

**HIT Policy Committee  
Meaningful Use Workgroup  
Transcript  
March 19, 2013**

**Presentation**

**Operator**

All lines are bridged Ms. Robertson.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you; good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup and Michelle, correct me if I'm wrong, is this for the deeming part only or is this for the full workgroup?

**Michelle Consolazio Nelson – Office of the National Coordinator**

We invited the full workgroup but we're focusing on deeming today.

**MacKenzie Robertson – Office of the National Coordinator**

Okay, so, I'll just do the full Workgroup roll call then. This is a public call, there is time for public comment on the agenda and the call is also being recorded so please make sure you identify yourself when speaking. I'll now go through the roll call. Paul Tang?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Paul. George Hripcsak?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, George. David Bates? Christine Bechtel?

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

I'm here.

**MacKenzie Robertson – Office of the National Coordinator**

Neil Calman? Oh, great, thanks, Christine. Neil Calman? Art Davidson?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Art. Marty Fattig? Leslie Kelly Hall?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Leslie. David Lansky?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, David. Deven McGraw?

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Deven. Latanya Sweeney? Charlene Underwood?

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Charlene. Amy Zimmerman? Tim Cromwell? Joe Francis? Yael Harris? Greg Pace? And Rob Tagalicod? Okay, any ONC staff members on the line?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Michelle Consolazio Nelson.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Michelle and with that I'll turn the agenda back to you Paul.

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

Great, thank you everyone for participating. We're going to pick up where we left off on the deeming Subgroup and I think the full Workgroup was joining us last call and in the meantime what I did was take all the excellent feedback we had from the last call and try to put it together, sort of reassemble the deeming, a deeming proposal for your consumption and feedback, and comments today.

Let me see, I haven't joined the web so I'm going off my own slides right now. Let's go to the one, the second slide where it says deeming and demonstrate high performance. So, the thought was – I have to get back to my ... and I'm going to try to ... slight pause here. So, remember that the whole principal behind deeming is that we would, we're making this transition between Stages 1 and 2 where we had a forced march in bringing everybody up to speed in terms of having a very capable EHR and PHR, HIT support of high quality care and we're moving into the outcomes oriented stage of Stage 3.

And this is a good time for us to sort of switch gears into more of a reward good behavior and part of the reason is by Stage 3 virtually everyone is now into continuing their progress but we're in the penalty phase instead of the front end incentive phase for most people and so we want to sort of transition from putting in and meaningfully using HIT over towards making good use of them in the new reformed world and counting on the pull from the payers side, from CMS for example, as we move from fee for service into models similar to Accountable Care Organizations.

So, you're responsible for a whole population and your job is to use these tools to do an excellent job from a quality and a cost point-of-view that's the Triple A, better for their health, better care and affordable cost.

So, the notion then in deeming is to take folks, provide folks with an alternative pathway to working on more of the process oriented measures that we had in Stage 1 and Stage 2 and say that if you are in the top, we don't know what percent that's for CMS to decide in this case, but I just threw out as a straw man, let's say the top 30<sup>th</sup> percentile or improved your performance and again, just as a straw person saying, let's say the gap between full performance the top 30<sup>th</sup> percentile and where you are currently, if you reduce that gap by some number, some percent and I just threw out the 20 percent reduction of that gap, that would be demonstrated improved performance. So, that is sort of setting a bar. Remember this is an alternative you can still go back to the staged qualification criteria that we've been using, but this is an alternative for people who are high performers.

So, trying to put together the feedback we had from last time created, sort of, created four, I thought there were five, created four criteria sets. So, one would say let's work on prevention of high priority diseases or health conditions and pick two of the following and again these are just examples, but let's say mammography screening to prevent breast cancer or at least early detection and treatment, same thing with colon cancer screening, influenza, prevention of influenza or pneumonia, dealing with smoking, this is along the Million Hearts, the cardiovascular diseases, so dealing with obesity, cardiovascular disease, polio screening and hypertension so that's blood pressure screen and follow-up. So, these topics are things where we having existing quality measures. We may want to – we are awaiting the de novo eMeasures that hopefully will appear by Stage 3, but it's these topic areas.

The second bundle in a sense would be control of, so that's much more outcomes oriented not just the process measures but control of high priority chronic health conditions that the Secretary has identified through National Quality Strategies and through some of these campaigns like Million Hearts. So, as an example control of hypertension, control of diabetes, prevention of heart attacks, control of asthma, control of heart failure and prevention of repeat heart attacks.

The third area is one of the areas that we've identified as something we want to move towards or focus our attention on and that's care coordination. The only thing that we have at our disposal right now, more things may be coming down the pike, is to close the referral loop and we know how important that is both from a primary care provider point-of-view and from the specialist so that's the one measure that we think addresses care coordination at least that we have right now.

And the fourth is disparities, another focal area that we've identified in the past and here, I'm not trying to create a new thing, but say pick something from number one and two, bundles one and two, and report on that according to disparity variables, so that's taking advantage of the disparity variables that we've captured in Stages 1 and 2, and now reporting on that, pick the ones that are important to your organization and be able to report on that. So, that's a way of trying to capture some of the discussion we had from last time.

If we go to the next slide, please?

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

Paul, can I ask a question?

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

Yeah, absolutely.

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

This is Art; can you go back to the other slide please? So, I'm not sure of the numbering here, it's got 1 and then it goes a, b and c.

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

Yes.

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

Would you do a bit of each of these four things or would you just do one of these four things?

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

So, you would do all four.

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

Okay.

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

So, you would pick two from one, pick two from two, do three and then four is pick some two high priority conditions from number one and two and report on them according the disparity variables.

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

Okay.

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

So, you would do all four in a sense.

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

Right, okay.

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

Paul, this is Leslie, I have another question – under care coordination one of the things we talked about was advance directives as another opportunity and I was not sure if that was discussed on last Friday's meeting, but a high performing organization in care coordination would be passing advance directives from organization to organization as an example.

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

Yeah, Leslie, why don't we come back to that, so these are, as I said, are examples so it doesn't say there isn't something more or there can't be different ones, but that's sort of the thought.

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

Thank you.

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

Hey, Paul, it's Christine, just to clarify, I think though that you were assuming that all of the functionality that we've agreed on from Stage, you know, 2 and 3, even the draft would still be certified so that systems would still be certified so the systems would still be developing new capabilities like for population health dashboard or whatever, but that if you choose this pathway you don't have to attest to them individually but those functions are still part of certification, right?

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

That's exactly right. So, in a sense everything that our normal pathway stays the same and this is layered on top of it. Now it stays the same module the things that we were talking about in the Consolidation Workgroup but your statement is correct.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Paul, it's David, I have a question also?

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

Yes?

**David Lansky, MD – President & Chief Executive Officer – Pacific Business Group on Health**

How much gets deemed? Is this to deem that you would have been a satisfactory meaningful user in Stage 3 let's say or PRQS or other federal programs?

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

Okay, thank you for introducing the next slide please. So, again, this is just an example and remember sort of the principle behind this is one, reward good behavior and two, give people the benefit of the doubt, people have already been with this four-to-five years in Stage 1 and Stage 2, they've put in EHRs and PHRs that meets the certification criteria, as Christine pointed out, and they've been using it and meeting the – let me just label them as process measures, they aren't all process measures, but sort of the EHR process measures to date, and we saw, based on our last meeting at the Policy Committee and all the ones before, the reports before, that people really blow by, we say, we might set a 10 percent threshold or a 30 percent threshold but people are in the 90 percent threshold. So, as we had expected and anticipated, once you turn something on there's really no reason to stop at a threshold they just go right through.

The other encouraging point is some people are now in their third year of reporting like hospitals and they are maintaining that very high accomplishment. So, we know that they just turn it on, make full use of the EHR and they maintain that throughout the stages, so those are all good things and I think we can count on that. So, one of the principles or the philosophy here is to give people the benefit of the doubt and really to deem as much as makes sense that if they are accomplishing – they're a high achiever by the slide, by the criteria that was in the previous slide then they probably are and that's the word "probably are" using, effectively using the following things.

So, we have demographics in place, they're recording it, they're taking advantage of it in the reports, they're doing CPOE supported by clinical decision support, transmitting and ordering medications, the CDS is taking advantage of the structured labs, they're able to report on patient lists by various parameters, they send patient's reminder because half of their job – you know, it's one thing to say, "Let's make sure the clinicians order certain things," the other half of the equation is patients need to be following through with those, so one of the useful tools are reminders.

You're taking electronic notes in your record, tracking tests to make sure as sort of part of the outreach. You are giving them a clinical summary, providing patient's health issue, specific patient education, they are engaging with you in VDT and communicating with you through secure patient messaging, and that you are maintaining up-to-date problems, medications and allergies.

And again, so we're not saying we can guarantee that each one of these are being used effectively but if you are in the top 30<sup>th</sup> percentile as an example on prevention and on control of high priority health conditions chances are, a really good chance that you're using all of these functionalities. So, that's just a, just a straw list for your discussions.

So, we have Part 1 which is the things that you would have to be a high performer on and as you all know in compounded measures, that is you have to fill all of the criteria it gets pretty rough even at that 70<sup>th</sup> percentile to fulfill all of them at the 70<sup>th</sup> percentile is pretty tough. So, once you're performing at that level you're probably making pretty effective use of this tool. So, that's the principle, the straw man. Open for discussion, questions and comments?

