individual purchasers and end users to offer input and there is a need to offer the opportunity for potential, I say pseudo just because I don't think we want to be in the process of certifying reviewers but I think so pseudo-experts who might offer input in the context of or the category of like a critic or a reviewer, or an outside third-party.

And so I think the best other functionality, I'm just talking about now this concept of being able to filter based on certain demographic criteria for the tool itself.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Steve I...this is Jorge, I have a question for you based on the two comments you just made. Dr. Waldren also commented on some public commentary and I was reading his comments last night, features versus capabilities that the vendor can write 1000 features and check 1000 boxes but clinically in the capability if I were to ask the vendor, does your electronic health record permit me to capture the clinical reasoning required for the clinical nuances that I need to capture for in providers notes I'm not sure a lot of people would be able to check that little box off yet that's one of the desired attributes of an EHR.

So, I think it's important for us to make the distinction between the capability to complete a clinically-driven task versus the functionality that is often times sort of the IT laundry list or smorgasbord of things that the EHR does and when you truly look at that from the EHR's perspective a lot of the end users don't even maximize or utilize a lot of those functions for many, many, you know, sort of user design principles, design issues. So, the distinction between the capability and functionality is something that I think we need to address.

**Steven J. Stack, MD – President – American Medical Association**

Jorge, I would agree with you and I think that you give a good example of a level of detail that I would not want as a filtering thing I don't think, at least not at an early stage recommendation for a, you know, an inaugural attempt at this kind of product.

I would say...I would describe it more as the initial filtering is target audiences, for whom is this product intended and people can then try to use their target audience where they fit to niche it and then those

kind of other details I think that functionality capability that would have to fall into the next tier of the process which would be at the much more detailed reviews and commentary, but that would be a different...that would be the next step it wouldn't be the first step at least in my current view of the thinking.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, this is Cris, I would suggest in the interest of doing this given our earlier comments it might be useful as we sort of keep track as we go. I want to make a suggestion that at a minimum we keep track of the kinds of data that we would suggest that ONC might directly or indirectly collect about certified products that would help enable this capability.

So, I'm thinking about CHPL as a potential raw resource for this. What we've just identified for example is the data to be collected should be the vendors view about what market, you know, what market are they suitable for, what features do they have those kinds of things.

And then regardless of what the actual solution outcome is at least we will have the possibility of a data source to populate this tool.

**David Schlossman, MD, PhD, FACP, MMI, CPHIMS – Missouri Cancer Associates**

Right, this is David, I'd also like to plus one on Jorge and actually I think his comments about capabilities rather than functionalities applies to the gaps in existing comparison tools because none of those really, that I've read, talk to the capabilities.

Practitioners want to know, you know, what health IT products will make it easier to manage chronic disease and population health, what product will actually give me clinical decision support in a non-disruptive form that I can integrate in workflow, what product will really help me improve care quality and outcomes rather than just divert my attention from patient and add two hours to the time it takes to accomplish the same old work.

So, I think that's a big gap in existing tools when we come to that slide and if there's any way we could incorporate that idea into our vision for the tool that would be really good.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

So, this is Liz Johnson, Cris in all of the...I think all of the depth that's being added to how we might go about it is going to be critical in terms of capture but I like your concept that we would capture the kinds of data elements we need and then as a secondary project then would, as much as the last three commenters, I don't recall your name, got into, you know, the difference between functionality and capability and how could we capture that data in a meaningful way? Today we'd want to just capture, we need that data included.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thanks, Liz, I think you get the gist of what I was trying to get to that we'll have other subsequent decisions.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay, any other comments on this slide before we move on?

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Hi, Dawn it's Anita Somplasky, just one question when you're talking about practice size, location, specialty when I think...I don't know if it falls under type or location but I think we need to be really sensitive to community health centers, public health departments, rural health centers, FQHCs they have very different needs, I wouldn't call it a different specialty, and the practice sizes and the part is meeting a lot of the reporting requirements for them that has been such an epic fail for so many of them right now.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

So, I don't know, you know, if under location we make sure or if you consider that specialty or provider type it's kind of hard because it's all provider types that are in there and it's not necessarily location because it can be very, you know, an FQHC can be urban or rural.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Got it. I think I can review the categories on that and come up with something you guys can iterate on for the next slide deck. Thank you. Any other comments before we move on? All right, next slide.

So, based on what we've heard I think these five bullets capture what I'm getting are the current gaps in the marketplace, the first one is that they don't completely meet the needs of small practice providers or specialists, or any of the other types of groups that we've talked about specifically because a lot of them don't have that filtering capability that we've talked about.

The second point is that the comprehensive cost, how we define comprehensive is still an open question and that's for a later slide. For this slide I think the discussion should just be about is this the comprehensive list of gaps but a good sense of cost whether that's base cost, everything else, just the barrier is cost is not transparent.

The third barrier or gap that I see is usability information is not available for comparison and this can be peer-to-peer, it could be third-party. I think a lot of what you were just talking about in the last slide touches upon this piece right here.

Then the next piece is that a lot of what we've talked about is people want to see not only information about certified technology but technology that may not currently be certified or may never be certified. So, there needs to be a merging in whatever tools are there that have that information so providers may not have...who don't want to have to go to five different locations to compare their health IT don't have to.

And then what we've heard is that although some areas such as population health or alternative payment models may be very important to be able to compare upon, compare health IT products on in the near future there may not be enough information to do that and I think somebody said earlier today like a beta model, the first round of model tool that goes out but this is definitely something that should be considered for the future. So, I will pause here and again I think limit the conversation to, is this the extensive list of gaps, are there ones that we've missed because we'll be diving into these a little bit further in some of the later slides.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Dawn, this is Jorge, on your third bullet you list usability workflow and safety information you actually have two attributes here but usability has, and it's very well documented, it's more than just these two things that you just listed here.

