

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
August 16, 2013**

Presentation

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

Thank you. Good morning everyone. This is a meeting of the Health IT Policy Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of the call. The meeting is being transcribed and recorded, so please remember to state your name when speaking. I'll now take roll. Paul Tang?

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

Here.

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

George Hripcsak?

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

Here.

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

Amy Zimmerman?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services

Here.

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

Art Davidson?

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

Here.

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

Charlene Underwood?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical

Here.

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

Christine Bechtel?

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

I'm here.

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

David Bates? David Lansky? Deven McGraw? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Here.

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

Marty Fattig?

Marty Fattig, MHA – Nemaha County Hospital

Here.

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

Neil Calman? Marc Overhage?

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

Present.

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

Mike – sorry, Mike Zaroukian?

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

Here.

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

Paul Egerman? Greg Pace? Joe Francis? Rob Tagalicod? Tim Cromwell? Martin Rice? Now, back to you Paul.

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

All right, thank you Michelle. Thank you all for attending. This is a follow up call after our HIT Policy Committee presentation and feedback, we are preparing with this call and the next call to come back to them in September, and I'll describe a little bit of sort of a proposal of how we continue our work. One, I want to certainly apologize, it was my mistake about the second call, my daughter's going to Spain and I want to send her off, so I did – there was a conflict and so I didn't recognize it so, it's me that messed up with the second call this month. I hope it's still possible that all or most people can join.

So as you know, at the Policy Committee one of the main – a couple of things were said. One is that really we emphasize how Stage 3 on schedule, we're working towards an outcomes oriented approach to the objectives, and that's what we've been saying all along and the tie between the detailed work we have been doing all along with all the stages, what we've presented to tie back to outcomes was not as clear. And so that's more a framing issue, and so that was asked of us is to remind us again how does this tie back to the outcomes. And the second piece is just all the details, and it's sort of a mixture of some of the feedback, obviously, that we're getting about how busy people are, particularly in the next couple of years, one example is ICD-10, and just the pace of the program. So combination is asking us to say first, let's make sure that we are tied to the outcomes that the program was charged to do and that we've really been using as our guidepost and it's one of our principles. And let's take it more in stages in terms of getting the Meaningful Use Stage 3 recommendations forward.

As you know, there's also certainly discussion about timing and we wanted to look at the timing for Stage 3, not Stage 2, in our next call, or at least in future calls, so that we can make a recommendation back to ONC and CMS on that aspect as well. So we're thinking right now is, both Michelle and Elise have worked very hard to try to take that feedback and then put a draft in front of us today so that we can discuss it, in terms of framing it in the outcomes – with the outcomes orientation in mind. And sort of reviewing that, taking a step back and getting that put together and developed and approved here, so we can bring that forward to the Policy Committee and seek their approval for the framework before we go back down into the details. And then if we get approval on the framework, we do want to look at the details and make sure we're consistent with that, so that's an important part of the step. How does that sound to folks?

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

Sounds good.

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

Okay.

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

It's a plan.

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

Okay, so let's go forward with the PowerPoint that Elise and Michelle put together, and we can start with the first one, actually slide 2. And this is just a reminder of the two high-level feedback comments we got from the Policy Committee. One is, make sure – let's reconnect, let's check our work, step back and check our work on the connection between the objectives we're putting forth, as well as the quality measures and the outcomes that we're seeking.

And the second piece on deeming, I mentioned this in the presentation, one is, I certainly when I've talked in between, outside of the context of the Policy Committee, gotten a lot of positive feedback about the whole deeming concept. Probably one of the biggest concerns well, that's really great if we have really good measures that demonstrate that we are indeed achieving outcomes rather than still focused on process. It's a fair comment and it's because of that, recognizing we've proposed all along, in fact our Quality Measures Workgroup about, I don't know, a year, year and a half ago, proposed a number of newer concepts that they thought would be a better measure of people achieving good outcomes. And we need an update on that, and we want to make sure at least some of those concepts are in the pipeline. As you know, there's a long lead-time to being developed into measures that could ultimately get NQF endorsement.

