



HIT Policy Committee Certified Technology Comparison Task Force Transcript December 1, 2015

Presentation

Operator

All lines are now bridged.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the joint Health IT Policy and Standards Committee's Certified Technology Comparison Task Force. This is a public call and there will be time for public comment 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. Anita Somplasky?

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

Present.

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

Hi, Anita. Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'm here.

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

Hi, Cris. Christine Kennedy? Chris Tashjian? David Schlossman?

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

I'm here.

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

Hello.

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

Liz Johnson?

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

I'm here.

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

Hi, Liz. Joe Wivoda?

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

Here.

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

Hi, Joe. John Travis? 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. And from ONC do we have Dawn Heisey-Grove?

Dawn Heisey-Grove, MPH – Office of Planning, Evaluation and 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 with that I'm going to turn it over to you Cris and Anita.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Anita, do you want to make some opening comments or take us through this or would you like me to go first? What do you want to do today?

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

Cris, you can go first.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well I think actually it's pretty straightforward. We have two things to look at today, a comparison framework proposed panel questions and then we'll get to the work plan, which I think is pretty straightforward. We had a really good call, I think, the first time around and did some good level setting, but we've got an ambitious schedule up ahead so I think it'll be important that we nail down the framework and the panel ideas today. That's really all I've got as comments to start with. Anita, how about you?

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

The only other thing I would add is that as we look at the comparison framework it was not put in any particular order but did include things that we thought were important, but your feedback is going to be really important as well. Did we get everything we thought that was needed? Are we...is there overkill? So we look forward to having your feedback on that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So with that in mind, Michelle or Dawn, does one of you want to take us through the comparison framework?

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

Sure, I can do that; this is Dawn.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thank you. Go for it. Did we lose Dawn?

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

Sorry, I keep pushing the mute button on my phone. Okay, I am now with you.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hi.

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

The comparison framework that I'm going to be talking through is what ONC has developed as a way of identifying the categories of technology needs that providers may be interested in when they're investing in certified health IT. Next slide.

Okay, so this slide demonstrates some of the key points to keep in mind when you're looking at the framework. Certified health IT as we all know is modular which means that providers can opt to purchase pieces of certified health IT or entire EHR systems. At different times in their adoption and use cycle, providers may be seeking different forms of technology.

So just remember from our last meeting, we had put providers into three very large buckets; those who are brand new to adopting certified health IT, those who may be purchasing modules to perform more advanced health IT functions and then those who may be looking to replace their current systems. So next slide.

This slide lists the different categories that we envision might be areas where healthcare providers may be focusing on when they're selecting their certified health IT. Before I continue, I want to re-emphasize what Anita had highlighted, these categories aren't prioritized in any way, they're not mutually exclusive. There may be some overlap. Also recognize that some of these buckets don't necessarily have certified health IT components in it, such as practice management. We just felt that it's important to include them in the framework, in recognition that it's still probably a priority for healthcare providers in general.

Finally, as noted on the next slide, we recognize that within each of these categories there may be information on the functionality, usability, accessibility, cost and user reviews or satisfaction. So can we go back to the previous slide? Thanks.

Okay, so a little bit...the vision behind the framework is that a provider who might need to compare certified health IT products might select one or more of these categories and then be able to compare the technology within that category. So for example, a new provider might be interested in identifying certified products that meet Meaningful Use requirements and therefore might just select the regulatory bucket and then be able to compare products within there.

A provider, on the other hand, who might want to just add the patient engagement functionalities to her existing system might select the patient engagement bucket and then be able to compare within that. It helps them narrow down their focus so they're not looking at everything under the sun.

And then a final example is a provider interested in transitioning to an alternative payment model from fee-for-service payments might need guidance on which areas to select, or might be aware that he needs to select population health management, quality improvement and patient engagement, and then be able to compare products within those areas.

So that's a very high level overview of that and I think that I will just pause here and we can have a discussion on this.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, I guess I would ask...Anita, I think maybe we should walk through these things, these slides in order; maybe comments on slide three around the areas of focus, do these seem right to everyone?

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

This is Steve Stack, it looks like a good starting point and it captures, you know, most of the major things that would occur to me. But I think as we go forward, we'll identify if there are any gaps that we've overlooked but it looks like a nice starting point.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah. Thanks.

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

I don't know, Cris, this is Liz; I don't know whether it's outside of our purview but one thing that I think is important that's not listed here is cost and I know we had some discussions about that in the Standards Committee. I realize that it's a proprietary issue and depending on volume and blah, blah, blah, but the other thing...

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

Well...

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

...that I would say is...go ahead.

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

Oh no, I think we think that that fell under that total cost of ownership.

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

Okay. Yeah, that's true.

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

If you don't...and again, if you don't think that that's clear enough because cost is absolutely one of the thin...one of the driving factors that folks, particularly the ones who are going to be looking for add-ons or those who really have to do a full rip and replace, that is absolutely an area that they're going to want to have that information.

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

So my only...thank you. But my only suggestion would be then it should be on the first slide because although it says the comparison framework, you know my thought process as I listen to the first one, this is like the big areas and I would think cost would be big. Just food for thought Anita and Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So I...

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

Yeah, and this is Anita, I absolutely agree and under total cost of ownership, you know one of the things to dive a little further into then is not just total cost of ownership to have it today, but it has always been very useful to try and get even a three to five year cost of ownership because you really see where some of the things where providers in practices in the past have gone with, let's press the cheap button. What they have found when we help them to think about or get those total costs for three to five years down the road, there were a lot of add-ons that are not there initially that really need to be considered.

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

Well, as is the ongoing cost of support, huge dollars.

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

Right.

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

Yeah, agree.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So this is Cris; I guess all that makes sense and I think for some segments of the market we can do quite well. The challenge of course is going to be to get the signal to noise ratio right.

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

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You know, we can in fact require a cost estimate and the vendors are not going to be defenseless or passive in response to that, they're going to want to position cost information in a way that meets their commercial interest; that's totally natural. So it may be really fair to say for a typical five person, primary care practice, you know we proba...a vendor probably can and should estimate what the cost is plus or minus 20% where the 20% would be judgement that the customer would make. Above that, I think it's going to be pretty hard. It's sort of a question of how much does an office building cost, you know, I don't know.