And so we should, at a minimum, at least include sort of what are the attributes that were voiced at the hearing with regards to usability, easy to learn for example the learnability, efficient to use, their performance, effective to use to completion, they prevent errors and that category those are the things that normally are attributes of usability not just these two items that you listed here.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay, so we need a better definition of usability that includes some of the things that you just cited.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Correct and then...

**Christine Kennedy, RN, BSN, MA, CNOR – Nursing Informatics Coordinator – Lawrence and Memorial Hospital**

Hi, this is Chris...this is Chris Kennedy, I agree with that because I was thinking the same thing about this slide when we talk about usability. When we listened to the folks yesterday many of them talked about the lack of support that they have, the lack of IT analysts, that they're just trying to, you know, keep it together in their office on their own and I think usability is a part of support in who is running that system in their offices is part of that usability.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, this is Cris, to Christine's point, that was Christine speaking correct?

**Christine Kennedy, RN, BSN, MA, CNOR – Nursing Informatics Coordinator – Lawrence and Memorial Hospital**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Sorry about that, so to that point I think we also heard that this needs to be consumable by someone with limited IT support.

**Christine Kennedy, RN, BSN, MA, CNOR – Nursing Informatics Coordinator – Lawrence and Memorial Hospital**

Right, absolutely.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And so I don't know if that fits in here or someplace else, but I think we heard pretty loud and clear that there are a number of practices that are really feeling like they don't have the expertise to do a good job with what they have today.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Cris, just to clarify, this is Dawn again, when you say it has to be consumable by someone are you talking about the comparison tool or the health IT product or both?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Sorry, I was meaning the tool.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That the ability to go to a...I think implicit in the comments was that the tools that are available today things like KLAS or CHPL, or so on probably don't meet the needs of a practice that doesn't have significant IT support and I think we would take that additional point and say going forward, this needs to be something that's probably, you know, management readable and technical readable but this can't be...

**Christine Kennedy, RN, BSN, MA, CNOR – Nursing Informatics Coordinator – Lawrence and Memorial Hospital**

Right it's almost...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Aimed at a...go ahead?

**Christine Kennedy, RN, BSN, MA, CNOR – Nursing Informatics Coordinator – Lawrence and Memorial Hospital**

It's almost like the practices need an advocate like to help with some of that, how to maneuver some of the tools if they...I mean, the tool has to be at that level.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

And this is Anita that was one of the big problems with the current CHPL site when folks were being, you know, these small practices they just...they couldn't figure it out and that was where the regional extension centers were able to really help them navigate that but most of those are gone now and, you know, these practices don't have the money to pay a consultant to come help them.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, I think about, you know, Liz is from a big group, I'm from a big group, Jorge is from a big group, frankly, you know, we don't have any...it's a challenge but we have plenty of resources to help us figure out what our options are.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Right.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And I would not build this tool for us. I would build this for, you know, the vast majority of people who have much more significant struggles than we would have.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, I agree with that completely, this is Liz, and I would also say when we get to some of those end user acceptance supportive of the tool we ought to be asking the kind of people that Cris just described not us because that's not the people we're trying to serve.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Yeah, that's one of the reasons why when you talk about usability one of the key components that is very often times left out is the subjective impression, are they satisfying to use that's a very important attribute of a tool clinically speaking that almost never ever gets captured. People complain a lot about it but nobody ever tells them, you know, why are they complaining or they captured their complaint in earnest.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay, so for this slide, just to recap I think I've heard that we need to add an additional gap that is the current tools are not geared towards individuals with less access to technical support and we need to provide a better definition for usability. Is there anything else?

**Joe Wivoda, MS, CHTS-IM – Chief Informatics Officer – National Rural Health Resource Center**

This is Joe...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And to summarize...

**Joe Wivoda, MS, CHTS-IM – Chief Informatics Officer – National Rural Health Resource Center**

Oh, this is Joe Wivoda, I heard loud and clear yesterday a lot of discussion around, I don't know what you want to call it, if you want to call it peer review or end user feedback kind of, you know, reviews, you know, and I know we talked a little bit about that but I heard that a lot yesterday and I wonder if that's a gap too that we should add.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

So, I...that's a very good point Joe and again this is Dawn, but I have actually put that in the resources as a way to solve some of these gaps so you're ahead of the game there.

**Joe Wivoda, MS, CHTS-IM – Chief Informatics Officer – National Rural Health Resource Center**  
Okay.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**  
And I heard somebody else had chimed in?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think that was me, Cris, talking over Joe, but yeah, I'm looking forward to getting to slide nine where you get into that.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

All right so we're ready to move to slide seven please. All right, so this is cost, we've talked about it a little bit already but...and a lot previously in previous meetings, but essentially what we heard yesterday and we've heard from the Task Force is that there is basically a lack of transparency some of that may be due to guide clauses, we talked about that a little bit yesterday it's unclear if that's real or I think somebody said an urban myth but it seems like at least the rumor of it is there.

This seems to be more important for features that providers feel that should just be baked into the products and I listed some of those there but then the open question, and I think we keep stumbling on here, is how should the cost be provided what's included in CHPL with the new certification I believe is a base cost but I've gotten the sense, in listening to you all, that this may not be sufficient and if it isn't the base cost what kind of things should be included in this and how might it be presented? I'm going to pause here.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

This is Anita, we tried, when we were helping all the practices, we asked for a five year cost of use and we are now at the five year point and those numbers were absolutely bogus from the vendors. And what we've been told by the vendors is they couldn't have anticipated all of the changes that were coming and that's why there is such a wide variance.

One year is absolutely not enough if we're going to consider total cost of use, three might be better and that would certainly get us to Stage 3 and force folks to think about it, but the base costs that are there are way off of what that total cost is and there is huge sticker shock but as I said, you know, the five year total cost has been...the estimates that were provided are well under what has actually been spent.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay. So, given that do you have a solution or a suggestion on what should...

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Well that's...I'm saying, if we're going to look at total cost of use it needs to be asking for at least the three year with Stage 3 in mind and including things like what's going to have to happen or an estimated cost of upgrades which was not included, you know, five years ago when we were in Stage 1 and for some of the changes that had to happen for Stage 2 which were very costly for practices.