So there's a Tiger Team, and I mentioned this in the Policy Committee meeting, there's a Tiger Team formed by some people from Quality Measures Workgroup and some people from the ACO Workgroup to try to look back at that concept list and see what to re-emphasize. And to check that against the pipeline that's coming through, with the hope that we would get some new measures, certainly by the time Stage 3 rolls around, to use both in the meaningful use – the traditional pathway for meaningful use as well as for the deeming program. Next slide please.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Umm – this is Farzad.

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

Oh. Hi, Farzad.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Hi, sorry I'm joining a little late; I just caught the end of that. I just wanted to first thank the workgroup members, the workgroup that I started my federal service in, with Paul, over four years ago, for really the amazingly thoughtful detailed work that's gone into this. And to thank Paul for doing a really amazing job continuing to get us sort of forward movement towards the real outcomes that have always been crystal clear, I think, in this workgroup mind of what we need to do, but have not, and I acknowledge this, and Christine pointed this out, is not always need to weight into how the regulations are written and talked about and education happens and certainly compliance is discussed, where it's I think, we run the risk of losing that tight connection.

And that was, I think, some of the feedback that we heard from the Policy Committee, who have not been as involved in the day-to-day of understanding the details of where we are and where we want to go and how these contribute to that. Where they reflected back I think, an even muted version of what's – what I'm hearing from folks on the outside, which is, they don't understand the connection between the detailed specifications of meaningful use and the measures and the compliance aspect of it with what they need to do to be successful in new payment and delivery models, for example. And I think this is actually a terrific opportunity for us to reinforce that message, to take that opportunity to make clear why it is that we're doing all this and how this relates to not killing people and helping people live longer. And talking to each other and talking to the patient and listening to the patient in language that is understood and that makes things, I think, simple rather than complicated.

So that, I think, is our task – it's – for this next presentation to the Policy Committee is to see how much we can simplify, how much we can hone and clarify that clean message of why we're doing this and how it relates to the true outcomes that we hope to accomplish. I'll add my kind of reinforcement to Paul's point that the quality measures are what they are, and we're not satisfied with them. And we're working very hard to improve them, and they are better. The Stage 2 ones are better and the Stage 3 ones we hope will continue to push on that. But not having perfect doesn't mean that we can't and won't be moving forward on using those same quality measures in a variety of payment programs and recognition and reporting programs. So, to the extent that these are the measures that are going to be used, we need to align with them and we need to be on the point of this, you're creating new and better measures, but we need to kind of have our feet on the ground and move ahead on this framework.

Something Paul that I'd love to hear the group discuss is if there are other measures that don't come directly out of the electronic health record, that are not eCQMs, but that are used in other payment and reporting programs, that are potentially even more meaningful. Like use of claims data for readmissions or total cost, redundant imaging or patient satisfaction surveys, whether deeming could work using external data collection and quality measures. So I think that would be an interesting discussion to hear as well. So with that, I want to again thank the Meaningful Use Workgroup and Paul Tang in particular, for your work and I'm going to be jumping off, but if there are any particular questions from the workgroup for me before I go, I'd be happy to answer.

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

Anybody?

Paul Egerman – Businessman/Software Entrepreneur

Hi Farzad, this is Paul Egerman. Hello?

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Go ahead Paul.