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

Yup.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So I think we want to be really careful that we don't...that we provide useful information and encourage this tool to do that without introducing noise to the system. Maybe my viewpoints are a little too strong, I don't want to shout down folks, but it feels like we ought to be clear about those kinds...

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

And this...

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

But, you know ones that we had talked about is, oh I'm sorry, at some point would be then like when you go to a restaurant, when you look up a restaurant it's got dollar bills, we didn't ask for specifics and I don't know if they'd like that any better. Just keep that in mind.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I like that.

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

Yeah and the other thing, this is Chris Tashjian, is that what they need to know is what have other people who have bought this, what have they...is there a way to tell them what they've had to buy extra or things that weren't initially seen when they initially selected the system that they have? An example would be did they have to buy whole new servers for thin client? Or did they buy PCs? Or did they buy, you know, did they have to get some kind of connection that all of those costs are things that really can hamper somebody that they're not thinking about when they first go to buy it.

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

Yeah this is Joe Wivoda, I really like these categories; I think this is a nice way to break it down for a comparison. The total cost of ownership one is really going to be tricky, probably just as tricky as the usability just because we covered a lot of it; the license fee is highly negotiable so that's going to be a cap probably, you know an upper limit, so we can expect to see that.

And then the total cost of ownership is...it can be very hard to calculate and like you said, coming up with, what are the other expenses that you had to incur to put the system in; that's a non-trivial question, that's pretty tough to get at. So, like you said, if there's an opportunity to have kind of the peer comment thing where people can say, "I also had to add these features." That would be really helpful.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right. Well, unless there are other comments on three, Anita, do you think we should move to slide four and get into some of these specific categories?

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

Yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So I guess I would suggest that we walk through these and get comments on them, maybe even in order although if people want to jump around, we can do that as needed, around what's really the most important information to put in front of buyers. We could talk about this all day and who knows, we may and the hearings probably will but, which of these things is really most important to the buyers and then we can match that up against what's practical or what's feasible. Does that make sense? And if so Dawn, maybe you can just walk us through these left to right, top to bottom; could we start with regulatory requirements?

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

Sure. So the idea behind the regulatory requirements is that there is Meaningful Use and that's the clear delineation of what is required and then there will be...there are some regulatory requirements that are coming through with other components of or other regulations, limiting this bucket to federal requirements because if we tried to expand the scope to state and other types of regulatory requirements that might be a little bit overwhelming. But the biggest, I think the first one that everybody thinks of when you talk about regulatory is what is needed for...to meet the Meaningful Use requirements and so that would be the first example I would come up with for regulatory. I'll pause right there.

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

So can we make the assumption though that they would also be for the e-Measure requirements that are coming out now?

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

That would be a perfectly great example, yeah.

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

Okay. Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But the...

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

Anything that's not a certified health IT requirement might fit in here.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

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

Yeah, hi, this is Dave. I think another thing that fits in this bucket is from the smaller practice perspective, I mean certainly I think every provider is going to want to know that the product is Meaningful Use certified but there also in the back of your mind is, if there's an audit, how easy is it going to be for me to produce the data that the auditors want to see is this friendly in supporting an audit if I draw that card in the Meaningful Use process?

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

Okay. That is also a very valid point.

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

And, yeah, a very...this is Anita, a very important point because right now what we are seeing is people who just have volumes and volumes of screen shots to try and prove what they did because there is nothing else available from their vendor.

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

Okay. Any other comments on the regulatory requirements; this is Dawn; I keep forgetting to say my name before I talk.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So this is Cris and maybe this is a philosophical question and applies to other things which is, but it especially I think applies to this square which is, to what degree do we think this ought to be a, you know a definitive user guide that really helps someone say, you know walk through products and do comparisons, those kinds of things in the way that for instance some of the health insurance exchanges allow you to compare options for yourself.

I'm just offering that up as sort of a hypothetical, as opposed to something that provides all the information that someone might reasonably expect with a little bit of a buyer beware feeling to it or intent to it. I'm assuming that we would not be all the way over into this being a comprehensive buyer selection guide recommendation because I think it's impractical in some ways, although others might disagree with me. And I'm not sure that we want this to be all the way on the other extreme which is, here's only basic information and buyer beware.

I know we're going to get feedback from the panels as well about what's feasible but I'd be curious just to hear what's on peoples' minds? What are their expectations based on what we read in the last meeting from the MACRA legislation around what this is intended to do? And Dawn, you may want to also comment from an ONC perspective. So does this simply list that it has a certificate and that's it, yes/no or at what level of other information do we expect or want to encourage? I know that was a pretty broad question, does someone want to...

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

This is Dawn...

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

Well Cris, this is Anita.

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

...go ahead.

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

One of the things and I think shortcomings that we saw to date were that there were folks who could say they were CCHIT certified...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

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

...but when you got in there, they were certified for one quality measure...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

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

...and if you happened to be a surgeon, that being certified for the diabetes measures meant nothing to you. So, I think to the other point, you know for the things that fall under this bucket, I do think there needs to be a little bit more granularity other than just a blanket statement that okay, this product is certified.

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

Are we going to be able to put; this is Chris Tashjian again. Are we going to be able to put in this what their experience or their...you know, I know we're going to talk about that in usability but, can we say...are we going to be able to say like 80% of the people who have used this software have reached Meaningful Use? That's the kind of information that I'd want to know when I'm looking at it.

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

Yeah this is Dave and that's exactly right. You want to know what fraction of users successfully attested. You want to know what percent of people who were audited, how they thought the audit process went and whether it provided them the data. You also want to know, has the vendor reliably over its history been able to progress through stages of Meaningful Use, adjust to changes in regulation and accomplish that process without putting a lot of hardships on the providers. In other words, update for Meaningful Use and regulatory purposes without having to take your system down for long periods or make you learn a whole bunch of new workflows.

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

I think that last one is really important as well because I saw a lot of people having to switch their EHRs because their vendor couldn't keep up with the changes in Meaningful Use.