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

This is Chris Tashjian, I would completely agree with that and then if there is any way we can get again...and going back to the customer experience, if we can have actual customers at least give us...and if you could standardize it or normalize it by cost per doctor or something like that in different sized groups but something that we could look at real world, you know, not estimates but what actually happened.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay. So, what we might need here is peer-to-peer as well as some information from the vendors themselves.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

This is Cris, I would like to offer up to the group just your input on the idea, I know I've been a little bit of a cranky pants on this issues before, that if you look like at a model like say PracticeFusion that is a peer software to service subscription model on a per seat basis, you know, you get to a point where products like that are pretty comparable across products for a practice that's relatively homogeneous or relatively small.

If you start looking at an integrated EHR for a large hospital system it's just a totally different class of purchase. It's like the difference in buying, you know, Microsoft Office versus some big ERP system and it feels to me as though we got into a lot of conversation on one size does not fit all and I think that's really true here.

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

I agree.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I'm a fan of trying to get to cost transparency, I'd just like to get feedback from the group, it feels to me as though we ought to have different kind of cost reporting methods for different classes of certified health information technology products and I'd like to hear if I'm alone on that or what you all here...I think I heard Chris chime up, chime in.

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

Yeah, I said "I agree with that." But the thing that I was...the way that I would sort it out is maybe by size of group because as you see by size of group it depends...it will really change what "a" they can afford to buy and "b" I think it gives you a more apples to apples comparison is when you're looking for it, you know, if you're a group that doesn't have an EHR.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, I think that's fair. Yes, good point. Do other people have an opinion about how we should think about cost based on size or type, or any other characteristic?

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, Cris, this is Liz, I agree with your approach. It's not...we're not going to get to a place where one, you know, shoe fits all, we're going to have to do some differentiation there. So, when we get into,

again, sort of the delineation around what kinds of facts we include we should have a categorization as part of that which would meet that need.

**Joe Wivoda, MS, CHTS-IM – Chief Informatics Officer – National Rural Health Resource Center**

And this is Joe again, if I could say something perhaps a little controversial. I really agree with you I think that there is a differentiation that we have to make for rural providers, for, you know, the cost structure for a cloud-based provider as opposed to one that's on site is going to be very different.

To me it feels like each vendor has to have a statement of cost that, you know, they choose on how to discuss that. I don't know how we really split that up but I agree that there is no...I don't think there's a real consistent way we could do it.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

So, what I'm hearing is...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So...

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

There might...this is Dawn, sorry, I just...go ahead whoever is talking.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No, Dawn, please go ahead, it was Cris.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I was just going to mention it sounds like. I think that you guys are reaching a point of agreement here. I mean, there's a general sense that the cost would be nice and if you already have folks filtering before they even get into cost or get into cost as a comparison metric, right, then you've already filtered by some of those demographics, the practice size and all of that.

If the providers...if the vendor is providing that basic demographic information and then they're providing some other costs, if we say, for this type of market provide your cost or cost range whatever you guys decide then we could also figure out if the products are cloud versus server based which I think is a very good point in terms of how the costs are calculated.

You could...you already know whether they're going to be rural, urban, small, large practices based on what the criteria that the vendors put in so you're kind of building on some of the other information that you received.

So, I think you could definitely build in a pricing structure that is based on some of these characteristics because essentially we're already asking them to provide that information for this.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, this is Cris again, yeah, so, I think you're going the same place I am. Given the earlier comment we had about what data we need here. It feels to me as though one thing we might talk about would be can

the vendor provide kind of a per seat per month or per seat per year kind of pricing as a potentially optional, not optional a field that they, you know...the data they would provide if that's the market they're in. I don't know if John Travis is on the line but my guess is he would say for some customers they would willingly offer a per seat per year license that's more or less a rack rate but for other purchasers there's no way they're going to offer that and if it's missing from the tool it's missing from the tool.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But I think, you know, that's the choice a vendor can make and if they don't appear to a small rural independent practice, small practice customer as having a price, you know, it's going to be a problem for them but a...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Cris?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Hospital is not going to expect to see that.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Hey, Cris, this is John and I joined late, but that's kind of my queue. I think you're on the right track that when we look at smaller, lower end markets, I mean...we have a group that we call community works which is mainly critical access and sole community provider kind of market segment for hospitals and then we have our hosted ambulatory solution that's where we get into far more bundled subscription models of licensing where, you know, it may be we certainly have to add or change the definition of what's in that bundle over time but it is predominately a subscription model of I want to try to really try to keep total cost of ownership reasonable for the market segment and it's everything bundled that I can reasonably put in a bundle that they're paying me a subscription for and not paying me a la carte or things like that.

And I really try to work over time to maintain as, you know, consistent a price point, I won't say fixed, but a consistent price point over time as I can and they don't feel any extra out of band cost structure that's not part of their subscription as much as possible that's definitely the motivation there.

When you're dealing with a higher end market segment that has...that may buy a core level of capability but then exercise discretion because...whether it's because they have make or buy ability given what they may have in their own development shop or they have the opportunity of choice for a third-party and they really are not...they're influenced also by a lot of buying behaviors within their own organization that may recognize autonomy of purchase decision or at least the technical coach for a buying decision, you know, could be somebody who's a departmental head or a section head that has a lot of discretion and may not want to go along with buying from a single source, you know, you get into a lot of other factors that influence why those may be, you know, a la carte decisions.