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

Hi Paul.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I have a question, which is, during the Policy Committee meeting, you made a comment about the value of percentages and increasing percentages versus throwing like just a specific number of events, I don't know if you remember that comment, but I thought that might be useful to repeat to the group.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Sure, sure. What we've found is that too much discussion and argument over thresholds is probably unnecessary because whatever the threshold has been, whether we had it at the 80%, 50%, 35, 20, whatever. In the past, people have far exceeded those, far, far, far exceeded those thresholds, coming in at 90-95%, where they've had to essentially incorporate them into workflows, and this makes sense. But the behavioral – the psychology of saying "do 10, or do 20, or do 25," is different from the psychology of saying – of a percent, however low, in that it can induce a sort of tick mark, tally approach to say, do 20 and then you're done, okay, let me keep a tally of, and when I've done 20 I stop. So that's my concern, there were a couple of measures that were suggested as being numeric fulfillment requirements and I would just caution us to consider the potential for this just adding a reporting burden and not changing behaviors –

Paul Egerman – Businessman/Software Entrepreneur

Great, thank you.

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

Farzad can – give you the rationale for us moving to the absolute numbers for your comment. Clearly one of the biggest comments – feedback we get about the entire program is that either actually as a provider or a vendor, it's sometimes the reporting or documentation that you did something is worse or more costly than actually doing it –

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Sure.

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

– and so, one of the reasons we toyed around with moving towards the number is because the denominator tends to be the thing that's most unclear and most variable in terms of how people interpret it, and a lot of that's driven by vendors, because they – the program in the measurement system. So that was the thought behind it and I wonder if you want to comment, because we're trying to reduce burden, and we've got –

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Understood. Yeah. Absolutely.

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

– the denominator.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

And I think, as we – you're absolutely right, that we don't want to get in a situation where there's so much work and ambiguity in the reporting that it, and I think there are some examples of that where people are – have complained about. So it's a great concern and I guess I would say let's try to find and reuse, to the extent possible, the way that CMS has done in the Stage 2 rules, however imperfect, can we reuse some of the same denominators and in some cases, use numerator for one measure, use the denominator for the other. So – and if it's just something that's just too hard to measure, then maybe we should think again about that.

Paul Egerman – Businessman/Software Entrepreneur

Right. Although – this is Paul Egerman – what Paul Tang just said about the difficulty in calculating the denominator does seem to add emphasis to Farzad's earlier comment that there's not a lot of value necessarily in increasing the threshold. If you increase the threshold, people are going to go through a lot of work of recalculating the denominator, even though they probably are at the higher threshold already.

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

So Farzad, this is George. Hi. So what it sounds like, and I don't know if this would be acceptable to the workgroup members, that we should have less emphasis not only on picking the threshold, but like what the threshold looks like. We could say something like, this should be low or a count, or something like that, which was our intent, and then we sit there for a long time figuring out exactly what it is.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yeah. I think –

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

– on the measure, like what do we mean by the measure so that you understand what we're trying to say

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Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yeah.

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

– but not necessarily then go into it – because he's told us repeatedly not to say that counts a problem is that we feel comfortable when we give a number, because it feels like, go from Stage 2 to Stage 3, something must have changed so let's go up on the threshold.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yeah. I guess part of the – maybe another way to think about this George is when is the appropriate time to be worrying about it? And thresholds are something that between the NPRM and the final rule is a perfect time to weigh in on that. Because people see what the measure is, they see what the totality is, they see how its defined and then there was a proposed rulemaking and that's something for which you have what's called logical outgrowth. It's easy to titrate that up and down within – between the meaningful use and the final rule, based on the assessment of the Policy Committee as well as the community responses we get.

So I absolutely agree with you that we should not – that this workgroup at this time should not be spending any energy or time on the kinds of details that will get worked out between the NPRM and the final rule. And I think that it actually has not only kind adds a lot of work for you and a lot of discussions that perhaps could be avoided, but also again gives the impression to the world out there who's listening that we're overcooking stuff at too early a time. That there's too much detail, too much complexity, too much specificity, so it's like no good deed goes unpunished example. But yeah, I agree with you.

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

Farzad, it's Christine. I was just – it's funny you should say no good deed goes unpunished because I was about to use that phrase exactly. I think one of the things we did learn in the RFC process was in those places where we didn't put very much detail, we had several where we specifically didn't name a threshold or give a lot of detail on the measure, we just focused on the objective, and everybody came back and said, well what does that mean –

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yes.