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

And this is Dawn and Cris, you had asked whether from an ONC perspective what we're looking for and I think that this is one of the areas where ONC is looking for you all to provide your opinion on this; should it be all encompassing or should it be a little bit of buyer beware, I mean, that's really what we need the feedback from this group. So everything you've been saying has been very helpful.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well the last couple of comments suggest some pretty comprehensive information...

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

Exactly.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...which just heads in one direction. I guess the thing that we'll be having to wrestle with as we hear from vendors and others, both the EHR vendors and the certification vendors for example, you know and the rating agency type vendors is what's practical, what can be done you know, and what's reasonable? So I think more to come on that. But I think the comments from the folks should be taken as is, that it's useful information, we should think about it.

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

So Cris, this is Steve. So I find with many of these activities that I tend to lean towards the less is more approach and the 80/20 approach as opposed to overwhelmingly comprehensive because my experience with these kinds of initiatives is in our desire to be helpful and thorough, we overreach and then we create things that sometimes sink under their own weight. Vendors can produce reams of information to put into these sorts of things that will be a cost they may not want to have but they'll comply with it if it's important enough to comply with it.

I think though that the points that others are making here are really good ones and so I would probably look at this as trying to cast the net widely at this stage of our collective work. And then I think when we get to the other end of this, after we get testimony to the group and we are doing the hard work of nailing down a final framework, I think then it will be incumbent upon us to make some prioritization and some elimination of what things are just nice or may even be somewhat helpful, but the effort required to do it just isn't justified.

So that at the end of the day we create a tool that is actually reasonable to comply with but then also usable itself by the people we're trying to help, which are the purchasers of these systems. Because if every vendor has a 50 or 60 page report and you're trying to review three or four or five vendors, people just aren't going to have the time to do that and it's not going to be helpful because the comparison tool itself has not done the hard work of providing an easily accessible comparison.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

This is Dave; Steve's exactly right. From the provider point of view, in this category, the provider really only cares is the thing certified for all the features of Meaningful Use or not. So from the doctor viewpoint it's pretty much a yes/no in that box.

M

Indiscernible.

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

So one of the things that...this is Liz, that I would warn you about is we're, and I'm sure you guys are too, very able to figure out what's been certified or not...and I don't know how to solve this because this is the balance between falling under your own weight and giving detail that people may find very helpful but may not use effectively is that to go certification may only be that the vendor attested they could do it, just so you know.

So that means that if I'm Joe Blow vendor and I say I'm absolutely capable of sending immunizations to the state registry and I don't prove that to anybody, I just simply attest that I do; so I'm not sure how to deal with that component. But we have certainly run into it where either the way that they propose to do it was not really viable or it didn't work in our system or 15 other things. I'm not...I don't have an immediate solution; when we kind of get to the panels and hear more experiences, we may come up with something that's creative. But that's my only concern is just because they say it's certified, it is certified, but how it works is an entirely different thing.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah Liz, this is Cris; I agree and I think we will probably hear from them that that may be a sword that cuts both ways, one of which is that they're...providers might be looking for assurance that certification exists broadly. On the other hand, some of that may depend on the particulars of the buyer to some degree and the vendor may push back saying, "I don't want to represent anything that warrants that my product fit this purpose." You know, those kinds of issues are challenges.

I have been a vendor before and it is challenging when you are asked a specific question for which there is not always a clear-cut answer; how do you answer in a way that doesn't disqualify you but also doesn't mislead? And even if you assume completely benign and completely transparent intent...

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

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...that's sometimes hard to answer those questions. So anyway, we'll need more feedback on that.

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

Agree.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

People have other comments about the regulatory requirements box? That was a dang good box to start on. Can we maybe move through some of the others?

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

Okay. This is Dawn, I don't know if this next box is going to be any easier to have a discussion about, management and financial system integration. This is one where there are no certification criteria on it. So the first topic for conversation could be in a comparison framework for which Congress has said certified health IT, do we even have this? If we don't include something like this in a tool, is that a big gap that would mean the providers don't find the tool useful? So this includes scheduling, billing, how it integrates with the rest of the certified health IT components and so, I will stop there.

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

This is Anita. I will tell you if a practice can't get paid, the rest is meaningless to them if they're independent, not being supported by a large healthcare system that will keep the lights on. So we found that although it was never meant for a practice management piece to be certified, practices need to know is it all included? Is it a separate module? Do I keep my own practice management? It's really important information for them and it's always the first thing that's going to go live in a change. So I think that...I think it's very important that this be included, but that's more trying to represent those small, medium, independent folks out there.

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

Yeah, this is Chris; I would concur with that. And again, for us it was critical is that they had to, I mean to be honest with you, this is one of the things that drove our decision to buy the EMR we drove was we did because it mated directly with the practice management. And she's exactly right, without the finances it doesn't work.

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

This is Joe Wivoda. Is there a way to maybe more generalize this topic and everybody might push right back on that. What I'm thinking is, this is really talking about internal integration within the system and I'm working with some of the EHRs that are rural that are not integrating their third party vendors very well, so things like prescription vendors and things like that, that maybe this is more than just financial system integration. Because that to me isn't interoperability to say that they purchase a third party system for patient education and it's not integrated very well with that. I wonder if there would be any support for maybe opening that up to say, financial and other system integration or something.

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

So Joe, this is Anita; so you don't see that maybe falling under interoperability, for example the prescription piece?

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

No, I don't because it's part of the base product, you know that rather than writing their own prescription module, they rely on Dr. First or some other vendor and then they don't integrate it very well. So to me it doesn't feel like interoperability because interoperability means something else; that means talking to a third party organization. Same thing with patient education; those are the two I'm running into a lot.

But we've seen this with other vendors where, in the past 10 years they've gobbled up a number of vendors and are still working hard at integrating all those disparate systems that they've now implemented. So I'm not sure how feasible it is to even say how well is the integration performed with third party systems or an internal integration, but I think it needs to be...I agree 100% that the practice management or financial system integration is a critical thing to look at but I don't think it's the only integration that's important right now.

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

Okay, this is Dawn.