And we're going to have some opportunities for those with 2015 certification edition especially in the public health realm because of so many, you know, new things that are being introduced that not every mainline EHR vendor may necessarily be in the business of doing right away.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, it sounds like we have violent agreement here that we want price transparency, we want to deal with the issues like the validity of the cost over a total cost of ownership basis that Anita pointed out. We want to make sure that we include in this some specifications with respect to what data should be collected so that it can support whatever tool...whatever venue in which this tool gets created and we want to note that at least in some instances, you know, cost is only going to be understandable in the context of something like an RFP by a large integrated organization.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

And...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But, again, I don't think large integrated organizations are going to look to this tool.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

No.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

You know when we looked at cost of vendors when we were doing our evaluation we looked at a whole bunch of sources but at the end of the day it was our finance team's plowing through our key responses that gave us our answer.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah and I think...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Go ahead, John, please comment?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

No, I was going to say, I think part of it may be under that last comment, you'd want to understand the cost in the context of the type of licensing model and whether or not there may be more than one of those and what segments they appeal to I think was kind of where we were there.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Exactly.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Does that work Dawn? Is that a reasonable conclusion?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I think that's fantastic feedback, thank you. Are we ready to move on?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Let's do it.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Slide eight. All right, usability. I got an in-depth definition from Jorge via e-mail while we were talking so we will beef up the usability definition here, but what I heard is that it's complex, there are going to be lots of how do you define it, what goes into it. It's also very subjective. So, what we heard a lot is not only do you need the peer-to-peer, you know, the user reviews but you're also going to need some third-party independent review or evaluation of the products.

What I did hear consistently throughout the conversations we've had and yesterday is whether there should be some certain requirements that should be part of this tool or should it just be an open call for information and so that's where I'm going to pause here for you all and see if you have feedback on that or anything else on the slide? It's that good?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I can't believe our group is quiet.

**Dora Hunter – Analyst – Altarum Institute**

They're waiting for slide nine too.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, I was going to say, I was going to say take that as consensus and move on.

**David Schlossman, MD, PhD, FACP, MMI, CPHIMS – Missouri Cancer Associates**

Yeah, hi, this is David, you know, the idea that usability is just subjective is really only partly true. As you know from Jorge, and I've worked on other committees with him, it does have a good definition and there is a vibrant research literature on both objective and ethnographic ways and user response ways to measure it.

And, you know, just as Anita said the five year cost of ownership didn't remotely match what was claimed at the beginning. Every EHR vendor says "oh, well, we've tested this with clinicians" and a practitioner goes in and uses this stuff and probably 10 times a day he says to himself in the back of his mind "there is no way an experienced clinician could have tested this and not identified for them this glaring problem that I'm running into right now that's impeding my day."

So, you know, we want to get some sort of a standardized transparent process where what the users feel at the end really is what they discovered in the user centered design processes they were using during development because there's a big mismatch between those two right now.

**Steven J. Stack, MD – President – American Medical Association**

This is Steve...

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

This is Anita, I...oh, I'm sorry, go?

**Steven J. Stack, MD – President – American Medical Association**

No you go ahead Anita I'll wait.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

No, I absolutely agree with that, you know, in terms of certain requirements. I know that Meaningful Use right now is not meaningful to every setting, you know, we heard that from long-term care and from PT, however, some of the basic things that are required for Meaningful Use are meaningful, you know, even if you go back to looking at what the core standards were and many of the EHRs struggled even though they passed certification they struggled to meet those requirements. So, I think that this absolutely needs to be, you know, that they all need to be able to demonstrate that they really can meet some of those basic requirements. There are many that still can't give you the type of drill down for demographics as to...you know, Hispanic versus Caucasian and, you know, that's just so important for population health and building it becomes, okay now let's build it, we're going to have to build another report and template and that just shouldn't have to be at this point.

**Steven J. Stack, MD – President – American Medical Association**

So, this is Steve again, recognizing that we're going to advise and make suggestions but many big things aren't clear now and may not become fully clear about who does this ONC or someone else and how is it done. I kind of think as we build a structure and a direction I think about how many different ways we can crowd source the inputs into this but create a structure that honors the 80/20 concept so we want to get the biggest bang for the smallest buck. We want to provide a framework or structure that highlights and gathers and focuses attention to gathers of information and focuses attention to those things most important but then relies on others to provide a lot of the content.

So, in this area with usability and the concept here of third-party independent reviews and peer-to-peer I'm thinking about, I bought a mattress recently and I've always gone to stores and bought mattresses, well, I did all the stuff people do and shopped around and looked and then I went online and Googled and I found, you know, these people who just apparently have a passion for mattresses and they have their own websites and they review mattresses and I ordered one online and it showed up shipped to me, I've never tried it beforehand and I'm very happy with it. So, I will never use that website again until I buy a new mattress but it was there when I needed it and it was wonderful.

I buy camera gear and I do the same thing with a different website and these people have a model where if you click on their links they get some kickback from either a commission or something from the party. So, the reason I say that is there are fairly credible third-party reviewers who have their niche.

So, if you look at a complex marketplace where you have, you know, certified or certified health centers and the public health centers that have different burdens that are not the same as everyone else ambulatory, more inpatient type setting, rural, small practice, big practice there may be other parties that have a niche so it could be that the American Academy of Family Physicians decides, hey, we're going to query our members and find the top 10 vendors used by our membership and we are going to have our own team go review them and we're going to create reviews and populate part of a tool like this and then there are other reviewers.

So, I think, I would say the goal in my mind would be to create a vision for a structure into which all this stuff could feed and then provide enough structure into what are the major domains that are important to be covered and maybe even for some of the most important ones some ways we would like them to be covered.

So, I see that as the way we have simplicity in design but hopefully create something worthwhile enough and robust enough to inspire and foster others to provide the complexity of detail that gets to some of these many important specific use cases that certain audiences will need to know and most others won't ever need to know. And I'm sorry if I confused things more than helped with that.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

This is Dawn and I think you spoke very eloquently and I think you're getting to where this group needs to be I think that that's exactly where we need to be going is if, you know, ONC creating this is just one option of a lot of different possibilities and may not be the best possibility right?