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

– and I – which I appreciate because and I definitely appreciate your conceptualization of this issue. I just think it's a very difficult balance because on the other hand, because of the timing issues and the way that people say look, we need to get started much earlier, they also say, even if you can send us a signal about what's likely to happen here, that's appreciated and we can get to working on it. So, I think it's a balance is all I'm suggesting, but I hear what you're saying.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yeah, yes.

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

Other comments?

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

So, this is Mike Zaroukian. Hi Farzad, thanks for all your great work. I wanted to respond to your question about other measures outside of eQMs that could work. And I'm not an expert on doing the crosswalk between these two, but one thing I'm seeing a lot of hospitals, including my own, focusing on is the Hospital Compare website from CMS –

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yeah.

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

– and to the extent that we could somehow take the same scores that are reported there and have them count as part of either the deeming process or whatever, your thoughts?

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yup, yup. I think those as well as the ACO measures – I was disappointed to hear, even on the Policy Committee, people questioning whether we've – we're aligned with the ACO requirements. And I went back actually and started reading the ACO requirements – kind of a is the earth round kind of question. And no, I mean if you want to accomplish those – the quality measures that trigger the payment, those quality measures if you want to achieve those, absolutely require the kinds of capabilities that we're talking about, and which the ACOs are now complaining that the current Health IT does not adequately support.

So if there's one thing that we should do is to continue to evolve and improve the functionality that's already in the – our certification and our meaningful use requirements that is kind of getting there, but is not there – all the way there yet. So for registry functions, for quality measurement, for decision support, for adherence, for patient engagement, they're in the direction, but they're not far enough, it's not easy enough for the ACOs to use them. So I think both let's use the measures quite explicitly if we can, and two, let's continue to press on the functions that will be necessary to achieve those measures.

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

Farzad, it's Christine, just say two quick things. I also went back and looked at the ACO requirements and in addition to quality reporting, I think this calls into question the issues about delaying the availability of these functions. The other functions are care planning, health and functional status, patient experience and then, of course, the population health dashboard. So I think –

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Exactly.

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

– my question here is, I think those areas that ACO needs, and also health disparities are two areas where we probably need to do some deeper thinking about objectives. Even if we're not going to go to the level of measurement and whatever, where we may have some new additions that I think we need to be open to, if we're going to help providers be successful.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

And I think we should – one of the things that we've heard is, we've got to learn from what's happening. And I would urge us to learn not only from what's happening with Stage 2 of Meaningful Use, but what's been happening for the past year and a half with the ACOs. And I think the workgroup that Paul mentioned that combines the Quality Measures and the ACO Workgroup is going to be really helpful in saying – bringing feedback from the ACOs in terms of what is not adequately serving their needs? What do they wish was in meaningful use and to roll that into our Stage 3 discussions.

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

I think that makes sense. I think – and I think my question here is, when we are going to get to a better understanding of the implications of our timing issues that are occurring and what our options are. Because my concern is that if we wait too long, or if we don't take a second look at some of the criteria that we've proposed, the ACO program is live now and it will be yet three or four years before we have EHRs capable of doing that if we delay. So Paul or Farzad, I don't know where the point in the discussion in this group that we'll take up those issues, I think we all have a lot of questions about implications and options, but if you said, give us some insight as to how we're going to approach that, that would be great.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Well I think that is the other side of the timing – Stage 3 timing coin. And what do we gain by extending – for Stage 2 and what do we lose? So I think that should be the important part of the conversation.

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

Agree. So before we get to wrapped up in it, is there a call or something where we as a workgroup are going to take that up? And I'm hoping, Paul, it's not the one that we just moved, because that's going to be almost impossible for me to make.