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

Well, Paul, it's Christine, you know, maybe while people are absorbing, I like the fact that you've got to do one from each of the four categories or, you know, two in the first two.

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

Right.

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

But you have to do something in each category I think that's really, really important and that there is a, you know, a performance to mention it's not just reporting anymore, so, I do like that. And I think for the most part in terms of the list on what gets deemed I guess my first question is what doesn't get deemed?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

So, that's exactly, this is George, that's exactly – but maybe for a different reason, I was going to say the same thing. I'm thinking a few things don't get deemed. Christine, I think you're just making sure that we're not missing something.

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

Well, I'm trying to ... like I don't see ...

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

Yeah.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

For further deeming. I'm saying let's go even further and just think of the three things we really want to do and let those be the three that don't get deemed now I'm sure that won't work, because that will be too far, but that's the direction that I would head.

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

Well, I think mine is really first of all a question and then I do have a comment about not deeming.

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

Okay, so let me try to pick on both of those, so, George let's say the two or three things we're concentrating on health information exchange, patient engagement and care coordination might be three that are things that we continue to work on.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

And maybe immunizations.

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

And maybe immunizations. So, health information exchange primarily that's left out, the whole electronically transferring the summary of care that's not in here.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

View, download and transmit is not in here either; this is Deven.

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

Oh, it is actually.

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

Yes, it is.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Oh, see, okay.

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

Because, I'm making the claim.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Well, yeah, duh, it's right there, sorry.

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

Yeah. Making the claim that in order to be a good high performer you really have to be working with your patients; that's the claim I'm making. So, patient engagement, it does not have for example uploading information from the home and we know that that's an area where we still have a gap and we still have a gap in standards and so that isn't part of this deemed. The third piece was care coordination, that's the summary of care, and the fourth one you mentioned George was immunizations and you'll notice that's not on here either. So, it may pass that sort of high level test.

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

So, my one comment and Paul won't be surprised by this, I do have a strong concern about deeming view, download for two primary reasons, one, is, yes people have been using electronic health records for four or five years, but they have not been doing view, download for that long, that's brand new to Stage 2. And my, you know, concern about that is that it does take a while for patients to, you know, begin to really use it and use it in ways that create efficiencies for practices.

But, the other reason is that if you take, you know, there is a large segment of the population that will not have a high priority, a higher priority health condition period let alone one of the two that are chosen to be worked on under the deeming path, they won't need care coordination because they don't have, you know, lots of complex needs and so that puts them in the prevention piece and, you know, if you chose colon cancer and, you know, smoking then it's a fairly small subset or, you know, it's one subset of a population not even fairly small, but there's a huge part of the population that gets left out.

And I think one of the things we're seeing and I mentioned this on the last call is that because providers are understandably working very, very hard particularly in the ambulatory setting, where we're talking about here, they're really targeting their workflow change efforts to the specific populations that are covered under things like medical home where there are new payments, you know, pilots that they're participating in or whatever.

So, my concern is that with respect to view, download if you deem it but, you know, you're talking about the, you know, a large segment of your patient population that really doesn't fall into a category that would need to be engaged if you're focused on two screening issues and only two chronic conditions.

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

Well, I'll respond to you having put forth the straw man and then open it to other comments. So, I think a big part of the principle here is giving people the benefit of the doubt and in a sense when you're on a forced march you're probably going to do – I mean, there's a temptation to do the minimum that's being forced, that's one of the benefits of switching it from forced march to let's give you credit for doing well. So, all of a sudden you not only have the incentive you're being rewarded for doing well at whatever makes sense for you in your population.

So, I think, this is encouraging better behavior than the forced march and that's why I'm thinking – so, you say people will be left out they're only left out from the criteria point-of-view. I think when we switch this over to you decide what's important for your population I think we're allowing people to do what's best for their situation.

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

Right, but, Paul, I just want to say, let me make one clarification I'm not talking about, you know, saying that the deeming approach versus I think what you're describing which is the forced march, which I don't love the term, of the, you know, original meaningful use pathway that's not at all what I'm saying.

What I'm saying is view, download, transmit applies to everyone and we all know that culturally patient and family engagement we have a ways to go so it's not like for me patient reminders for example makes total ... or patient education makes sense deem in some ways because, you know, you really are focusing those efforts on, you know, the pieces that are related to performance.

But, view, download, transmit applies to everybody and it creates conveniences for everybody and there is a big network effect the more people are using it both on the provider side but also on the patient side. So, I just don't think...I think it's like progress notes, it's like opening up progress notes to patients that you described last time where you said we need to sort of get that out in the society or get that into our culture that's what I'm worried about with view, download. I think it's different, because of patient and family and engagement.

Now, when you say we don't want to deem, you know, we maybe want to have one thing in patient and family engagement that we don't deem and then you mentioned uploading home monitoring information I actually think there's a more natural connection there to the, you know, prevention and control of chronic conditions than anywhere else.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Yeah.

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

So, I'll be quiet but my vote is not to deem view, download.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Yeah, no I'd have to, this is Deven, I would have to agree with that, you know, absent evidence from Stage 2 that the requirements on VDT are being met and even surpassed, which would suggest to us that, you know, that the initial sort of requirement of that category with very specific thresholds actually worked and it took off and people recognized the gain. I think this is one where I'm not willing, absent better evidence, to take our foot off the gas.

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

This is Leslie and I totally agree.

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

Let me ... so; let me question your hesitation about VDT. So, one the most efficient way and the most effective way to qualify for the access that we had in Stage 1 and VDT in Stage 2 is to make it available to everyone because our thresholds were quite high. I think Stage 1 was 50 percent, right, for access or something? So, it's a very high percent, you know that they exceeded that. We can certainly make it conditional like if in Stage 2 we find people are at the 80-90 percentile or 80 or 90 percent for VDT then would that give you comfort? I mean, we can certainly make it conditional on that.

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

Well, Paul, this is Leslie, and I think transmit is new. So, even if I have the ability to view or download my record the ability to have that record sent to someone at my request is new and so by deeming VD and T we end up potentially losing the critical mass that we would get by keeping it in. So that is my concern. And VDT is for everyone as Christine said it's not just for the chronic condition patient and if deeming is saying that we deem that you're doing all these things for all patients because you can prove it in the high cost critical areas I think we miss opportunities where we're trying to get critical mass and this would be one of them.

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

Right, I guess, Paul, I think there's more risk in deeming it than not so I would suggest that the fall position be not to deem it unless there is some compelling evidence that we should later, because, you know, we did interviews with about a dozen providers, you know, last year where we talked to them because we really wanted to understand their experience with on-line access and we talked to a number who actually had failed in their implementation and a number who had succeeded.

And the ones who had failed they had really failed because it never got built into their workflow so they were able to like hang on and kind of keep offering it and keep the portal alive for a couple of years, but it never really got integrated and it took them some time, the ones who succeeded, it took them time to figure out how to get it into their workflow use it in a way that creates efficiencies and it took patients time to have a need to get on.

So, the two year issue is just too short of a time for me to feel like given what a policy priority engagement is and how this particular type of engagement is not only applicable but it's very, very powerful when you get information into people's hands, this is the one that I just wouldn't deem.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

So, one other option, Paul – this is Deven – is to switch the default on ...

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

Exactly.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

To say we're going to leave it out absent compelling evidence that it in fact really took hold.

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

Great, that seems like a fair compromise. What about other people's thoughts on this topic?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

I didn't understand the last proposal. You mean we do...say it again?

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

I was proposing that it come off of this list, but with a note that we will take a look at the experience in Stage 2 and, you know, if there's evidence that in fact that VDT really took off such that we can be more confident that adding it to the deeming list is not going to mean that it goes away.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Okay, so that sounds fine to me, this is George, I would add almost everything else too that's not already on there to be honest but VDT is okay for me to be off as the one that represents patient engagement, one to represent care coordination and one for immunizations and most other things get deemed that aren't on the list. I'm not sure just because they're new in Stage 3 that they absolutely cannot be deemed, but I'm fine with VDT being the one we focus on.

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

So, what else would you add, George?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

I'd have to – let me pull up all our – let me see if I can get to ...

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

Well, in care coordination ...

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Everything that's not, I mean, all of quality.

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

Yeah, but George in care coordination you've got medication reconciliation, you've got the care summary, referral received already on the deeming list.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

I have to get the list of the non-deemed, but I'm saying that nothing is sacred, it's just an idea.

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

Yeah, no.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

That by this time if you achieve high quality you don't have to do Meaningful Use to avoid the penalties accept for these end areas that we really want to push on right now and they are, you know, patient engagement, care quality and immunizations.

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

I don't see healthcare event notification on the list which is probably good.

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

It's probably good to leave it off or be on deemed? To deem or not deem?

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

Not deem.

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

What about ...

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

I would just pick a few things to focus on and I would deem everything even though we – I understand we have an agenda it's just an idea of a different way of looking at it that we're just going to really narrow down focus by the third stage, anyway that's just what I was thinking.

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

This is Leslie, and with regard to ADT alerts that's really not about managing the patient that's managing all patients that says, "Hey, I've got an alert, someone just admitted here," so I agree that that shouldn't be part of this deeming.

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

Does anybody remember the threshold for advance directives?

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

Well, it's just present or absent and it's the most popular menu item for hospitals.

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

So to date, I think they exceeded, way exceeded it as well?

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

Oh, yeah.