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

What...this is Anita; what do other folks think about that?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Anita, this is Cris; I think the thing we're going to have to, I'm probably going to be a broken record, but I think some of this is just how to...everything that anyone has asked for on this call makes complete sense that someone would want to get. In my mind the question is, how much of it can we put through some sort of consumer guide capability that is what we're tasked to recommend as opposed to what should people expect that they would have to get as part of their own individual verification?

So in my mind it's going to be the art of the possible and at this point, I think we're representing more the view of the provider than the view of the vendor. We don't have our vendor representative, John Travis for instance...

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

Oh, I just joined Cris, sorry I was...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

John Travis, I'm glad you're here. So I just think we're going to need to look at a balance of those things. Just to acknowledge that it isn't simple is, I think, my only comment.

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

Yeah I...this is Joe again; I couldn't agree more. It is not simple. I'm not sure how to do it without a third party testing regime.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yes.

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

So Cris is the question here how to validate? So the comparison framework, I was talking with ONC staff yesterday on what I said I'd follow up on which was kind for the data they make available. Is the question here one of how do you really qualitatively and reliably validate vendor statements that might be made in a comparison framework or independent vetting of the statements vendors make in a comparative framework?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think it's both of those attributes, isn't it John, potentially?

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

I, yeah, well because a lot of the information I think, even an independent party, you know at least at some level is going to rely on statements the vendors make. The thing that is, maybe advantage isn't the right way to say it, but subject to a little more scrutiny is what will happen through the surveillance process that ONC and the ONC ACBs have set up that at least for the disclosure statements that vendors make now don't know to what level there will be the opportunity to vet them on the face of it but one point of accountability that will always be there potentially is the ONC ACBs will have the ability to do field audits, both reactive and random, that in part could challenge the veracity of vendor disclosure statements that might be part of the basis of the comparative framework.

So for example I think when I joined I heard a statement made to the effect of use of a third party component for e-Prescribing, the degree to which it integrated well with the rest of the clinical EHR of a vendor, a client of that vendor might make complaint about the fact that they have difficulty making use of certain features that are part of that third party integration. The ONC ACB presumably is going to go vet that against disclosure statements that the vendor is making about that very integration so one would expect the disclosure statement that vendor would make would be the nature of the relied upon software for e-Prescribing.

Now it's hard to say to what depth they are making statements about that or to what depth they're saying, in order for that to work, you need to do A, B, C and D and if you forgot D, it's not going to work and maybe the complainant forgot D. So it then becomes a matter of ease of use or ease of implementation. So I don't want to chew it up too much, but I think part of the challenge here is realizing that what we're presenting, you know to what degree is it reliant on self-collection, or I should say self-reporting of information or to what degree is are we providing guidance for someone to go build a tool that would be independently developed.

ONC believes, and I think, I don't know who from ONC is online, maybe Mike Lipinski or somebody, but a lot of the belief of the Open CHPL is to provide information that could be used by independent parties from ONC, from the vendors to be able to construct evaluative comparative frameworks, which is why I thought it important to have them talk about, and I think they're going to do it in January, talk about what is in that data set that's available to the Open CHPL.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

This is Dawn and yeah, the hope is that we can have somebody from our Standards Group come and present in January to help inform that.

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

Yeah and I found it very helpful or thoughtful to reflect on the fact that the intent of the Open CHPL is, in part at least, to make information available that third parties could use to potentially construct evaluative frameworks to compare the vendors. So, that will be helpful. I think the more that a framework can be built that's not, strictly speaking, reliant on representations directly made from vendors unvetted, the better off it's going to be.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So John, is that a comment that applies sort of globally, specifically to this practice management financial system integration category?

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

I think it's a global comment and certainly is applicable to here.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, yeah.

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

That may be hard to achieve, but that raises the importance of data sources like the Open CHPL or things that are part of public test reports the vendors have had to...are obligated to make available that are public and leveraging the disclosures that they make, that they're required to make by regulation, which are going to be a little more in a better class of reliability I think that some other information might be that's not specifically challenged.

I don't mean to at all denigrate to say pure marketing information, but when they're statements that vendors are making in response to regulatory requirements I think they're going to be able to be held up to scrutiny and they're going to be taken perhaps with more veracity. Or if that's not true, there's greater consequence to the vendor that could jeopardize the certified status of their product if they're not living up to the disclosure requirements. So as a source of data, general principle is that might be something that is of greater value.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So I think one of the kinds of global comment that we may want to take into account is assuring that the sources of data that are curated or encouraged by the federal government are consistent in some fashion. It would be a bad thing if Open CHPL had information in it that was in some ways inconsistent or different with what might be in these comparison frameworks. I don't know if there's a risk of that John, in what you're saying.

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

Yeah, I don't know. So much of it is new and I'm kind of looking ahead beyond what may be there to date, not to say what's there to date is bad, but given the 2015 Edition rulemaking on disclosures and surveillance and the Open CHPL, I think the potential is there for that to be a significant and valuable source of information and held a bit as gold standard.

So, you read the regulation in the disclosure sections and they may...and ONC does make statements that, you know as kind of the gold standard or master source, the authoritative source for information about certified products, the Open CHPL is set up to play that role because most of the information compiled on it has either been subject to the certification process, is available in the test reports and the attestations vendors make or is information that's been collected about the product, you know even out of surveillance activities, especially where any corrective action might have been involved. So, its information that is requi...that is collected based on requirement of regulation, not based on necessarily statements the vendors would make that you'd expect to see in marketing collateral the vendor would put out.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Makes sense. Are there any other comments in this box or shall we move to the next? Dawn, do you want to take us to the next one?

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

Sure. This is on...so; the next box is privacy and security. Part of this is pretty straightforward and would be easily available to reference what John was just talking about, the criteria that have been mapped into Open Data CHPL. But the other component that the role of our ONC folks felt very strongly about is especially considering that most of these to...this tool should probably be aimed at small practice providers is how easy is it to turn those privacy and security functions on in a system.

If you have to do a whole bunch of work to get it to set up or it's very complicated in some way, is that a good thing or a bad thing or should that...I guess I should rephrase, should that be included in the tool and how could that be included in the tool? Is it even feasible? So that's some of the thought behind that box.