So, if we create a structure and we tell the market this is what people, we heard people want then I think that, you know, the market being what it is might just take it and run with it.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Yeah, we have...this is Jorge, there is some very strong examples already in the marketplace today that are beginning to scratch the surface and Steve the work that you've done with the AMA where you have actually held public forums and solicited end user clinical sort of a voice of the practicing clinician as they are speaking about the do's and don'ts with regards to Meaningful Use and EHRs, that's a perfect example of how individuals are being heard which is one of the problems with first generation EHRs a lot of these clinical individuals their voices were simply not at the table and so creating an infrastructure that will permit an ongoing sort of quality assurance, evaluative component that allows individuals to voice the good and the bad and the ugly will only improve the clinical product that these people have to work with.

**Steven J. Stack, MD – President – American Medical Association**

Thank you, Jorge.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

**This is Dawn are there any other comments on this slide?**

**Steven J. Stack, MD – President – American Medical Association**

I think we all want to get to that promised slide that's upcoming.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I think slide nine might be anticlimactic. Slide nine please. Yes, there it is. Maybe we're talking about slide 10, next slide. All right, so this is a high-level overview slide, kind of trying to summarize some of the key points that I've been hearing repeatedly. The first...and this builds on what Steve was just saying, that it's possible that we need to just provide this as a data but also a structure, as Steve mentioned, that this way folks can take that data and use it to build a tool that is accessible to their targeted audience. So, we heard that yesterday and we heard it today.

A thing that we've been hearing a lot and people mentioning is some kind of scoring or rating system so that you can compare products across a range of values. And then also that we need both peer-to-peer user reviews as well as possibly some independent third-party evaluations for something like usability. But if we have both of those things there needs to be a clear delineation of where the information is coming. So, I'm going to pause and see if this slide maybe lives up more to your expectations than slide nine.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, you're on 10 right now is that right Dawn?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Yes, this is slide 10.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Sorry, I'm not looking on the...yeah.

**Steven J. Stack, MD – President – American Medical Association**

Yeah, so this is Steve and in the silence that has ensued I would say if I made a wire diagram I'd break this thing down into, you know, layers and then buckets, and I think we want to create buckets where things like specialty organizations could put things in, other party, you know, if KLAS has usable detail, if HIMSS has usable, you know, external reviews.

I mean, think about like Edmonds.com if anyone has ever bought a car and used that website. You can go there and there are the specs that probably the manufacturer describes the vehicle they're selling and then they'll have people who have purchased the vehicle and who go online and post their comments, their experiences and then you'll have for many, if not, but not necessarily all, where Edmonds has its own expert reviewers who get a, you know, lent car and take it for a weekend and zoom it all over the place and then they write a formal review and someone can go in one spot and they can pick which of those buckets they want to look at, some or all or none, you can query by manufacturer of car, the specific model of the car, the year of the car, new or used. I mean, so there is that filtering and then there's the data that comes after that filtering. So, I think we would want to do those things.

Now, a scoring or a rating system I am...I'm eager to hear the thoughts of others but I'm ambivalent about because I think ultimately the consumer who is going to purchase this stuff is going to be the determiner for which things seem to meet their needs and some of this is going to be subjective in a way.

So, I think if there is scoring or ratings it might be, and just to use the example of the American Academy of Family Physicians, say they did review the top 10 vendors as they understand their membership uses with family practice and maybe they created their own rating system and they had a comparative tool, well maybe just for 10 EHR vendors and out of a much larger marketplace that audience could go and look and go "hey, the AAFP did this work and they've comparatively rated them."

But I don't know that the tool itself should comparatively rate these things because I'm not sure what degree of credibility or reliability, or reproducibility we're going to create unless you put in place a much more robust infrastructure like a consumer's union or Consumer Reports who is going to go through and

rigorously create methodologies for each of these major categories and I think that this is going to be such a large project that is a boiling the ocean activity and therefore I'm not so sure that this tool itself should, by design, ensure that there's a scoring or a rating system though it should allow for the possibility that contributions to it may provide some of that facet.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay, so I think that what I'm hearing...I'm trying to...I like your idea, if we provide data or if the concept of this tool that we're talking about developing is more of a set of data elements that can be filtered and used by other organizations and that is the tool by which we speak then what we're saying is, we'll provide all the data and then whoever uses it to create a comparison something for, I don't want to use the word "tool" again, a comparison something for their members or their audience they can do that rating system or they can build that in if they deem it necessary is that correct?

**Steven J. Stack, MD – President – American Medical Association**

You know I would qualify though because you use the word comparison and...

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Yeah.

**Steven J. Stack, MD – President – American Medical Association**

The slides show scoring and rating. I think we could and should have criteria for some of these major domains and we should have vendors and perhaps even other, you know, the end users or even others have the opportunity to fill out a quick template, this is the 80/20 rule, there has to be a survey of sufficient utility but also small in size or else people won't use it and we say "yes" or "no" or you rate things.

I think we can provide a comparative tool where someone could pick three vendors and they could line them up next to each other and look across columns what the answers to questions are either provided by the vendors themselves, provided by people who have reviewed or rated the service.

I think we can provide a comparative tool but providing a comparative tool is not the same as scoring or rating, you know, determining a score or a rating, its...does that make sense the distinction I'm making?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

I understand it. Does anybody have any feedback on that? I think that's a very good distinction to make.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think, this is Cris, I think we should note that. I guess what I'm struggling with is what it is this sort of split of what...if we're making recommendations to ONC who is making recommendations, I think, recommendations from the Secretary back to congress about what must happen, what could happen, etcetera.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Correct.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

It feels to me as though...I want to take a stab at this. I know we don't want to get in too much solution design at all and in particular at this stage, but let me offer this for people's consideration, one would be we want to emphasize the idea of data collection by ONC as part of the certification process in order to support whatever tools are developed whether that's by ONC or by someone else.

I would argue that table stakes is the idea of collecting the data and making it available. One of our panelists talked about opendata.gov which in fact fostered all sorts of great innovative things over the last 6 or 7 years.

I think a subsequent piece would be to say that we see the power of both expert and peer-to-peer rankings and that our belief is that given the dynamics of the health IT market and the fact that these purchasers are complex and so on that a combination of objective data, expert data where it exists and peer-to-peer where it can be fostered is a good idea.