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

So, I'm wondering if that could be, at least for the existence, that could be deemed.

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

Yeah, the only challenge with that, because we went through this in the consolidation group is it is brand new for EPs.

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

Yeah.

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

And that's the question.

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

Okay and you didn't want to have different ... that's fair.

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

Right.

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

Paul, this is Art; I think I generally agree that VDT should not be on this list. I wonder whether secure patient messaging is really something that should stay on this list as well.

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

Well, I'll just point out from our experience once you open it up its – I mean, it's a done deal and both parties like it. There's a workflow issue around it at times, but I think once you start communicating you just find out what the efficiencies are and the convenience factors are so it didn't seem like it needed some other push, because both from Stage 2 and from how we're going to working in ACO world it just seems like it's a done deal and no brainer.

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

Just, you know, the logic that we just went through around VDT seems to be somewhat applicable the same sort of condition we have this new method, it involves a patient, I totally agree with you that once it gets going and the patient's engage no one is going to turn it off neither the patient nor the institution it's just that, as you said, the workflow and has that really been achieved and, you know, in Stage 2 will we get enough of a boost in that area and will we know enough going back to the way that Deven described it, set it to a default that it won't be included unless there's good evidence and when there is evidence we can put it in.

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

I agree, this is Leslie, because otherwise you're still focusing on deeming around a particular chronic disease and then the critical mass of people that could be benefitted are not encouraged through the process to communicate with, I agree with that.

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

The other option – it's Christine – I mean, I respect the fact that we want to try to deem as many items as possible here, but I absolutely share Art's concerns and Leslie's concerns for the same reasons. I think, you know, in my logic I was a little bit more comfortable but not all the way comfortable with deeming messaging because if we're not deeming view, download I assume that messaging will be in some ways part of that.

However, we – I think, Paul your experience at Palo Alto notwithstanding, I think there are a lot of examples that we hear pretty routinely where patients say "gosh, you know, I sent a secure message but they never replied" or "it took them 3 weeks" or whatever. So, you know, one possible idea would be to deem messaging but ask that the system automatically, which is can, generate a report that the provider sees about timeliness of response, because that's what I worry about.

I assume it's going to continue to be available on the portal and we're not deeming VDT, but you want to make sure that people are still using and benefitting from it. So, you might just go to a, we're going to assume you're using it but you need to report the average response time which is common I'm told across systems today that they can do that in an automated fashion. There's no performance requirement, but there's a reporting requirement.

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

So, I think it's just the philosophical approach. I think mandating turnaround times is pretty micro.

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

No, I'm not – again, I'm not saying we should mandate a turnaround time I'm saying that they should have eyes on it that that would be one way you could deem it, otherwise, I do share the concerns that Art and Leslie are describing.

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

Well, I think there's a lot of forces at play for providers and the patient satisfaction is one of those and if in the cases you site if you write something and nobody answers you for days they're not going to like that, it's just not good for anybody. And, so that, I think, once you have this facility it's just like having the telephone system you don't mandate the report people figure out that if they want to have high patient satisfaction they can't ignore messages, they can't ignore phone calls so on and so forth and that's what I'm – I mean this balance between how much you mandate the use of a tool versus how much in this stage particularly you look towards the outcomes. Other people's thoughts on sort of ...

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Paul, its David.

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

Yeah?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

I've got a bunch of thoughts and I don't want to throw them all out at once but I'll just kind of react generally. I think the overall structure and concept is right. I think accepting a few areas makes sense. I like George's general premise that we deem everything except, you know, the areas that are needing attention, but I also think the countervailing requirement is as the standards for what those levels of improvement or outcomes are become higher the more encompassing the deeming and I think the current list is a good start, but it won't be robust enough to capture the domains that we would want to assure ourselves that people are actually executing on.

So, I'm wondering about a couple of things that might address that, one is how, you know, thinking about this, how have you thought about specialists versus primary care and we've got now more than half I think are specialists that are going to have fairly narrow practice scope and what they would pick as measures to satisfy the requirements might look different than what's on this list and they might under perform on some of the deemed attributes because of that unless the measure selection is very elegant.

And, I know you're going to come to CAHPS issue but I'm also wondering to you get at some of the issues that Christine and Deven, and others raised if there is a way to utilize a patient rating of service quality or access or availability as a means, very similar to the way we you'd rate chronic disease performance with any of those measures you would rate patient engagement performance based on the patient's own rating. So, as we're moving toward an outcome-based metric the same would apply to the patient's involvement rather than a process metric.

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

Right, those are excellent comments, David, let me try to address them. So, one, I think after we finish this initial discussion I want to go to the questions we asked ourselves and specialists and hospitals are one of those, so we'd have to take different visors if we like this framework we would just work with this framework and say, well what makes sense in bundle one and two for specialists or for hospitals so that's still work to be done.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Okay.

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

The other one was the CAHPS and actually thanks for reminding me, that was an approach to be much more outcomes oriented, because really the patient's perspective on view, VDT, my access to information, my access to my care team is far more important in the end, it's far more outcomes oriented. So, that was another approach to deeming essentially the patient engagement part. I think that has a lot of merit and that would be something worth people worth commenting on.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Just one flag, a big problem with it is it's not at the individual provider level unless someone spends a lot of time and money, so we'd have to think about methodology.

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

Good point, very good point.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

The other functionality that was not on your list that I worry about is – there is a little tiny slice of clinical decision support implied by the reminders and the, you know, chronic care compliance stuff, but to satisfy a couple of measures is very different than robust implementation of clinical decision support and similarly the quality measurement production function, which George has mentioned in passing, I'd be concerned that the ability to sort of teach to the test to perform to the test to say, yeah, I can generate a quality measure for these two things that I'm using for deeming is dramatically different than the capability we're trying to inculcate of, you know, data mining, analytics, reporting improvement across a wide spectrum.

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

Fair point. I think the key answer to those two questions is the level of performance. So, I guess I would assert that if you are a high performer you probably couldn't escape using clinical decision support with some effectiveness, but that's up for discussion.

The other thing is the third, the top ... performing at the 70<sup>th</sup> percentile or better on multiple things is pretty tough, it obviously depends on what, the multiple things you choose, but it's like composite measures where you may start out in a composite diabetes measure, you might start out performing at the 5 or 15<sup>th</sup> percentile, so it's tough when you combine them all.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Actually, I was going to mention one other thing, Paul, which is implied in this, I think, is public reporting of performance and that would be very dramatic, a dramatic change and I would personally support it, but it would cause some discussion.

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

Yeah, that's correct that's why it's an alternative pathway and so that's the counter availing balance measure for how high you set the threshold. So it needs to be, if you set it too high then it becomes a bit of a double jeopardy situation, if you set it at a reasonable high and people agree, well, yes this is where I want to go anyway then we're trying to avoid it being a double jeopardy yet having people engage and buy into this is a good approach and the main thing is that this is a voluntary alternative pathway.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Well, the danger or at least what often happens in our last 10 years is once its public reporting and there are high stakes tied to it like avoiding penalties then it becomes subject to audits and gaming, and ...

**Paul Tang, MD, MS – Internist, VP & CMIO – Palo Alto Medical Foundation**

Yes.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Questions about who is participating and who is not and that would potentially be a parallel bureaucratic process we have to think through.

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

So, let's start with overall – so, one deeming, then two the framework sort of listed here and three get a little bit on some of the details and then we'll ask ourselves the questions that we laid out in our face-to-face meeting as a check of work to be done yet.

So, overall deeming, so I think some of David's questions point out, you know, raised the question some of the issues around deeming. So, with those issues in mind do we still think that deeming is a good pathway to have as an alternative to a meaningful use objective?

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Paul, this is Charlene, I just I wanted to support the deeming approach. A lot of the feedback that we got even in Stage 2 and this even takes it up a different level and I think maybe in a direction David was going is the more that we can integrate the initiatives that are driving payment reform and the new care models which means to do the potential to accelerate the industry change would seem to be higher so that whole thought process relative to the question about how do these fit in and align with the convergence of measures, the harmonization so that we can get them to line up sooner and faster would be a really positive step that we could take I think. So, I don't know what – I'm concerned that there is duplicate reporting and we're going to have to sort through that.

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

Right.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

You know, but if it can become more one in the same sooner that would be a huge step in the right direction and maybe that's too far of a reach for Stage 3 but I wouldn't want to preclude us from thinking about that.

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

Good comment. So, I think, you're saying deeming is a good – it in a sense accelerates the move towards the outcomes and your caution is that we certainly don't want to create extra work and CMS is the one that would pick these measures anyway.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Yes.

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

We'd want to make sure those are aligned, right?

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

And the effort by CMS and I know that Christine – you know, to align those measures we would like it to happen sooner and quicker so that we can actually do the reporting from the EHR and integrate the program sooner. So, again, I think this sets us in that direction, you know, and the vision is it could be that direction, but, you know, we might not get there by Stage 3.

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

Other people's comments on deeming or not deeming having a ...

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

This is Leslie and I really support the deeming ideas I just would like to make sure that when it's a critical mass and we benefit more by having more people participate in these things then we need to be mindful of that versus only a particular chronic condition or disease.

So, when something is very, very new I think it's more how do we get broad adoption and then when something matures its, hey we know, we can deem this as being done, because a good organization using advanced EHR use is using all of this functionality.