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

This is Anita; again, I think that while this is straightforward there are really important components to this. One of the things that we saw, again for those small and medium practices on the ability for the staff to be kept up-to-date on privacy and security, it was the practices reminding the vendors that, “okay, for this year we need to do it again.” Things like that that I think that it’s not just again a simple yes or no, that there needs to just be a little bit more detail about the encryption, as I said how the staff gets trained or what it is that they have, currently have in place.

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

Anita, this is Liz; so I think your points are well taken. I think I struggled, when I saw this I struggled a little bit because I wasn’t sure whether this meant the capability of the application, the physical security that was put in place you know, that has to do with managing the application. If this is application...let’s just start there, is this application-specific?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think its module-specific maybe, Liz. This is Cris.

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

It’s what specific?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think maybe a better way to say it would be module-specific.

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

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Just...language...

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

Yeah that’s...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...CHERT.

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

That stuff is going to be certified Liz, so, you know.

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

John, was that you?

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

Yeah Liz, I was just ma...on privacy and security, the way it will be certified going forward with the 2015 program will be based on the scope of the module and whatever other criteria are...so, if you certified as things out of 173-15A which you'd consider most of your clinical...

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

Right.

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

...then you're subject to certain security requirements that go with that functionality. So that might mean, for example, I'm not trying to be completely accurate but I do recall it would include all of the authorization, user administration type of stuff, the auditing...

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

But yeah, yeah.

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

...reports.

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

Yeah, it requires all the HIPAA stuff.

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

So...

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

The reason I asked the question is if you say HIPAA stuff then I get it and plus everything else. But I'm also thinking when we say ease of use, I think it's the right thing to ask, I'm just not...it's kind of back to where we were talking about some of these other categories, how to balance ease of use against complexity, blah, blah, blah.

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

Yeah, you know ease of use, maybe I'll say it a different way; the vendor is to make statements about, and I'm trying to remember if these would be things that would be publically available, but if it's not an endemic part of their product meaning, like for us with Millennium you well know our authorization security is core to the system.

But if there were reliance on a third party product to do say user authentication because the product uses external directory services, part of the certification is for the vendor to reveal any of that. And so it might go into more a question of configuration if it's got a lot of reliance on third party components. That's not good or bad, but it might be more complex than what an unsophisticated buyer or smaller provider could take on than somebody who is doing that more extensively. Or to be aware of the degree of which there's reliance on the vendor to provide services for hosting management and a lot of technical security may fall to the vendor's remote hosting and it's not something that...in that case, maybe the small providers going good, I don't have to worry about encryption the vendor's storage system is going to deal with it on the enterprise storage that they use for the hosting environment.

So maybe it's more like things that you'd want to know based on the kind of provider you are whether you would really want to take those on. They add to your full cost of ownership to have to contend with them.

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

Yeah, so we're on the same page. I think Anita's right, I think this is a very difficult area, particularly for small entities, whether it be a hospital or a physician office, but it's...and it's often very confusing because if the case is not found within the, I mean, you know, you may name somebody as Security Officer in a small, very small hospital or very small practice, but they're not cybersecurity experts generally speaking.

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

Right.

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

So this is...

M

Yeah, this is, go ahead.

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

This is Steve. I was just going to comment that obviously this is an enormously important area but it's also an area where I think we could very quickly get tangled up in the weeds. And so the...when I think about having a comparison framework for certified technology for EHRs that would be useful to physician purchasers and users, think about docs being infuriated by cumbersome user interfaces, things that don't generate reports that make compliance with auditing easy and effortless, maybe not effortless but really easy. Things that have an upfront reasonably well know cost of ownerships rather than something that expands substantially after the initial purchase price is paid. You know, things where if they do decide they're going to change to another vendor they can get their data and they can take their data to another vendor in a usable format and form without having to essentially start over from scratch.

So those are the kind of things, I could rattle off more but that seem to me like an end user purchaser, you know the quality measures, you've got to comply with that. It's just testing that they could do one is of no value, it has to be they have a robust portfolio and support all the quality measures, all the e-Quality measures so that you can pick from whatever is currently in that years portfolio from the government through your tool.

So, those are the kind of things I don't think that this comparison framework is going to even scratch the surface on something like privacy and security. And when I say that, I don't mean to say that there shouldn't be perhaps some element or criterion that's addressed in this, but I would not...I think if we try to go too much into the detail here on that topic, we're just...we'll have a difficult time leveling the other ones as well.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Fair point, Steve; very fair. Any other comments on privacy and security?

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

This is Joe Wivoda again. I would...I'd like to reiterate the, you know we talk a lot about the privacy and security stuff and the ease of use portion under privacy and security, it really has to talk about how easy or difficult it is, and I don't know how you measure that, to be able to do periodic auditing because that is a weakness in many, many systems right now. And they all have to be able to do it, they all can do it and some vendors it's very difficult, some it's very easy. So, I would echo that, let's keep that in mind as we move forward on that. And I don't know how you measure it, but that is something we have to be aware of.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Fair point. Any other comments or should we go on to a really easy topic like usability?

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

Ha, ha.

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

So...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Gotta get your comments in here every now and again. All right, I think we should plunge into usability; this will be nothing but fun. Dawn, same...about ONCs thoughts about usability.

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

So usability for the purposes of the comparison framework actually expands the typical ONC definition of usability for the context of patient safety to usability for patient safety as well as workflow because as Steve just noted, usability is, you know how aggravating is it? Or the user interface, is that acceptable to the provider, is it causing more work than not? That's what we hear a lot about how frustrated the providers are getting with their products. So we felt like even though this is not part of the certified portion of the technology, it is a big component of being able to select the right technology for the provider. And so yeah, I think I'll stop there and open up the floodgates.

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

This is Chris...