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

Yeah, I – the plan is to see what we can accomplish with the current topic and slide deck we have. It probably will spill into the next call we have for August. Assuming Farzad is comfortable, we're sort of postponing our final get down to details of the objectives – the recommendations for objectives and quality measures until the fall, and I would see us having an in-depth discussion on timing of Stage 3 prior to that. So, that might be a September call.

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

Yeah, in the Policy Committee my suggestion was to really keep the Stage 3 stuff moving. I don't know how much we need to delay it, our consideration, not the stage, I mean, our recommendations. If we can unhook those two things, I think that would be helpful because again, it's important to send the right signals to the industry. So I am a little bit concerned about –

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Christine, I guess, again no good deed goes unpunished. I guess I just want to reflect back to you something that I'm hearing a lot of, which is that our – however well-intentioned desire to give very early signaling, right? That's what people want, they want years to begin their planning and so forth, is right now not helpful because what people are dealing with and focused on is what's right in front of them, which is finishing up Stage 1 and getting a grip on Stage 2. And what the overwhelming sense I'm getting, from both vendors and providers is, that they don't have the cycles to really engage with that signal around what Stage 3 is like. And that they're really – the vendors in particular, are not going to start coding anything, no matter how clear the signaling is from the Policy Committee, until they kind of get through the Stage 2 crunch. So, I think it's okay, we have some time on that signal.

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

I think that's helpful then, I mean I might just flip my suggestion then and say, I'm not sure if talking about even with respect to today's slide deck all the way we frame things is as pressing then as getting to really understanding the implications of any kind of a shift in the timing of the stages, right? And what our options are – what if the reporting period is lower, well – etcetera. So – but I feel like we're not prepared today to really get into that, because people need to understand how the penalties interact, we need to understand the reporting options, we need to understand all of those fairly complicated policy implications, and that is not what I see teed up for today. And I'm sure ONC is doing an analysis of what we gain and what we lose through the delay, so when could we expect much more detailed focus on that?

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

I think we heard Paul say that we can do that next month, but I guess I would disagree a little bit Christine, that this doesn't matter. That the discussion of how – of the why Stage 3 and what is in Stage 3 it's crystal clear in your mind and in the minds of the Meaningful Use Workgroup of what we gain. But it is not at all clear, it became apparent, to even the Policy Committee, in terms of why – what is it that at a macro scale, at a conceptual scale, kind of the understandable simple message, what is it that we need to do for Stage 3? If there's no gain for Stage 3, then we can delay it forever, right? So understanding what is it that we're stepping up to and why, I think is the critical next step and I hope that you have a good discussion today. Thanks everybody.

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

Appreciate you're taking the time Farzad, to speak to us and give us some more direct feedback about this and answer some of Christine's questions. I think we have our work set out for us. I think it is helpful to do exactly what Farzad said, which is make sure all the workgroup's been doing in the details is crystal clear to people. And if it's not, go back to our heritage and the principles that have been guiding us and make sure we one, reframe it and two, make sure we have appropriately connected the dots and we definitely need to make that explicit to the external world, including the Policy Committee. Any final comments or questions of Farzad?

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Thanks everybody.

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

Thank you Farzad.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Bye, bye.

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

And actually, that was a really perfect introduction to the slide that's before us all now, it's sort of reemphasizes points which have been on our – I mean, have been our guiding principles all along, but – clear as possible, or as visual, let's say. And I'll just give one anecdote, just to completely reaffirm what Farzad and Christine was saying, I mean in our – the health system that I work in, we absolutely – what we have and more, in order – as Farzad was talking about the ACO experience is, once you start needing to practice this new medicine, this new model of care, you just have to have better data in a more timely fashion in front of the very people who take care of people – of patients. And so that's probably the driving timeline, and I think that's what Christine is saying, too.