So, I just, I don't know what that tipping point is, but I'd hate to see us lose all of the patient engagement, patient convenience, care coordination things for the non-critical chronic areas because we've deemed it in the chronic care areas.

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

Other comments about deeming, presence or absence of a deeming option?

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Yeah, this is Deven, I mean, I absolutely think we need to continue to pursue this, you know, sort of mindful of keeping an eye on what the actual experience is in Stage 2 on some of the areas where we're really trying to push the community in a direction where there isn't a lot of activity like exchange of information among disparate providers and the patient engagement piece, but, you know, especially given that the amount of the dollar incentives is decreasing in Stage 3 and then out into the penalty phase and we had always sort of had the escalator approach where we anticipated, you know, sort of moving to reward of outcomes, I think this is the right step to take.

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

Okay, any other comments about deeming, not deeming?

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

This is Art, I'm in favor of deeming for all the reasons you mentioned earlier Paul I think just with a few exceptions to the current list. But, I'm totally in favor of the concept.

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

Yeah, it's Christine, likewise and I would echo exactly what Art and Deven said. I guess, I'm not completely – I don't think David articulated a show stopper or Paul in your mind. I mean, what are the – it would be – what I think would be helpful would be keep going down the path, you know, get some agreement about, you know, a proposal for what's deemed and not specifically and then, you know, move forward from there and figure out, well what are...are there other issues that we didn't think about that we need to, you know, for example take on outside of, you know, the criteria, but more the nature of the program changing, etcetera. I just, I guess I'm not tracking what the concern is that would stop us from considering the pathway at this point.

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

Well, let me turn back to David who raised legitimate concerns and say, would you favor continuing on working out the deeming given the issues that you raised?

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

And could you just say again what the kind of core issues were?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Yes, I'm in favor of proceeding. The issues to me are that the scope of the reporting measures be robust enough to capture significantly the meaningful use we're talking about in the various deemed categories and obviously, Paul, agreed that applies to the other specialists and hospitals conceptually as well. But there are then several content areas where I particularly have my radar tuned to that are like the clinical decision support and quality measure capability that could be sub-optimized if we have an outcomes list that is too thin or narrow. And that we try to capture the patient assessment of performance as a ... rather than trying to replicate the process measures for the patient's side.

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

Well, it's Christine; thank you, David, that was helpful and I agree and I do think that, you know, it's worth pursuing but it would be – I think, we have to really get down into detail and talk about which quality measures are – I mean, Paul, you've listed a bunch of areas on the list, but, you know, I think looking at the specific measures and then making sure, you know, we're talking about reporting those across the whole patient population not just Medicare or Medicaid for example, you know, and getting into those details would be really helpful.

And I think it's probably time to, in my opinion, move it off of a PowerPoint deck and really get it onto paper where we would articulate some of the details and nuances, and begin to look at the concerns that David's raised, which I think are right on, because, again knowing that this is one of two pathways that you could choose.

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

Okay, so let me move forward. So, I had enumerated a set of questions in increasing detail that we could move through in the discussion. So, it sounds like we have consensus about pursuing the deeming pathway as an alternate to the traditional Meaningful Use objective pathway.

Now the next question is let's say let me just call it the framework, if you look at those four criteria, now this is module what specialists and hospitals or even whether this covers primary care, but so, is this set up – and I tried to mirror the national quality strategy and the priorities so there is prevention, there is control of health conditions, there is care coordination and there are disparities, is that a good framework or is there something else that needs to be added or modified?

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Paul, would an alternative be – I know in terms of care coordination is one of the categories patients and families or in the – I know care coordination is, but is there another category in there that might touch on the concern that we have relative to patient engagement in the framework?

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

There could be.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

I forget the – Christine might know the domain, you know, right off the top, but ...

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

You mean are there patient engagement-related items in other areas?

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Well, I'm saying if we look at MAP and look the direction of the National Quality Strategy...

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

Oh.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

There is no – is there other – like Paul has these four domains, care coordination was one of those, but is there a family and patient engagement domain that's important? You know, we talk about healthy people and ...

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

Right, they're not great. I mean, they're not great because most people define patient engagement as self-management and so I think outcomes measures are more reflective of patient engagement, but it doesn't get to engagement. You can get to outcomes a lot of different ways, so it's kind of a tossup, but the short answer to your question is I don't think there are particularly good patient engagement measures that are ready.

There are some nascent shared decision making measures or measures of decision quality and things like that, but, not a lot. But I can, I mean, I'm happy to go looking and digging, and see what we can come up with some of them though will probably not be NQF endorsed, some of them would be, you know, we'll see.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Paul, I think, what happened to patient safety in this roster and appropriateness and resource use?

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

Okay, did we add that in ... if we do add that what would be a measure that would ...

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Part of this goes back to whether the list is so far optimized for primary care versus other context and how, you know, whether...are you thinking we just defer the question of non-primary care and we just have a discussion first about primary care or that we try to encompass both in one structure and scope of items?

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

Well, so the question right now is, is this framework suitable ...

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Right.

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

Across all ...

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Okay.

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

Leaving aside the details and it may or may not be.

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

Well, we need hospital though, right?

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

Yes, yes, yes.

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

Yeah.

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

So, that's the next level we get to. The first is – this the appropriate framework. So, what David just asked about is patient safety and efficiencies as other domains.

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

Yeah.

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

Now in some sense we also can't make this a recapitulation of quality measures because then we'll just be reinventing it.

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

Well, no, Paul, I had sent I think in early, you know, kind of a broader list of, you know, if you had some measures in each of these areas, I mean, if you're talking about performance I think, you know, we're not asking people to report every single measure there is we're saying you're doing really 4-5 and then you're stratifying 2 of them, that's not a heavy lift here I think.

So, the idea of performance being not just clinical but also, you know, resource use and efficiency is one that we've talked about for a long time and the Policy Committee has been behind. So, it may be that there are some combination of either a measure or there were some things that were, you know, sort of imaging results and formularies that might begin to get there on the functional criteria side. I don't know, David, how you feel about those?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Well, yeah, that's where my mind was going. I was going back to our original list of outcome domains that we've used for years and seeing whether, you know, in effect the population public health one is being captured by the prevention bucket and it's funny, because in a way the control of high priority conditions doesn't exactly fall into one of our old major five categories.

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

Well it does fold into the domain of quality strategy, right?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Yeah.

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

So, if we look at – in theory you can't control a chronic health condition if you're not coordinating.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Yes.

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

So, I mean, in some sense the care coordination sort of doesn't belong there you could almost use George's approach and say, well this closes the referral loop we just keep it in the objective and that's another "process measure." Really it's controlling health and care.

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

So, Paul, you're saying pull the referral loop out of the measure but don't deem it? Is that what you're saying?

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

Well, and don't deem it, basically, using George's rule it's something we're working on it stays as a process measure under meaningful use objectives but it isn't something you're measuring against for the purpose of deeming.

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

Right, I'm okay, I mean; it's just moving it from this slide to another one.

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

Yeah.

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

Okay.

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

Yeah or moving it back essentially not ...

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

Right.

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

Not saying that this is an “outcome measure” because it really isn’t it’s a process measure.

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

I agree with that and maybe it’s something, you know, I’m not sure, David, what you have in mind in terms of efficiency or resource use if it’s a functional approach like closing the referral loop is for care coordination or if it’s a quality measure and then, you know, the applicability of that measure across multiple provider types. Usually efficiency measures are more applicable than not.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Well, it goes back a little bit to the decision support instance, we take something like overuse of imaging if that’s supported by clinical decision support the – I’m trying to, you know, that’s a pretty crosscutting concept to a lot of practitioners, is there a way to pull that into our measurement framework or is there a category on this deeming, on this framework slide which would ultimately capture a measure like appropriate use of imaging.

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

Ideally there was something called total cost of care.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Okay.

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

And that would be much more of an outcome and then we would say, gosh if you do well on that you’re really doing a lot of things, one you even know what your costs are, two – you know what I’m saying?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Yes.

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

That is sort of the stuff we wanted to have on this list, just nervous about getting some of these granular things because then we’re just recapitulating the quality measures.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Right.

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

I mean, I suppose one possibility is to call out this efficiency domain and be asking for some measure that is yet to be developed that would capture it at a much higher level.

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

I don’t think we should pursue yet to be developed measures though I worry about that.

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

Yeah.

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

But overuse of imaging I think we do have a measure already on that, right David?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Well we have a low back imaging measure that’s widely used.

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

Oh, right.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

But that ...

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

Which doesn't make sense in terms of broad/broad applicability, but, so maybe it's, you know, we do have the imaging results in the functional criteria so maybe that's one thing that doesn't get deemed.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Well, I also wonder if we could go back to Paul's suggestion a few minutes ago of recognizing that individual specialties or groups, or settings will come up with their own proposals for what populates these categories but we don't yet have the whole list.

And if they had a category at a high level like appropriate use of diagnostic testing and we, for now, just said that's likely to be a category and the benefit of that is it implies the functional use of clinical decision support and then not yet presume to know what the measures will be in it although it raises the question of whether we...if we don't already know the measures will we have them in time for this process?

I'm somewhat in the same bucket on safety, if we have an outcome measure like medication errors or skipped measures for surgical complications or whatever it will be a fair amount of specialty specific granularity to that.

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

If David Bates is on the line and does he have any ideas as far as the patient safety and some kind of overarching measure?

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

Sure, I'm on line and I'm thinking about it.

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

Yeah, right.