That's not a very powerful recommendation if we're itching to try and design a tool but I also want to be cognizant of the fact that, you know, if someone from Amazon or, you know, Best Buy, sorry, Yelp or Consumer Reports were listening to this call they might be sort of amused at our naiveté of how you'd put one of these things together and, you know, they may have even better ideas about what to do.

So, too many words, but I wonder if people agree with the idea of open data and data collection as the root and an observation that both expert and peer-to-peer are necessary in this market? Then we can make subsequent comments after that. Does that work for people or is that too soft?

**David Schlossman, MD, PhD, FACP, MMI, CPHIMS – Missouri Cancer Associates**

That works for me.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

It works for me.

**Steven J. Stack, MD – President – American Medical Association**

Me too, Steve.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Yeah, that works.

**Christine Kennedy, RN, BSN, MA, CNOR – Nursing Informatics Coordinator – Lawrence and Memorial Hospital**

It sounds good.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, then do we want to have any more conversation about how would we want to foster either survey or crowdsourcing kinds of tools? That's where we were when I interrupted, but do we want to discuss that any further about what we might do to advise ONC to advise the Secretary, to advise congress about how we might foster a crowdsourcing kind of feedback?

**Steven J. Stack, MD – President – American Medical Association**

Well, I...okay, so and now I'm cognizant of your remark about...this is Steve again, that those who do this for a living would laugh at our naiveté because I feel very laughable right now at how naïve I am, so...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Actually you sound very sophisticated but I had no idea...I wouldn't be able to say what you said a few minutes ago.

**Steven J. Stack, MD – President – American Medical Association**

Okay, so what I would think is if you took all the technology that is certified and even just as a starting point, because if people don't use certified technology they can't qualify for Meaningful Use, right, and so that's a big part of this and that is in ONC's domain for the certification.

So, if you said, okay, everyone who has a certified component or a comprehensive tool what could congress know and ONC do? We could say, you have to populate the vendor data, the vendor has to populate the vendor data in this tool and of course remember, I have a parsimony principle I keep applying. I don't want to make tons of busy work for people, not for vendors, not for clinicians, not for ONC we've got enough busy work to do already, we've got to get rid of it.

So, if they have to populate, there is a requirement of certification or a tool that has simple yes/no questions so that the first screening of filtering for a target audience can be populated, if we can then have them have to answer questions on a key but discrete and small set of, can you do this, yes or no, and then give them options if they want to provide a product description as they describe it, things like that.

So, if we say they have to do that and then we...say you work with an Amazon or you work with someone else to create a tool, JD Powers, I mean, there are tons of people who do this stuff, you create a tool that then has those categories, that essentially has wireframes and that people can go in and either fill out a survey an end user so it's easy or outside entities can fill out a standardized survey and then attach, if they will, either a narrative document if they have their own review they've done and you create those buckets it is no more difficult than going on my smartphone to buy a movie ticket and I can see what the critics say about Star Wars The Force Awakens and I can see what the viewers say about it, and I can see what the producer...how they describe it, right? So, I can look at those things and filter it.

So, I think if the vendors have to populate it but we make the workload very reasonable so it's not just another annoying thing for them to have to do and then the others are given very usable and desirable buckets to put information into we create the convening place and I think that...I agree with you Cris I don't think that the big sophisticated integrated delivery systems are going to need this stuff. You have your own robust infrastructure and it's a relatively small universe of providers for some of this stuff, but who knows for some of the modular stuff it maybe that even your folks could use a tool like this to go and say, hey, we need a module...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Steven J. Stack, MD – President – American Medical Association**

That allows us to do home monitoring and...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Steven J. Stack, MD – President – American Medical Association**

It's a growing area.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, yeah.

**Steven J. Stack, MD – President – American Medical Association**

And we want to look at...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Steven J. Stack, MD – President – American Medical Association**

This thing. So you use it...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Great point.

**Steven J. Stack, MD – President – American Medical Association**

As the first cut and then you go back and then you do your own detailed research but for those who are in smaller community practice I think this is going to be...this could be a substantially usable tool and if we can do it well enough with the structure on the front end...and I wouldn't underestimate the power of our recommendations for what we hear people say because I think that this is a niche that there are people in this community who could step up and help populate.

And I think we do provide a value. I think we provide a useful input into the journey of trying to create something that can help health IT be more transparent, more, you know, purchasable and adaptable to those of us who are frustrated right now at the current state of affairs because we feel it's too opaque and not responding to our needs.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Can I...this is Dawn, can I just propose if we're working for simple buckets what I've consistently heard from this group the buckets might be cost, usability and possibly what I call, playing well with others, I think people have called it integrate well, if we're talking about modular components how well does it...is it plug and play or is it complex, or easy to solve. Would those be three buckets that you're considering or might it be something else entirely and I'm completely off the mark?

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

You know, this is Chris Tashjian, I think keeping it simple like that makes it more effective and I think those are reasonable categories.

**Steven J. Stack, MD – President – American Medical Association**

I have no opposition to raise to it I just would have to think through it a little bit more.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Agreed, I'm with Steve.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Sure. Any other thoughts? Okay moving onto the next slide, slide 11. So, the next three slides takes some of the sources of data, and we're getting back to Cris's question from earlier, if we're talking about supplying or having ONC or somebody else or where do we get this information and so one of the things that we've come up with consistently is peer-to-peer input and so there's a question of whether it should be, you know, if you guys think it should be survey-based or crowdsourcing, or a combination of it and then what I've heard in some sorts if we're going to propose that it be in this format do we want to also include some of these questions that folks have phrased and proposed as ways to collect some of this information, so I'm going to leave the conversation up and see if there's any input on this at all. Is this too detailed for the purposes of the recommendation is another question?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, Dawn this is Cris I'm sorry I don't think I really got the gist of the question. Can you...and maybe others did but can you just say it concisely again? I'm sorry.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Sorry, it was not concise the first time, yes, the intent of this slide is if we're suggesting that we need peer-to-peer input how might...how are we suggesting the data come through? Are we suggesting it come through surveys? Should it be crowdsourced? And if we're suggesting a survey do we want to propose questions as those that are listed below are some of the ones that I heard yesterday specifically? Or do we need to even go into this level of detail?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I guess, this is Cris, I would opine that unless ONC wanted to go down the road of specifically specifying, managing or building, or, you know, contracting for the construction of a site like this I think we would probably only note that either or both might be sufficient depending on what market interests think is best.