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

Well, this is Dave; as Dawn and Steve said ability to integrate with clinical workflow, not get in your way and present usable clinical decision support to make you a better rather than a worse doctor is certainly in the top three of the practicing physician concerns. The thing that I worried about on reading this is it talks about user reviews and sort of in the small Midwestern world I live in, doctors are at this point kind of overwhelmed trying to keep up with explosive knowledge growth in their specialties, take good care of their patients, cope with four different regulatory programs and not go bankrupt as we're making the transition from fee-for-service to advance payment models and we're kind of suspended now somewhere in the middle.

And they're just overwhelmed and kind of run down and so the question is, how are we going to get enough users to write at a granular enough level that will have a statistically diverse universe of information and your people using the tool don't want to scroll through 100 reviews. There are ways to take this kind of ethnographic data and draw common themes out of it, but that's going to be a tremendous amount of work to try to process it, even if we can get our docs to write it. I don't have good answers to those questions but that's sort of what popped up in my brain when I read it.

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

So this is Steve and I guess, I think I want to give a useful example here, but I don't want it to be too strained of an example. So I can think of all sorts of clinical scenarios but let me take a really current one.

So, everyone on this call knows we transitioned to ICD-10 on October 1 and all the certified vendors will say that we can code in ICD-10 and we are ready for that and it was only the doctors who said we weren't...it was going to be hard; so, or that it was going to draw on us. So we're now two months into this transition and the large enterprise vendor that is at one of the hospitals I have took two discrete workflows that...the selection of a diagnosis and eliminated all the quick picks so that now you have to manually type in every single diagnosis you want to search for, and then it gives you an overly generic option which then the tool that's supposed to help you specify it is so cumbersome nobody uses it so we all then just dictate or free text type in diagnoses. So now essentially none of that's structured data because it's too cumbersome to use so it's all free text now.

And then when we used to have structured data diagnoses, there was actually a code assigned, it would suggest patient education sheets that were relevant to those discharge diagnoses. They disabled all those crosswalks and so now we get a search box and if you come in with a sprained ankle and a broken arm and a laceration because you had an injury and there are three different things we want to educate you on, we have to search ankle sprain, laceration arm, we have to search all that manually.

So somehow, if comparison frame or tool like we're talking about on this task force is going to be useful to anybody who would we want to benefit from it, we have to get...it has to be able to meaningfully convey not does someone say that "yes, our software does this; it allows you to pick a diagnosis, it allows you to search for diagnoses, it allows you to provide patient education." But does it do it in any way that is in any semblance of helpful, efficient, usable because I could see how some...the vendor I'm thinking of could answer all these questions in good faith, "yes, we do all those things." But, I don't know a single person using this particular vendor who wouldn't happily, well I'll be polite and say throw darts at the vendor, you know for the disruption that that has caused with no end in sight and no apparent announcement of corrective action being taken.

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

This is Anita, I couldn't agree with you more on that perspective. One of the things is, and I don't know how we get to it is this function...is the functionality available now and is then getting into, does it fit within the practice's current workflow or are there impacts that are going to represent major changes, such as what you just said; now having to type in which adds, you know every minute that you're adding to a visit is backing the day up more and more.

So I don't know how you get to those kinds of questions, but those are the things that have to absolutely be in there to understand it because the vendors can all answer yes to many of the items, it's just what is the pain going to be to that hospital or practice to do it. And we heard that with ICD-10 that yes, yes, yes but the functionality of course was not available when many folks were going through it and they're now realizing the inordinate pain that goes along with it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, this is Cris. Again we're coming up with recommendations about what ONC ought to do to recommend the creation of buyer guides in this very complicated space. So, maybe this is over-ambitious but I'm trying to think about the, what are the paragraph of word of wisdom that we can provide to ONC as opposed to, you know necessarily taking it upon ourselves to design the whole thing, as it were.

So, what...is there a way that we can think about a minimum set of guidance or principles around usability that are most important to purchasers and are most actionable by vendors? I think that's kind of the challenge we want to lay out for ourselves. Can anybody improve on that sort of general statement?

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

I think that...this is Joe Wivoda again. I think that's really good and are we trying to reinvent the wheel? Wasn't there a Usability Workgroup; did they have any recommendations that came out that we can kind of lean on or go start with?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Great point, Joe. Michelle...

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

So we had, we had an Implementation, Usability and Safety Workgroup on the policy side. They did some work early on and they responded to some of the NPRMs, but they haven't met since. There is talk at ONC to think through a possible task force, so that may be happening, but in the meantime, I'm not sure if there's much work that we can lean on.

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

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well also Michelle, wasn't there an attempt to try to have usability as a certification measure? There was discussion of that leading into Stage 2. Is anything there worth harvesting or am I mis-remembering completely?

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

No, you're not mis-remembering; the certification rule isn't my area of expertise but I know there is something on usability in there but don't ask me exactly what it is...

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

This is...

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

Dawn might know better than me and I should have lean on somebody...ONC; sorry John.

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

Yeah, no that's all right. Cris, there was and there is...so the focus of it was on vendors conducting some of the testing was the main emphasis of it, meaning on the release that they intended to...they have the opportunity, I believe at least to do that on the release that they were representing to their certified product and not on interim releases leading up to it necessarily because we had to have consistency there.

But the focus of the test was on vendors selecting representative panels of end users, mainly clinical end users out of their client base to help provide feedback on the usability of the features of it. In 2014 CHERT there were about, I think 8 or 10 criteria; the list is more like about 15 or even more for 2015 certification. The approach remains pretty much the same; the vendor has the opportunity to identify their standard basis for how they will do that testing and it's focusing particularly on safety-related features as to what criteria got selected and the way the feedback is to be oriented. And there's a fair amount of information in both the 2014 and 15 rules and test procedures on how that was conducted, but it was vendor directed.

So the vendors had to provide a report out on their methodology for conducting the usability testing and publish a report of the results of the usability testing. And it didn't necessarily compel, it was a report out, it wasn't quite like a scorecard or a report card on the usability it was a report on the findings and then the vendor response to the findings. So it didn't necessarily compel the vendors to do particular things or attain particular levels of satisfaction. It established parameters for how big the user panel needed to be and relative composition of it so that it held relevance and it had to be representative of the kinds of providers or organizations that would be typical of the client base of that vendor, things of that nature.