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

But, I'm struggling.

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

Right.

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

I mean medication errors is, you know, is more of a process measure and things like the SCIP measures are good but they, as David just said, they only apply to specific areas, that being said, in principle I'm in favor of having something around safety, but I can't figure out ...

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

How to do it?

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

Yeah, exactly.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Well our goal is to know that meaningful users are making a dent in let's say adverse drug events by virtue of the capabilities of their technology and that is great, I think it's a great prototype of what we're talking about with the whole deeming strategy, if we could really, if we count adverse drug events that would subsume an awful lot of functional and process protectiveness of the technology.

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

Right, we don't really have a good approach for doing that. I mean, one, we do know kind of which pieces of decision support are especially important but to sort that out you really need to have the person take a post implementation test and I think that's kind of a compliment to this approach but I don't see how to make that part of what we're talking about now.

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

So, do we list it and say TBD, work to be done, or not list it because we don't have a suitable measure right now? This is both patient safety and efficiency.

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

Right. I mean, I was leaning towards not listing it but there's an advantage of having a placeholder too.

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

Yeah. Well, if we don't list it we can at least still have the footnote or the preamble about here's work to be done and that's part of our recommendation.

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

Yes.

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

Okay, so let me use that as a default for right now. I'm sure the Policy Committee members will have a conference on this as well. The next level of feedback request is now how do we deal – let's take the visors of primary care, specialty care and hospitals, can this framework, the same framework we use for all or do we need their own version of this framework? So, let's try primary care, does this even...do the enumerated subtopics work for primary care with tweaks? I tried to pick on the things, you know, Million Hearts, I tried to pick on the things that are already being used.

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

Yes, I think they do.

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

I think they do too.

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

Okay, so we sort of ... this works for primary care. So, let's take off that visor and put on the specialty, can we see picking appropriate topics under high priority, prevention of high priority disease in most specialties?

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

Can we take some examples of specific specialties that are eligible for meaningful use? Like ophthalmology? I don't know.

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

Well, let's take easy ones first so cardiac, cardiology and CV...I mean that's probably going to be well covered. Another common condition is diabetes so endocrinology we certainly have in the second one, but ... and obesity is part of the "prevention."

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

Pediatrics.

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

Pediatrics.

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

Have asthma, but maybe diabetes, I don't know.

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

Where it gets harder is if you go to say neurosurgery or ophthalmology.

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

Right.

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

Now GI is way up there in people who have qualified for meaningful use already, how would they fit in?

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

Well, they might, I mean, they might, I mean remember too they still have the other pathway.

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

Yes, that's right.

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

But, I think if we could have something that was an adaptation and maybe we ask, you know, for feedback on this, on, you know, do a blog or something that we've done before, you know, like a FACA Blog, but if there was a category of, you know, or an approach for the more specialized specialists if you will that might be really worth thinking through, because it would still be nice to have them really focusing on performance and still doing, you know, obviously there's more that they need to do around care coordination even if that came out maybe for specialty – I don't know if – you know, we've long debated the ability to create a specialist track, but, maybe there is something that we could actually preserve.

What about – so here's an interesting idea, I'm not sure if it's workable, but, what about if you said to people you either have to do number two of number three, right? So, you either have to, you know, something from prevention but then something from either the chronic conditions or care coordination and we made care coordination more robust and it may be a bunch of process stuff and functional stuff, but, you know, the care summary piece for example should get a lot better and easier with Direct, and let's not, you know, forget that I think it was about 80, no, I think it was about 2/3 of people deferred the care summary in Stage 1, no, I'm sorry 85 percent deferred care summary in Stage 1. So, it's, you know, in essence new for a lot of people in Stage 2.

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

Right, and care coordination actually applies to everybody it's nice in that regard.

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

Yeah.

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

But can we – are we measuring it in other ways than care summary?

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

What I'm saying is could we come up with, I mean, there aren't great care coordination measures but there are some, so, but I think there is probably a blend of some coordination measures and some processes like care summary and closing the referral loop because we just don't...as proxies for more robust measures, because we just don't have very good ones like at all.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

This is George, I agree with Christine. I don't think prevention applies to everybody first of all. I don't know how much prevention a neurosurgeon really does with their patients it depends on what disease they're seeing, but it may be that care coordination close the referral loop is for everybody and then there's a 5<sup>th</sup> category which is expanded care coordination, which is more extensive and applies to the specialist and that would let them drop off either number one or number two and I don't know if there are people who would need to drop off both number one and number two. It seems like we might have to add more measures to your list A through H and A through F known as B.

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

Or the ...

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

Thank you.

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

The other way to approach it George, what about, you know, or you're participating in a registry and you're doing care coordination and you're doing a registry, so ...

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Exactly, that's what I mean, so, we would expand care coordination and we would have to define what is that and it might be the referral loop, the summary and the registry might be it and that's the deeming thing that lets you drop either number one or number two. And the question now is: Is there anyone who has to drop both number one and number two?

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

Well, and if they do have to drop number one and number two are we comfortable with saying well then you probably should go with the first pathway which is the consolidated path.

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

Right. So, for number two the way to get on this list though even for specialist and this is where the limitation may occur is we want to only put the control not the process measures for number two and yes if you're specialty and part of it is self-fulfilling, in other words, specialty societies that have not advanced control outcome measures are going to have less to choose from and we may not be able to put them in the deeming pathway.

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

Yeah, I don't think everybody has to be in the deeming pathway. I agree with that.

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

Yeah.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Okay on your argument Paul then number two would be required but might need to be extended a little bit.

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

Correct.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Because you're also doing the QMs, but that would be number two, but number one I don't think prevention is a concern.

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

Correct.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

But you're saying that ...

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

But then you do the ...

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

The problem is that we may not want to deem so much if they don't do prevention even if it's not their fault.

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

No, I think you're – I thought – so everybody has to – you have to do two of them between one, two and three. So, if you're a specialist and you have specialty quality measures that are controlled or outcomes then you can pick two from there and you have to do something in care coordination, as you say, you expand it to registry and summary, and referral loop, and fortunately it's all still process measures, but you have to either pick from two or number three and if you cannot find two from one through three then you'll just have to go back to the usual pathway.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

That's a little more lax than – I was going go force everyone to do 1, 2 and the current 3 or drop 1 or 2 and do an expanded 3 and is that what you meant? I don't want to make it too complicated.

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

Yeah, it's a bit complicated, so, I guess I was saying if we could ...

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Just go two out of three.

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

Yeah.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

We could put close the referral loop.

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

Oh, here's an idea; sorry to interrupt.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Go ahead.

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

So, we do – so we drop 3 from the list instead of 1 you could substitute 3 then it's a little bit, a little bit simpler. So, from a primary care point-of-view you're doing 2 from 1, 2 from 2 and doing 4. From specialty you're doing 2 from 2 with an expanded set of available specialty measures that are controlled or outcomes and you may substitute – you could, as a cardiologist you're supposed to be participating for example in 1 prevention or you could substitute from an alternative list of 1 which is care coordination involving registries, summary of care and referral loop. I'm not sure the way I described it was less complex or more simple, but ...

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Paul here's – now that I'm looking at this, why do we have 3 and 4 instead of just leaving them objectives? Like if they're objectives and they're core then they have to close the referral loop so why don't we ... now that I'm stepping back ...

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

Yeah, yeah.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

We're kind of coming up with alternatives meaningful objectives.

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

Yeah, yeah.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

And really the deeming is really in 1 and 2. I understand why you added 3 and 4 but now that I think about it if close the referral loop remains a core functional objective that we don't deem for anything else then we're forcing it anyway.

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

Yeah, right.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

And if we change to stratify the population functional objectives so that its core and we don't deem it then we know everyone is going to do it no matter what and we only need 1 and 2.

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

So, this is Art; George are you saying that among the objectives would also be contribution to registries like ACOs or jurisdictional registries?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

We were, yeah, I mean, well, now I'm a little stumped because I've got to rethink the whole thing now that I just said what I said a moment ago, but two moments ago I was saying, yes we could include registry as an alternative as Paul suggested to number one. Like pick expanded care coordination as a onetime. So, either you do prevention or you do better care coordination and then you also do control, and then you do the others. But, now I'm looking at 3 and 4 and wondering how that helps me over just having functional objectives in the regular route.

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

Other reactions?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

The deeming part is 1 and 2.

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

Other reactions to what George said, which really is going back to the framework and saying whether that – do we just have essentially two domains, prevention and high priority chronic condition and have as many prevention measures that are in the NQF endorsed set and as many control or outcome measures for number two as in NQF and then you have to pick two of them in each.

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

Right, but once you pick two of them you then have to meet certain objectives under 1 and/or 2, right?

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

No, you would just have to be performing at the ...

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

One or two?

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

You would have to be performing, so if it's 2 out of 1 and 2 out of 2 you would have to be performing at the 70<sup>th</sup> percentile or better in all 4.

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

And the 70<sup>th</sup> percentile or better means what for contribution to registries?

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

No that's no longer in the picture.

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

So, the deeming would that mean that that is something that would not contribute to registries or they would still?

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

Really deeming is only about prevention or control of primary chronic health conditions and if you do well at those at all four of these things then you would be deemed the satisfaction of that list, the next list. Registries are just one of the tools you have to perform well.

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

So, is registries on this items deemed?