I mean, I don't think we can tell, you know, if our conclusion at the end is, boy we think the existing incumbent vendors should do a better job on this and the thing that will help kick start it is, you know, the bully pulpit plus open data equals better outcome from KLAS and the rest then I don't think we would have an opinion about survey versus peer-to-peer.

I think if this group wants to take a viewpoint that says that either or both have value we should, you know, speak up to that and we can include it, but at the end of the day unless ONC is going to run it I think that whoever the vendor is will do whatever they think is best.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay, that's a very valid point. Here's my question then to build on that and then folks can chime in. The question that I'm hearing is so some of the information that we've already cited is going to be collected by the vendor and we've proposed or have heard mention of doing it through the certification process.

What we're saying here, what I'm hearing you say here is that this would be something that the marketplace would do and I think that's what I'm hearing.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right, got it.

**Steven J. Stack, MD – President – American Medical Association**

Yeah, yeah, yeah, so this is Steve, so you...I mean, you stepped into a wonderfully confusingly complex area so how do you detail and then how do you compel something and then not be the one who provides the thing that's compelled.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Steven J. Stack, MD – President – American Medical Association**

So, how do you compel someone through certification, because I don't want the certification process perhaps to dictate all this stuff I'd like the certification...I don't even think I'd like...I don't have a strong opinion on this.

I mean, I know vendors...vendors have got to respond to certification like I respond to regulations right? We cringe at the proposal of any new regulations to help us because they seldom seem to help, but if you...if certification said you have to report to this outside thing but then ONC doesn't somehow either contract for it, stand it up, ensure it happens well then your mandating that something be done that may not exist or may not exist in the way that you envision it. So, there is a complexity. So, I might say to be determined later.

But what I would say for your slide here is...when I think...when I read survey I think of somebody sends something out and asks for information to come back. I would say that we'd want vendors to self-report certain factual information, at least I hope it would be factual, and then...and when I say that I mean that we could come up with questions that were concrete enough that it's not asking them to be subjective and presenting or pretend it has or pretending to present it as fact.

But then I think the rest is largely crowdsourcing and having if you build it they will come and that's were, you know, a group like the American Medical Association and other big clinician groups and others, you know, if the tool is well designed it very well would make a huge push to say, look you've got to go and populate this with information because we've asked for this, we want this to be useful and if it's going to be useful you are the only people in possession with the knowledge and experience for what it's like to use these things, you are the only people who can populate that with the data you've asked for so go do it now. So, then it has to be made easy and that's where a great slick interface design of the likes that a Google or an Amazon, or an Apple do it's important that the tool be designed with a parsimony of input required to get a, you know, very high usability.

And that's...so I think that it's not formalized surveys sent out and asked for response which have dimly low response rates, you know, consistently. Its vendors self-report that provides the first layer of things and then others, crowdsource and populate with the press of those of us who are interested in the success of it pressing people to really help populate it.

Those other two questions you put at the bottom were ones that I think I had mentioned yesterday just because net promoters, you know, people I think in the satisfaction business say that the net promoters score is one of the single most useful predictors of people's satisfaction, their likelihood to recommend, you know, and so I think that...I think we could suggest some questions we think directionally would be useful to have in there without having to prescribe it unless ONC is either doing it itself or contracting out and specing out an, you know, RFP.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

So, Steve, this is Liz, so what...I like what you said, I'm a little...got lost somewhere around where the data would sit because I agree with you if it's not managed, you can't ask questions and then not have a place where we can go and get cumulative answers. So, are you envisioning that a private...that there is a private answer to this that we set the wheels in motion? Is that what you're saying?

**Steven J. Stack, MD – President – American Medical Association**

Well, this is tough so I would say that this is a...it's a discussion we need to have. I would say for today it's a discussion we may need to say we have to come back to discretely just for this topic because it's kind of a big one.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yes.

**Steven J. Stack, MD – President – American Medical Association**

But, so I don't know, I don't have...and I sometimes sound like I have more certainty than I do so I apologize if that's the case but I should say "ah" and "uhmm" more it would make me sound less certain perhaps, but maybe uhmm, uhmm, uhmm...but so say one variation of this would be what if certification required vendors to populate a certain amount of information as the first level to populate a tool and therefore then we have all certified producers in there and then ONC concurrent with that went out and did an RFP and say "we're going to provide exclusive contracting to provide a tool like this" and maybe there is some small amount of funding but then there has to be a revenue stream perhaps to support it and so it there a way...you know is there some revenue stream for some basic support for it that's now a business plan really for how does it work and there is a whole...that's a complex thing but I could see some third-party doing this.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, me too.

**Steven J. Stack, MD – President – American Medical Association**

And I could see some third-party doing this in a very scalable and economic way because if you're just creating the infrastructure that other people populate the data now you need cloud storage and you need, you know, logically well laid out interface design and that's essentially App development right? So App development with database development and cloud storage. So, I'd have to think there is a community of people who could step up and do this if we could just create the right environment and there is some business model that provides, you know, to make it work but I don't know the complexity that's beyond my pay grade I guess all the detail.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

So, Cris and Anita, it sounds like...I mean, I agree with Steve and I think it's worthy of some discussion but I think it's a lengthy discussion potentially in order to get some structure around the answer. Do we ask the questions now or do we plan for a meeting when we can have the more in-depth discussion? What are you thinking?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Can I posit a...

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

A very, very good point.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

This is Dawn...

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

I also...

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Can I posit a third option? There...