So the report I believe is supposed to be a part of the Open CHPL and I think that it was supposed to be part of what, at least a summation of it in some form, part of the test report from 2014 certification although I think that's been inconsistent as to whether or not that's really been included in the public test reports. But for 2015, I believe that's intended to be part of the Open CHPL so that would be one of the sources of information...to draw on.

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

Yeah hi, this is Dave. Those are part of the Open CHPL and I've tried to read a couple of them and they're absolutely incomprehensible to the average provider.

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

Right, yeah, this is Anita...

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

Again that's vendor...its vendor directed.

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

...that's...it took getting down to the practicalities of being able, you know if you don't have a CIO to interpret it for you or someone who is really, really up-to-date and well read on this it's almost just like words on a page. I guess I, and maybe I just oversimplify it when I think of usability I think of the ease of use; did it perform intuitively and with ease and the impact to workflow and the cost considerations for, do I have to have additional hardware in order to do this module or this EHR? What's the ongoing maintenance that's going to be required? And does the functionality work?

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

So this is Steve; so on this point here's where, and I know we haven't talked about witnesses and stuff but here's where when we have our hearing part of this...our work, I actually think asking some people who do usability work and who do human factors research offer their thoughts on are there ways to do high-yield, lower effort you know, survey tools or identify a really high impact criterion that they'd get a good glimpse into what we're trying to capture here without trying to boil the ocean. And so I don't honestly, I can postulate things, but I'd actually rather have people who have devoted their life of study to the topic, offer some suggestions and see if they're able to be helpful in that regard.

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

This is Joe Wivoda again. What we're really talking about is how do we measure usability and I looked, a simple Google search of measuring usability EHR showed me an AHRQ report on usability that lists a series of different usability tests that have been developed over years for computer systems. And maybe that's a start, to say that that article should be revisited and those tests should be considered as part of the usability and along with, you know customer reviews and the like as well.

But that's what we're really, you know, I have a hard time wrapping my head around how do you measure usability? I can think about how to measure usability for a specific task, but generalizing usability to me seems hard so, maybe this AHRQ report is something that we should look at and consider when we think about usability and how to measure it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Makes sense. Does anyone happen to know how usability is reported today in some other advisory, you know existing capabilities? I'm thinking about the typical kinds of one. Does anyone know how usability is reported today?

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

I will venture to go to the landscape that Wiley Coyote does when he walks off a cliff and standing there in thin air...this is John. I...most of it...the things that I can speak to are what we do and we do try to do panels that are mostly going to be driven in one of two ways, and these are of client personnel as well as some people that work in the...that have the clinical background to do so that admittedly are also internal.

So they will do structured workflows that are scripted that are deliberately designed to expose new features, end user interfaces, things like that to get their feedback on ease of use looking at metrics like number of clicks, elapsed time to complete a task, things like that and then also general impressions of the ease of use. And that's a lot of what is done through the development process.

And then, I don't know, I think for the most of what else I hear about are going to be more survey driven that are not necessarily in context of, "I've got the application in front of me, I'm using it;" and that might be more independent evaluations that are done of kind of aptitude and attitude surveys, both done by vendors like KLOSS or KLAS when they focused on that as a topic or Gartner going out and doing more independent surveys. And I don't know that that involves a lot of observed, independent evaluation of someone sitting with the user and seeing them in use of the system; most of them I think are done by survey.

So I think what I don't know of a lot of things that aren't done by vendors, if you will, that or they're doing it for the sake of their own development needs for improving the look and feel of their products and the ease of use, that's done by independent entities involving coming in and conducting that kind of thing through direct observation or that sort of thing. I get the impression most of it is by survey, online, mail, other means.

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

Hi, this is Dave. It's summative, scenario-based usability testing is...there's a huge literature of it and it's also, there are standards for it from the National Institute of Standards and Technology, NIST 7742 and 7804 and 7804-1. But it's very labor intensive, it's very expensive; it's not the kind of thing you'd do for fun. The vendors do it because it helps them make a better product and there's a business case for being more competitive in the market.

But, I actually did one 15-person formal usability study at my hospital and it just took me hundreds of hours to get it together, recruit the participants, acquire the data and then interpret the data. And I finally made a presentation that I gave at the Human Factors and Ergonomics Society meeting so something came out of it, but it was very difficult and it's only the vendors at the moment have the resources to do that kind of thing.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah. Well Anita, what do you think, should we continue on this topic or move on to another one? We're...

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

I think we need to move on in the interest of time because we only have 15 more minutes of peoples' time.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Dawn do you want to take us to the next one or are there others that you would think would be of particular interest that we should comment on today?

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

I think...sorry, this is Dawn. From the boxes here I think the other one that might be good for the folks on the line to comment on is the interoperability services bucket. Now I know that folks had referred to this earlier; this is kind of a large thing, not surprising since it's from ONC but it includes not only connectivity to a HISP or an HIE, but includes e-Prescribing, any kind of interface connections that you have as well as the ability to connect to other EHRs.

And when we were talking about this bucket, we were thinking about not only can the technology do the connections but how easy is it to get those connections done and those kinds of things. Again, crossing the line between certified technology and how much do we get into the function and the ease of use and usability that we know that providers are asking for and whether that's even feasible.

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

And Dawn, this is Anita; so important but that other part that kind of overlaps with it then to for the interoperability services is the cost of doing that because right now these interfaces are very expensive for the small and medium practices.

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

Here, here and this is Dave. You know, in addition to the x number of thousand dollars per year per doc, the HIEs at least in my states are having trouble maintaining a business model and so they want it in their contracts the privilege of de-identifying our patient data and then throwing it into their big data analytics, which made us very uncomfortable. So it's not only the cost to the docs, it's a sustainable business model for the HIEs themselves.

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

Okay. So that's helpful. I don't know if there are any other buckets that folks want to particularly focus on; again, this is Dawn...

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

Well, thi...

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

...total cost of ownership has come up a couple of times and I know that's a big key element. And this is something that we're really struggling with is, it's definitely a request from providers to include, but how much do we include? Where do we draw the line? That's the other one that I think is a big...