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

I think so, what do you think, George?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Say that again? Registries – are registries on this? Well, I was thinking, I was putting registries on, again, two moments ago, but then when I had the thought from one moment ago now it's not making so much sense. But, if we want registries as something that's important to have then we just don't deem it and it remains a functional objective. I mean, so maybe the point of deeming is to keep it at the things that really show outcomes either prevention outcomes or care outcomes. So, we don't end up ... because what I realized as we were talking two moments ago that we were suddenly creating a parallel set of functional objectives.

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

Yeah or quality measures.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

And quality measures, exactly.

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

Let me – so let me raise it back to the group essentially calling the question again about the framework. Do we want to change the framework to just being high performance and prevention or control of chronic health conditions?

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

I think control is really central, this is Christine. I mean, we promised better outcomes here, so that's the name of the stage.

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

So, would you agree to ...?

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

I also think though that it's in part because you can't get to them, that's part of the deeming for me is it gives us a lot more confidence or using things like decision support.

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

So, are you in agreement with George's proposal that we just have essentially category 1 and 2?

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

No, well, and plus disparities?

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

Well, no he's saying disparities we can require ... it's sort of required in the objectives, so ...

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

No, it's absolutely not. I mean, we have patient lists that's what we have.

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

Well, we ...

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

Do you mean in the functional objectives?

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

Yeah.

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

No, it's absolutely not, the quality measures aren't required to be reported by disparity variables. All you have in the list is very paltry it's the ... or in the functional criteria is the list/population health dashboards. There is no guarantee that anybody is actually looking at their health disparity data. So, I would not deem that at all and I'm not sure why we would worry about deeming it when it's just taking the same measure that you are reporting and stratifying it, it's not hard.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Well, what if – maybe we answered it, but we just say you have quality measures that's the Quality Measures Workgroup, if you achieve N percent on the quality measures that you've selected and they're doing all the work to make sure that specialist are engaged than that's the deeming and then we figure out which things to deem from there and not have a separate list.

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

Can you say that again?

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

I'm not sure I understood that.

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

Yeah, can you say that again?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Not create our own list of prevention and control but just say you have to – I mean, David Lansky, you have to perform a certain level on the quality measures half of the program, like, why didn't we go there first?

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

Because we're not ... because we're trying to get towards the outcomes and most of the measures are not outcomes so we're only giving credit for outcomes.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

David's – there anyway, right? I mean ...

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

I'm sorry?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

If we can do it he can do it.

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

What?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

I'm just saying that if the Quality Measure Program moves to outcomes why am I – it's because we want to be very specific – I think we started it because we wanted to be very specific about what outcome measures and make sure first of all that they're outcomes measures, B come up with a reasonable threshold but make sure they match, will crosswalk well to our functional objectives.

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

Yes.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

That's how we ended up here. What I'm saying is as we kind of make this more general and say, well we can deem a whole class of functional objectives, as we do less very specific cross walking then why are we duplicating the quality measure structure.

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

As opposed to what?

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

I think, we're doing two things, George, one is we are limiting, we're taking only a subset of quality measures that fit into evidence-based prevention and control of high priority chronic conditions and the second is we're actually having a performance threshold which is also different from the current program.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

This is David, I think where George is going makes sense to me that we end up at the same place coming from either starting point either starting by trying to identify a measure which captures some functional requirements we want to deem or starting with outcomes-based quality measures and saying which do which functional areas do these capture that we can now deem.

And if we went to the Quality Measures Committee and said, what do you have for Stage 3 in the area of outcomes that do capture more specialties or provider types we could also start from there and work back toward what is therefore deemable and basically bring the two strategies together.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Right.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Ending up with a better list of outcomes measures which give you, you know, a pass on a lot of the functional measures.

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

Okay, I'm not sure I understand the difference. Okay, so here's how I was thinking about it to come up with a straw man is take important health conditions and evidence-based interventions whether it's evidence of colonoscopy preventing colon cancer and etcetera or control of high priority conditions. So, in a sense it's a little bit like you said from the quality measures side only filtered by high priority conditions. Did I understand that correctly?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

Yeah, that made sense to me.

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

Okay.

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

But that filter is where we start losing some of the specialist.

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

Correct but then, so then we have to broaden the filter for the specialists because of the paucity of measures that fulfill the other criteria. So, I think, the bottom line from what George and David said is we just go towards to expanding, you know, cast a wider net but the filter conditions are the same, i.e., control or outcomes for the wider net and if we don't have enough quality measures that fit that capacity, that filter then unfortunately those specialists just wouldn't have this alternative pathway to take advantage of. Does that make sense?

**David Lansky, MD – Pacific Business Group on Health – President, Chief Executive Officer**

It does to me.

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

And where we agreed I think with care coordination is leave that back at the functional objective. Now disparities I think Christine's point is that there is no requirement to do reporting based on disparities, that's not to say we couldn't make that one of the requirements in the traditional program calling out as a separate thing under the deeming qualification doesn't necessarily, I mean, it sort of doesn't fit with the other two, which is George's point.

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

Well, I don't understand why it wouldn't fit in deeming if you're reporting performance why wouldn't you also be reporting performance among the, you know, by let's say the, you know, top 5 percent of your population on race and ethnicity, it's the same measure that you're reporting. You're just saying that my performance was X, you know, across my entire population and my performance was Y across, you know, this sub-population.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Well, that's a good point, Christine. So, what we're saying is, here is a question though. If I'm doing well in this half and poorly in that half, but my average meets the threshold am I qualified or do I have to meet the threshold in every subcategory, sub-population?

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

Well, I think, the approach we talked about earlier, at least that I had in mind, was that maybe for Stage 3 it's really performance across the whole population, I mean, as much as I really would like to push that envelope, but I think they have to be separate if in averaging amount in some way, I think, but, you know, you guys correct me if I'm wrong, but that, you know, you're really reporting your data so you see it and then maybe in Stage 4 deeming you do more of a performance across, you know, where the populations are stratified. I don't know. I mean, I just don't know enough about performance against disparity variables, but, I think you have to at a minimum report it. And if there is a way to have a small performance linked to it, great, but if it's going to cause people to have, you know, push back against this then I think there's so much utility in having people look at their data according to disparity variables that we want to keep that.

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

But we could keep in the traditional program, in the existing program we don't have to...

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

But it's not been in the existing program yet, Paul, and ...

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

No, I mean, we add it, we can add it to it.

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

Well, but I'm asking, I have asked this every time we've gone through these discussions I push for this and what happens is we don't get to it, because it requires the Quality Measures Workgroup and CMS to then say that the reporting in the quality measures has to be done by disparity variables. We've pushed for it for since Stage 1 and it hasn't been done. So, let's tie it to performance, but, I think there is compelling evidence that we have not figured out how to get it into the other part of the program. So, I think it absolutely should be in both.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

All right, so the argument here is that number 3 is a functional objective so we would get rid of that. Number 4 has a functional component to it like the act of being able to do this certification plus using it once or whatever, but Christine your argument is that, well since we're doing 1 and 2 it would be natural to also do the reporting this way, we're not measuring how well you report or anything it's just kind of saying, well since you're doing these other two, since you're doing 1 and 2 also send it stratified by the ethnic group or whatever, disparity, and that kind of covers that area. So, it's not really a number 4 it's orthogonal to 1 and 2.

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

Right.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

It's just another way of reporting it.

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

Right you could integrate it into 1 and 2.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Yeah, yes.

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

And say like control of high priority health condition including among an underserved, you know, predominate, underserved population or whatever, but then you do link it to performance and we just need to think that through. I mean, that is the ideal state and I think integrating it is a good idea; we just need to think that through a little bit.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

So, we end up with 1 and 2 again, but in our description of 1 and 2 we state how it has to be reported.

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

Yeah.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

And list the requirements if it gets separated by group.

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

Yes.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Okay.

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

Other comments about that point?

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

Yeah, this is Art; I just wanted to comment a little bit about this last thing about disparities that Christine is bringing up. Indeed I think it's important for us to see disparities, but I believe we've already discussed this, I think Neil was the one who pointed out earlier that the disparities aren't necessarily going to be seen within a practice they're more likely to be seen across practices or in aggregations of practices. So, you may see disparities there, but the real benefit of looking for disparities maybe when aggregated at different practice levels or across practices.

So, if we're really focusing on disparities registry comes back into play here as an important piece because you would be able to see something by contributing to an ACO, by contributing to a public health registry at a level you might not see within the practice.

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

But, I guess, Art, I mean, I understand what you're saying, but, I think, you know, my concern is or my thought is, you know, we did this with the language requirement that we originally proposed for Stage 3 where you would identify, you know, for any population that is a non – you know, where their primary language is not English and they're more than 5 percent of your population you provide patient education materials in that language where publically available.

So, I'm thinking of it in the same way here that look if you've got more than, you know, X percent, and I don't know what the right, you know, number is, but, maybe it's 5 percent for language or maybe it's, you know, 10 percent for race, ethnicity, I don't know, then you need to at least know the kind of care that population is receiving from your practice. I do think that's important.

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

I don't disagree, I just think that, you know, there are values at multiple levels.

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

Agreed, agreed, but, I think we haven't even gotten to a point where anybody is stratifying their quality measures in their own practice or in their own hospital and we've been wanting to do that for many decades so that's what I'm really hopped up about over here.