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Sure.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Next week or next week on our panel, panel three is a vendor panel so it's the health IT vendors or developers and panel four are the tool developers. So, some of these open questions that we're talking about maybe something you want to raise with them to help inform your decision.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah that's a great point.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

That's a good point, yeah, exactly.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And then on the 19<sup>th</sup> is our last kick at this before we take it forward and I think we only have an hour and a half next time. So, you know, I think we're going to have to do a pretty quick turnaround on those kinds of issues. Anita what do you think?

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

I agree, I agree. We could spend days just...

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

I have a question...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Go ahead Chris?

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

No, this is Jorge I'm sorry, I have a question.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Oh, sorry.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

That's okay. We...does anybody envision the tool also having some utility for the non-MD's meaning all the other clinical personnel that are effected by the use of these tools themselves? And the reason I say that is that, because this is thought to be most, the highest vocal...of the tools but nursing and other personnel that are effected by almost the same or even worse usability problems almost have no voice in this dialogue and I think it's important that we also expand the ability for other clinical personnel to have the ability to shape and influence the performance of these tools.

Yesterday we had a presentation on the physical therapy individuals and behavioral health to some extent but this is not just about the MDs, I think we need to expand the utility well beyond because as everybody knows on this call the people that have to touch the keyboard are many and we're not getting a good sense of how this is impacting and, you know, a good example, I work in surgery and a lot of the, you know, nurses that used to be circulators are now data entry clerks for charge capture in the operative rooms so we've almost lost a good bit of the work that they used to do and this gets replicated in almost every instance and every clinical environment.

So, my only comment is that I think we also need to expand the voice of the other clinical personnel to be included in whatever tool we think about.

**Steven J. Stack, MD – President – American Medical Association**

So, this is Steven and I absolutely agree with you. So, in a wire diagram seeing how this would work one bucket for the crowdsourced user reviewers would say clinicians and under clinicians would be physicians and nurses, and physical therapists, and respiratory therapists, and we won't capture every one of them but we can try to capture the majority and then have another category. And whoever would design the tool and maintain the tool would note it, would see, you know, and could add specific other categories that need it but you could have a standardized survey of some sort that they still fill out, you know, an eight bullet list, you know, response so that people can get a sense or a relative rating on key areas and then a narrative comment section and we've all used tools like that online.

But I would absolutely agree with you. There are millions of nurses who are as infuriated as physicians right now and as I like to say for good reason, as like the Pope for Doctors in the US for this one year trying to lead this profession, I would love to have, you know, our nursing colleague's voice amplified

alongside ours because they're as challenged as we are just wanting to have a tool that supports the work they're doing.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I'm noting that we're getting towards end of time here. I'm trying to look at the agenda here real quickly. Are we going to...are we planning to open for public comment here? I guess we are. Dawn I think we need to wrap up with whatever next steps you think you'd like to see from us between now and our next meeting.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

So, I think that next steps, given that we have to have the recommendations written fairly quickly and we have a really tight turnaround and it sounds like folks have some ideas or maybe thinking of visuals or wire diagrams or anything like that in their heads, if you have something that you want to be included in recommendations or anything like that please send it to Cris, Anita and myself so that I can try to include them into the next round of slides that you see that will show up I guess on the 19<sup>th</sup>. So, if there's anything you feel like is not covered here or we haven't talked about definitely let us know. I don't know Cris if that is what you're looking for?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think that makes sense and Anita I'm going to throw a curve ball at you and maybe Dawn too, it feels to me as though off line we should start to outline some of these ideas and potential report. I know probably Dawn given everything we've seen from you so far you've probably already done that but it feels like we ought to outline that a little bit for feedback from this group and it would be great if we could at least circulate some preliminary ideas maybe even before our next hearing. I just worry about going from, you know, what three days...

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Hearing, to meeting, to read out just seems like we're not going to do this justice if we don't do some preliminary work before the 15<sup>th</sup>. Anita and Dawn do you agree with that?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

**Absolutely.**

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, if so, I'd say the three of us will put our heads together and begin, and others as necessary from ONC, and we'll circulate some ideas to this group for your feedback. I would say please do exactly what Dawn said, if you have ideas please forward them but in addition we'll begin to create a strawman

document to circulate over the next week. If that makes sense, Anita I apologize I started being pushy at the beginning of the meeting before you were able to join, I kept being pushy, sorry about that.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

No worries.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

It feels like we ought to open for public comment.

**Public Comment**

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

Yes, Jaclyn can you please open the lines?

**Jaclyn Fontanella – Digital Project Manager – Altarum Institute**

Sure. 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. If you are on the phone and would like to make a public comment, please press \*1 at this time.

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

We did receive a few public comments through the chat and we'll send those out to the group following today's meeting as well.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Perfect, thanks, Michelle.

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

It looks like we have no public comment so thank you everyone have a wonderful weekend and we look forward to getting any feedback as Dawn mentioned and you'll receive something from us probably early in the week and we'll talk to you next Friday during the hearing.

**Steven J. Stack, MD – President – American Medical Association**

Thank you.

**David Schlossman, MD, PhD, FACP, MMI, CPHIMS – Missouri Cancer Associates**

Talk to you next week.

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

Thanks, Michelle.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Thank you, bye now.

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

Thank you.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thanks, Dawn, bye.

**Steven J. Stack, MD – President – American Medical Association**

Bye.

**Jorge Ferrer, MD, MBA – Health Information Specialist – The Veterans Administration**

Thank you.

**Christopher H. Tashjian, MD, FAAFP, FHIT – Vibrant Health Family Clinics**

Thank you.

**Public Comment Received During the Meeting**

1. Jennifer Voorn: key features- should also be filtered on- like MU stage 2 items: secure messaging, electronic access, patient education, etc.
2. Jennifer Voorn: that way when the consumer is shopping for software, they can get the size, specialty and provider type focus... as well as key software features that would benefit those key areas
3. Susan Clark: Susan Clark, eHealthcare Consulting - Regarding software vendors and certification.....How the measures are calculated are far too open to interpretation and we have seen many vendors whose MU or CQM reports do not appropriately reflect the rule as written.