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

So Dawn, this is Anita and I know, and I don't mean to be so vocal, it's just we hear it over and over again. The cost kind of goes into every category we've got. So for the total cost of ownership, I don't know if part of every category that we've got here if cost has got to be one of the considerations there if vendors don't otherwise feel like they can easily come up with a total cost of ownership.

But, we were just talking about the interoperability piece, being able to find out, okay, what is that cost going to be for someone to be able to get their lab interfaces, to be able to get radiology or what is the cost going to be to be able to actually participate in any of the HIE, HIOs? And that same cost is going to come into play for the patient engagement piece, for the population health management/quality improvement/APM.

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

This is Chris; would it make sense...the other Chris. Would it make sense that under this total cost that we have the costs of each additional thing or each additional piece that's required to meet Meaningful Use? Kind of what was said earlier is like well yeah, you have one cost but then if you have to do a...write an interface there's another cost, but you can't meet Meaningful Use without the interface. So basically drive the cost, the total cost around everything that's required to meet Meaningful Use, including interoperability, including data migration, you know including all of these other categories that are required in order to meet Meaningful Use.

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

This is John again. As part of the disclosure requirements, I know I sound like I keep going back to that but, it won't include amounts but vendors are...there's very much a more specific level of disclosure that's being asked for than was with 2014 certification. The regulation...particularity in it that then has kind of a reasonable main standard that somebody implementing, should they have known about this or if they had known about it, it would have fairly set their expectation and types of cost is getting significant emphasis on that.

So again, that might not get you all the way there as a data source, but it could help with this bucket. It would at least reveal the kinds of things, or it should if done properly, that would go with each...should go at the criteria level. The one thing that I'd say that we want to be real careful about here though is, there are going to be some things that aren't going to be revealed by what it took relative to the certification.

The big wild card that I'm speaking of is going to be in the registry space for public health where there is no standard. It is, to me, a very open potential for fee-for-service programming, if you will, by vendors given that they may face a lot of different requirements to enable submission in means that are not based on a certification standard to professional society or specialty registries of various kinds that exist. I don't know that we know the impact of that yet, but I want to make sure that there's an accounting for that when we say, you know maybe that's in another bucket, but I don't see public health listed as one so I would tend to put it here or maybe in population health management.

But there's going to be a potential for unfortunately the kind of alleged nickel and diming for the sake of supporting registry submissions that plays out there as potential. I think we need to make sure we're accounting for things that may go beyond, strictly speaking, the certified capability when it comes to use requirements that exist for which there is no specific certification requirement. So somewhere that needs to factor in here.

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

So, this is Steve; if I can offer a couple of thoughts. One on the cost of ownership, I do think that this is an important part of it and I think that we should continue to explore how we can encapsulate this in a usable way.

As far as of these 12 items here, I would...recognizing there's value in all sorts of things, I would suggest just on looking at the words on the page, the boxes that say qual...the APM one and the accessibility one which I don't quite understand, that those two of the 12 boxes would be, at least on the top level, easy for me to just eliminate altogether because I think APMs, that's as specific as what you're personal arrangement is or what group you're in or what your efforts are. So I think those two things could just be dropped. We sound like we have more than enough to deal with, the boxes we've talked about already.

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

I caught APMs, what was the other one you thought we could drop, accessibility?

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

Accessibility, what does...I don't know what that means.

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

Yeah, agree.

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

So this is Dawn. There are criteria in the 2015 Standards Rule that identify...will allow a user to identify products that are accessible to individuals with disabilities. So if you have trouble seeing, maybe it might make the screen bigger or certain standards that will help with that and so that's accessibility and it would work for the patient engagement side as well as for the provider.

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

Got it.

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

Ah, these are the fun one...see, because no one can ever speak against these things without seeming somehow cold or insensitive. I just...I'm trying to think of how every user is going to need some of these other things and that is important, so I would not want my comments to be construed as any kind of insensitivity to that not being an important item. But I would say that should be a very minor item or I would still say could possibly go from this particular thing because the vendors, I think, should be motivated for the same reason I'm hesitant to even bring this up, they should be motivated to make sure their products are accessible and comply with the law or the regulations.

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

So this is Dawn and I think that brings up a very good point and something that I think this task force could definitely help us with is, starting to prioritize how...what you think in terms of these categories. Twelve is huge and probably not feasible, you're right; but if we can start prioritizing these and say these are the ones that absolutely have to happen, here are the crucial things within these that we think need to happen or a tool needs to include, that would help.

And so it sounds like you're starting to do that by identifying those and no offense taken at those, I mean, it's a valid point, all of them. And I think that's where that direction is a useful one to start heading in.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So we're almost out of time. This is a good conversation. We also...we have not gotten to our proposed panel question topic. Michelle, I'm going to ask if you have some thoughts about how we might want to organize our time here; I know we need to go to public comment.

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

We need public comment. We do have an administrative call later this week to talk about panelists.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

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

So I might suggest that we give everyone homework to review the panels that we've suggested and the questions that have been suggested and think through potential panelists and either send those names in advance of the administrative meeting or have those names prepared to talk about at the administrative meeting. Just based upon the time we have left I don't think we'll have any time to walk through any of that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Anita, does that work for you?

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

I agree, yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right, so homework for everyone is to read through these and provide some sort of feedback. The administrative call is what, the day after tomorrow I think, right? Is it on Thursday or...

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

Yes, it's on Thursday.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay. So I'd say if people have comments about that if they could provide them to Anita or me or Michelle prior to Thursday that would be great. Does that administrative meeting include everyone Michelle, sorry, just for clarification?

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

Yeah, so it's not a public call because we don't want to discuss people on a public call, so...but it is for all of them, the members of the task force.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Great, thanks, so we can all talk about it then. That sounds good.

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

Yup. Okay, so hearing nothing else, let's go to public comment.

Public Comment

Lonnie Moore – Virtual Meetings Specialist – Altarum Institute

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 telephone 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

It looks like we have no public comment so; we'll be in touch soon, on Thursday.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right, thanks everybody, good conversation today.

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

Thank you Cris and Anita.

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

Thank you.

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

Thank you.