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

David Lansky probably knows more of the details of trying out that at the practice level; it really gets to be small numbers in any of these stratifications whether it's the heart failure re-admissions or some of the disparity variables. So, I think one of his points he made when we talked about CAHPS is it's at the group level and that makes some sense, it's really hard to get down to individuals.

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

Well, I think the concern, again, maybe it's worth doing some, you know, work off-line to figure out the best practice on this, but I just am having a hard time believing it shouldn't be done at a practice level, but that being said, you know, I always thought that the small numbers problem was more an issue with like public reporting for example or, you know, again, maybe if it's performance that's linked to it as well, so if you, you know, just make this you've got to know, even if it's five people, you know, you have five African-Americans, you know, it's hard to imagine with, you know, any one of those chronic conditions, you've got to look at that health information and if 3 of them have suboptimal outcomes we, you know, leave it to you to address.

But all I'm saying is just doing the basic stratification even if you don't tie performance to it for a small numbers problem is not publically reported so they wouldn't be de facto identified. I just think it's important and we ought to, you know, look to the folks who are experts to help figure out how could do that in this construct.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Well, this would allow medication analysis at the central level if they wanted to say of the people reporting if you know just – you don't know individuals but if they know this number of patients per practice they could aggregate across and say in general here's how EPs who participated in the deeming had this degree of success in this group, if they did.

I mean, it's just a matter of – we're talking about stratifying it's not – when you send in your reporting measure you're going to say, you know, this number of patients were this group and this number of patients were that group and that's it.

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

Yeah.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

So, it's not a big – I think it's just how you report and it's a matter of sending the ethnic information and race and gender information, etcetera with your report.

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

Right.

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

Okay, so let's ...

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Or it just appears from the list.

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

So, I'd like to try to consolidate what we're agreeing to or not. I think from the framing it looks like we're addressing our thinking to think of basically two bundles or two domains, one is prevention and the other is control of chronic health conditions. And we would add to it other available NQF endorsed measures that fit those and that's the way we would handle specialties and I still have to do hospitals. And for those specialties where there are not sufficient control quality measures than that would leave them having to...I mean they wouldn't be eligible for the deeming program.

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

Right.

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

From a hospital's point-of-view I guess these are not – prevention isn't as appropriate, well actually, prevention and control may not be as appropriate, there might be a set of outcomes oriented ...

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

Safety.

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

Hospital measures.

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

Yeah, safety, re-admissions, infections. I think, you know, looking at things like partnership for patients, looking at the – well, VBP but also at the re-admissions reporting program. I mean, I think there's enough there and actually, Paul, I sent you some of that in an e-mail as well. So, there are a fair number of more outcomes oriented hospital measures.

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

Okay.

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

But, what I don't know is whether you need more than one bucket where, you know, you have screening and chronic condition which makes sense for the ambulatory setting. I don't know if you can have just one bucket that applies to all hospitals that's a mix of safety and re-admissions or, I mean, I'm just not as familiar with the hospital setting.

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

Okay, anybody else want to comment on that? I suppose you could have two buckets one is on safety and one is on ...

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

Admissions, re-admissions.

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

Yeah, re-admissions is – I mean there's still a lot of uncertainty about just what it means and what's the goal there, but at any rate there might be – so safety and quality or something like that.

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

Yes.

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

Other people's thoughts on just how to ...

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

Actually, you know, Paul too let's not forget patient experience because they all do, I believe everybody on the hospital side has HCAHPS and it's published on, you know, MyMedicare.gov or hospital compare rather.

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

Yes.

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

So, patient experience might be another category.

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

Okay, other people's suggestions on categories for domains for hospitals in the deeming program?

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

Care coordination probably, right? You do have the CTM-3 measure that is hospital specific that's more about transitions. So, I think there actually are probably more coordination measures that you could do on the hospital side.

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

That makes sense.

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

Yeah, exactly, that's where the healthcare event notification, I know it's a functional piece but that could come in here.

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

That could and would provide the most benefit to the hospitals too, because as they try to coordinate their care, this is Leslie, and those ADT notifications go out to the providers the likelihood of having a more coordinated care is much, much greater.

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

But, I think that's a functional measure so it's just like we dealt with in the close referral loop, it's not to try to move functional measures somewhere else, we're trying to take a different approach.

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

Right, but it is – I totally agree and if it's possible to do we should, but I'm not sure it's totally possible in care coordination which is more a testament to the measures, lack of measures.

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

Right.

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

So, but you do have a slightly larger number and I think some of those are in the pieces that I sent you, but if not we certainly have folks here who could give you the list that like the MAP has worked on.

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

That would be nice to try to see what the MAP has worked on from a hospital perspective.

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

Yeah.

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

And elevate it to the “outcomes.” So, for example, a measure, it might be a better measure, outcome measure to have the – it’s not outcome it’s still process, but seen by PCP within X days, three-to-seven days, because a number of things have to be done for that to happen. It’s really not – it’s almost seen with the summary of care, but at any rate, so you can see the struggle, but it would be nice to have a more outcomes oriented measure rather than dragging a functional measure into here.

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

Agreed.

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

Okay, yeah, I would appreciate some help if you have people on your staff that have been working with MAP to a get slice from the hospital.

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

Yes, sure.

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

Okay, maybe, let me move toward some of the other questions we posed to ourselves and get the groups feel. So, one of the things that were listed on the deeming slide was the use of both absolute threshold and that’s something, you know, we can throw a number out there, but CMS ultimately would determine that. What do you think about improvement as an alternative to “good performance” and the approach of sort of reduction of gap kind of approach?

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

So, you’re saying, Paul, there’s ...

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

There are two ways to show that you’re a good performer, one is to pass the threshold and another is to show a significant improvement.

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

Right, so what’s the question?

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

Do people agree with offering both those approaches to “good performance”?

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

I’m not sure I feel particularly qualified to answer this question, but I think the question that I have is I definitely understand the need for improving performance, you know, it does mean that they have to report at baseline though and we need to make sure that’s doable.

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

Well, it would be the previous stages, so we already have that.

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

No.

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

They don't always report on the same one, correct.

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

Yeah.

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

So, I mean, see these ...

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

So, they'd have to report at the beginning of the stage, which is a two-year thing so that's okay, but it's just that if they select deeming they have to report then, but it probably means there needs to be a bailout point, I don't know if there should be or not, you know, if they just realized, oh, my gosh they just can't get there from here in two years, although that's sort of hard to imagine. So, I'll take that back, but, anyway, so there does have to be a baseline reporting and we have to make sure that the population health dashboard is functional so they know what their performance is as they're moving forward.

But in terms of the top 30<sup>th</sup> percentile why would we offer that piece? What's the advantage to that? Because the only question I have is whether people who are already, you know, performing in the top 30<sup>th</sup> percentile would just pick that and not have to do any workflow change whatsoever.

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

Well, this is under reward good behavior. There shouldn't be a penalty for people who have over many years achieved a high performance.

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

But if they're already at 70 I guess I'm trying to think through, you know, gee could they be at, you know, 85? How do they feel incentivized to get to a higher performance level, because, you know, I mean, if they're at 90 okay, great, good job, but what if they're at 70?

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

Well, Christine people who are already performing don't stop. I mean, you have to give people the benefit of the doubt. Also, want to make sure other people have a chance to weigh in here.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Yeah, so Paul, I'm actually fine – this is Deven – I feel like we had this discussion about sort of high performers we've kind of had it all along where we've sort of recognized that with very little effort there were going to be some systems that were going to be able to qualify even for early stages of the program just because they made investments early on in a period of time when we didn't have an incentive program in place.

And the idea is not to sort of punish them for being good at what they do, but to acknowledge that in fact that that's where they are and I guess I'm more than comfortable than it appears like Christine is with, you know, going ahead and saying, okay, especially again in Stage 3 where we have less money for incentives on the table anyway to say, you know, continuing good job and even from the deeming standpoint where they hit thresholds that's a very good thing.

I also, though believe on the other hand that it's been our goal all along to get the entities that didn't make the early investments and that are working very hard to do the workflow changes and to provide better care to reward them for improving even if they can't hit the top level of performance, it's a little bit harder though for me to judge what constitutes significant improvement. So, I'm going to have to defer to others on that, but I'm in agreement with the concept.

We have always had an environment where people are at very different levels of performance and struggled with how to figure out how to structure this program which doesn't allow us to vary the incentives at all to meet that environment.

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

Thank you, other comments on that question? Okay, so I think people are in agreement to have both options of absolute threshold and improvement.

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

Yeah, Paul, it's Christine, I am in agreement I just want to clarify my question was designed, it was really a question so I didn't mean to give Deven or anybody the impression that I'm not for it, I just want to make sure, because this is a different and new approach that we think through all the facets so if we're only talking about performance in the 1 and 2 categories that makes sense, but if we are on, you know, for 3 and 4 does that – right, because if you build disparities in – so anyway it's just a question and what I heard you say anyway was that you don't feel like it's, that there's any gaming that occur specific to this proposal and if that's the case then great.

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

Well, it's not to say that – I mean people who perform well have put – it isn't by accident they have a program to do that and they don't stop, so I don't know that we have to ...

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

Yeah, I understand that and that was the answer I was looking for, so, thank you.

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

Okay, thanks. Next question Christine also raised is the double-jeopardy. How would you know until the last – you know, one way is to look at it and say, oh, gosh we'll measure December 31<sup>st</sup> and we'll see if we can deem or not well that leaves you without looking at the other pathway.