But there's this balancing act that we've always been doing all along of when – what do you need, when do you need it, but also, when can you talk about it? And I think part of the feedback is talking about Stage 3 – the details of Stage 3 is probably something that's just overwhelming at this point, at this juxtaposition of getting off of Stage 1 and going into Stage 2, as well as everything else that's on people's plates. So, it also falls in the no good deed goes unpunished, as you said Christine, where we're trying to be extraordinarily responsive in terms of everybody's request that we give signals as early as possible, but the timing just happens not to be right, right now. So I think we're not changing the character, the tone or even the objectives, we're just sort of making sure everybody's clear on – and that we represent the framework and the heritage of the set of recommendations that we call meaningful use.

And so before you, on this slide, we want to reinforce and sort of visualize for people, how the objectives we talk about in detail really actually are derived from, let alone – or guided by our desire to improve outcomes. That we want to link it to the quality strategy, that's what HH – HHS determines the priorities for the country. It so happens that we derived our initial classification system based on the National Priorities Partnership that NQF hosts, and so does NQS, the National Quality Strategy comes from that same place, which is why it's so good that we're well aligned with the Quality Strategy. We're going to point out in this slide deck that we've – that there are a couple of domains that are missing from our current four, there's actually six now, and we'll talk about that. A Million Hearts gives a domain of focus.

And, as we've been talking about so far already, is linking it to the future payment models. We're basically – we're the supporting cast for trying to get these systems, these EHR systems, HIT systems to provide the data and the efferent – the effector arm to people who need to operate in the new models, the models that we all think are better than our pay-for-service kind of orientation. And maybe there's a way, at least visually to present our recommendations in this outcomes framework. I'm not sure, as you'll see, that it changes that much of the content, but clearly we have room to improve in terms of how we present it. And there's another piece is, certification criteria, we've been using it in a different way, we've sort of been using it in a sort of a postpone or let's get the functions in the products first and then let's get the use – drive the use.

Now certification, although it's tied – it is related to a certified EHR that people have to use in order to accomplish meaningful use, certifica – ONC has a certification program that can actually exist on its own, somewhat decoupled from meaningful use. I'm just throwing that out as a possibility in thinking, but just to remind us that that – they're not specif – you have to have a certified EHR in order to deliver – in order to be deemed a meaningful user of the system, but it also doesn't exclude having a certification program, such as ONC has, in driving functionality. I'm just putting that out there, don't really want to – we – (indiscernible). Next slide please.

So a word about deeming, remember we wanted to switch over to trying to reward – where people have already gone through Stage 1 and Stage 2, by the time they've done Stage 3, we're trying to reward good behavior and we'll back off on the process measures. The flexibility has been really widely appreciated, so, much to what we were planning all along is, we get the process, it's sort of a forced march and then we're sort of saying, let's focus in on what we're trying to achieve, which is good outcomes. And in a sense, there's a bit of a handoff to the other programs like ACO and PCMH and Primacy Care Initiative. So that's what we were planning and we want to have our objectives reflect that. Now part of the – actually, for both the ACOs and for us is to have good quality measures, and that's just reinforcing the point, we still need good quality measures and we want to make statements about that. And then the final one was what Farzad raised, which is let's go check with some of these other programs, like ACO, and see what measures that may not be primarily derived from clinical systems, that may also be part of measuring good performance, and not exclude those. Next slide please.

So, for today's call, and as I said, it probably will spill into the next call, we'll talk about reframing the – how we thou – think about and thought about Stage 3 recommendations. And our goal then is to have an approval, and understanding and approval of this outcomes driven framework at the September meeting, with instructions that we – if they approve that and see that linkage, then we would go and recheck our work in terms of the details we've been working on. And make sure those follow that framework or those are consistent or live in that framework and come back in the Fall, it may be not – October, November may not be the right dates, but it's the Fall.