So, one possibility is you say, the reporting occurs in less than one year and then so you have the choice now you still can make the mistake of saying I'm going to report the last part of the year and put yourself in double-jeopardy, but hopefully people would understand what that means is you either have to use your real-time dashboard or conclude your reporting, you know, three months or – so if the reporting the reporting period is six months let's say then you can pick any six months in that reporting year, but it's to your disadvantage, you would be incented not to wait until December 31<sup>st</sup> or to keep close tabs on your real-time dashboard.

But, any rate, so one possible response to double-jeopardy is to reduce the deeming reporting period to less than one year. What do people think of that or a different idea?

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Yeah, I agree with you, Paul, that the reporting period should be shorter.

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

Yeah.

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

Yeah, I think that makes sense, it's Christine, I just want to make sure too though that, I mean, I don't want people to be in a situation where they really have to in essence do all of the functional requirements on the, you know, other pathway just in case, because, or I'm not sure if that's going to be an issue I guess it's more of a question.

I don't want to set it up so people have like two record keeping systems in case they can't make the deeming either, so that, you know, there has to be some way to give them some confidence before embarking on the path, you know, I wonder if it's possible to have them, you know, maybe they ... everybody can report at baseline if they think they may want to do this pathway there needs to be a baseline because we have to have a way to get to the 20 percent, you know, gap reduction, but that there's a point at which they can say, okay, no I'm doing the consolidation or yes I'm in and in the next 6 months we're doing deeming and if we don't make it we don't make it, but there's like a check-point. I don't know does that make sense or am I way over thinking it?

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

Well, I think that's the purpose of having a less than one year reporting period and I just would sort of throw out a straw man of saying 6 months and chances – I mean, the approach one would take is, okay I know where I stand at the end of the last year am I on the path to really doing this well and deeming, yes, I believe so. They're not going to stop doing the other things because that's how they ended up in a good performance anyway.

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

Right.

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

So, they'll measure the first six months and they'll know that they don't have to do the extra reporting work in the second six months if they do well. I mean, that's an approach it doesn't handle all the things, but in a sense people still have to "worry about" I mean, they still have to execute the functional requirements.

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

Yes.

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

They just don't have to – there's a lot of burden on this reporting side.

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

Right.

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

They don't have to take on that burden if they have performed well, that's sort of the theory here.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Is there any way for them to also start checking? Like can we make sure that the system is certified in 2015 so they can tell at the end of 2015 how they'll be doing in 2016 or something?

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

Yeah, that's part of our reporting clinical dashboards functional objective which turns into a certification requirement. In theory that's why we're providing them that tool.

Okay, so we handled the specialists, we're going to look at the hospital and then the other is – a question we had is will we have the available QMs that we need in time for this and that will be an open question but it's one that CMS will know because they know what's in the pipeline.

So, we would have as part of our proposal we would have examples of where we think, you know, what it would look like. CMS, if they accept this proposal, would have to fill in the details, because knowing what is in the pipeline for measures in category 1 and 2 for example.

All right, taking a step back how does this feel to folks? Are we on the right track? Now, remember the next stage for us is to present these ideas to the Policy Committee and get their feedback, I'm sure we'll have a similar discussion, but that's where we stand, are people comfortable with that?

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

I am; it's Christine.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Yeah, likewise, it's Deven.

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

I am too, Dave.

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

Me too, Leslie.

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

This is Art; I'm in agreement.

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

Great, thank you. Okay, what I'll do is I'll try to digest what we've discussed today update these slides, we'll try to pull in some more and maybe ONC and the combination of ONC and Christine your input from the MAP especially on the hospitals could help flush out category 1 and 2 and the equivalent on the hospital side and then that's how we'll describe this, you know, our framework for this program and get feedback from the Policy Committee.

Now the other thing we were going to work on from our last call was how to put together a presentation for the consolidation. What help do you think you need from us, Christine, we have another call scheduled do you want to spend that time working on how to ... essentially a similar, you know, the analog to what we've discussed today for deeming, a similar discussion for consolidation?

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

I think it's just a matter of presenting what we discussed, right?

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

Okay, but it's up to you whether you think there's more work to be done.

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

I don't think so, I mean, because this isn't our last crack at the apple before this meeting, right? We're going to be able to refine based on feedback we get there and ...

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

Right.

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

Okay, so I don't think so. Michelle and I have some time set up to talk about how we can present this most easily and efficiently, so I'm happy to run that by you once Michelle and I talk.

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

Okay.

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

But I don't think we need a full workgroup call to figure out the presentation of it if that's what you're thinking.

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

It's just any remaining discussion issues.

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

I don't think so I think we got through all of them.

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

Than if you can pass through ...

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

Oh, you know, I may be taking that back – I, Michelle, I don't know if Michelle is on but now I'm thinking back to the care summary, there may be, can I do a little bit of thinking on that?

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

Sure.

**Michelle Consolazio Nelson – Office of the National Coordinator**

So, this is Michelle, maybe we – right now we have a call scheduled maybe we will only need an hour of it and depending upon my conversation with Christine tomorrow we can decide if we think we want that meeting.

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

Okay.

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

Yeah, that's a good approach.

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

And the other thing is you'll have to pass to me your consolidated list.

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

Yes.

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

So I can put that in deeming and to answer people's question, yes, I think as part of the presentation we should also show what's deemed but also what isn't so people understand.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Yes.

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

That would help I'm sure.

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

And where did we come down on the patient and family engagement ones that aren't deemed in your mind? Because, I heard lots of people weighing but I think you didn't agree and I'm not sure where we ended up.

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

Okay, so I'm sure – so, we certainly agreed that VDT would by default be not deemed and then if we have good – if people excel in that in Stage 2 early indications we might put it back in deeming. I'm not sure we had an agreement on secure patient messaging we can do the same approach with that if that's what people want.

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

That's probably safest. I mean, I'm comfortable with that.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Yeah, likewise, it's Deven.

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

And it would be nice after we see your consolidated list if we could pull one or two more things to be deemed because, you know, we want to make – if we want to push this side we want to make it worth their while.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Right.

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

As, I say, it's mainly a reporting burden thing that we're trying to alleviate.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Yes, although the secure message I'm not – well, anyway we can talk about that, yes.

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

So, I'm saying other things if there's something else we can pull in.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Oh, yeah, absolutely.

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

Yes.

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

We want to make this as attractive as possible.

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

Yes, I agree.

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

What David said about wanting to make sure it's, you know, somewhat of a reach but not out of reach otherwise it also kills the program. Okay, so I'll take another stab and I'll throw this ... and I'll circulate it to the group and we'll wait for your – we have that call scheduled and we'll wait for your indication about how long or if we're having it.

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

Great.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

So, Paul, this is Charlene.

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

Yes?

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

I have just one more request going to through this process and I'm totally in support of the direction. One of the things either the small teams, small sub-teams have not done or I don't think we've done as a process is go through some of the specific item by item feedback and I know there was a lot of work by the industry to provide that, so again, as we're thinking this through how do we plan to, you know, reflect that in this thought process?

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

Oh, absolutely Charlene.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Yes.

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

No, thanks for asking. So, the next step to reiterate that point, so first we even say whether we're in the ballpark it's almost like the question I was calling at the beginning of this is deeming still, considering the advantages and disadvantages, is this still a good program to pursue. So, we're going to vet both the thought of consolidating and the thought of deeming in front of the whole Policy Committee, let's pretend they agree with the thought and they give us a certain input then we need to go back incorporate that input and then take all of the information, the feedback we got from the RFC and plug that in.

**Charlene Underwood – Director, Government & Industry Affairs – Siemens Medical**

Okay.

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

So, yes, that was incredibly helpful feedback from the RFC, we were only deferring it a little bit because it would be a shame to do all that work and then consolidate.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Okay.

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

So, we want to consolidate, deem and then plug in all of that feedback.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Great.

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

Does that answer your question?

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Yeah and I think we just need to communicate that or you need to communicate that.

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

Absolutely.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

Okay, great, thank you.

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

And we have, because of the – what Marilyn said about no new NPRM this year that's what gave us the additional time after the April meeting to work on that incorporation. Any other comments about today's discussion?

**Michelle Consolazio Nelson – Office of the National Coordinator**

This is Michelle, just thinking process I realized that we don't have subgroup calls on the calendar so to the subgroup leads we'll probably start doing those after April.

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

That's right.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Coming out of the Policy Committee, so just a heads up.

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

And that's the other subgroup, the Category 1, 2, 3, 4?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Yes, yes.

**Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs**

After April – that's good.

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

Yes. Any other comments before we open it up? Okay, could we open it up to public comment please?

**Public Comment**

**MacKenzie Robertson – Office of the National Coordinator**

Sure, operator can you please open the lines for public comment?

**Rebecca Armendariz – Project Coordinator – Altarum Institute**

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-2976 and press \*1 or if you're listening via your telephone you may press \*1 at this time to be entered into the queue. We have no comment at this time.

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

Okay, well, thank you for another productive discussion. I will do my best to incorporate this all into the updated version and certainly let me know where I've let you down.

**Deven McGraw, JD, MPH – Center for Democracy & Technology – Director**

Thanks a lot for all your hard work Paul and Michelle and other members of the staff.

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

Yes, thank you so much.

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

Thank you.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Thank you.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks everybody.

**George Hripcsak, MD, MS, FACMI – Columbia University NYC**

Thank you.

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

Thank you.