Part of that is gaited on two things, one is listed there, we do have this Tiger Team that's to report back in October, and I don't know whether there'll be full recommendation approval then, or will it be in November, that's sort of the hedge in terms of Fall. And the other piece is we would love to have feedback on Stage 2. We have the fears of Stage 2, but what about the early people getting in, what's the experience of that. So in a sense, we would love to have the data from that ongoing program, as well as knowing more about the quality measures that would be the pull, both for our objectives and for our measures. People agree with that in general? Make sense?

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

Yup.

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

Next slide please. Okay, so let's talk about some of the recommendations for presenting in September. Next slide please. So focus again on health outcomes, we want to use the CQMs to drive this and we want to incorporate the deeming function as an option. Next slide please. So this is a reminder, and probably a graphical representation that we are addressing these six domains that live in the National Quality Strategy.

And if you'll look at that, lo and behold, four of those things, safety, patient engagement, care coordination, quality and prevention are explicitly named in our four categories. Prevention lives under category 1, for example. We have not dealt – we've dabbled in, and it's mainly driven a lot by not having enough measures to drive in the accessible and affordable care. We've had things like generic substitutions, we've had imaging, high-cost imaging and things like that, some of which didn't survive – we recommended and didn't make it into the final rule. But what we could do is then look at all six of these things, because they come from the National Quality Strategy, and use that as the model and then see and drill down and see how we can support those domains. Next slide please.

So if you look at it, it does feed very nicely – the National Priorities Partnership goals, with the National Quality Strategy and our meaningful use objectives – all stages.

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

Hey Paul, is this the time to make a comment on this approach?

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

Sure, yeah.

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

I think there's one really essentially thing that's missing, which is eliminating health disparities.

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

Good point and I guess we get a little bit of credit on elevating that, both from the very start, because we added that to our category 1, but good point. So we'll have to make that clear. Thank you.

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

Paul, this is Michelle. We had tri – so we might not have it called correctly, Elise and I kind of went back and forth on this, so we tried to include the disparities – within the accessible and affordable, so when we get into more of the details, you can see that, but maybe we call it something else so it's a little bit clearer.

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

I don't think only accessib – affordability, I mean – is one of the disparity variables, but there are a lot of others and it probably do – it fits in more than one of these categories.

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

Yeah, it's almost its own category because you can't improve on it if you don't have your eyes on it. So I actually think it's a separate thing.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Paul and Christine, this is Kevin Larsen. This is an ongoing discussion at the National Quality Strategy as well. The decision has typically been made within HHS that disparities is an important characteristic that crosscuts all of these, so, its included in all the domains –

W

I wonder if – I gave him a –

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

I'm wondering if – somebody needs to mute their phone – okay. So yeah, in my mind I was thinking there's another bar either horizontally and potentially actually more vertically on the left that has disparities in there, because it really does affect it – all these things.

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

Yeah, I would agree that it should be called out separately and it could be horizontal or vertical. But it reminds me of when we – when the Policy Committee was first created and we said, oh, we won't have a separate Privacy & Security Workgroup because we're going to embed it across everything, and we never did and we ended up having to create it.

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

Yeah. And they have been – they've been embedding themselves across the domains, so I think they've been working well, but – and I think, to the credit of this group, that we have a better eye on that from Stage 1 and we're really taking a very strong approach in Stage 3. Thank you. Next slide please.

Okay, here's the beginning of the mapping, and this is courtesy of ONC staff. So, as you see, improved quality of care, boy we've been on it. We've got a ton of stuff, because that's really the first foray and it's an obvious thing that electron – you know, computerized records can do. So we had a number of things that really improve the quality of care just by getting stuff in and having reminders about things, you know and decision support. So we had –

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

Hey Paul, this is – just to clarify, this is just the mapping, this is not anything to do with deeming yet, this is just –

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

– right, just mapping.

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

– in Stage 3, these are the additional things, you know – .

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

– correct.

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

– okay, great. Thanks.

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

And I'm sure we've missed stuff. So, we've stuck this on the board just to like talk about the idea and then we need to go through with a fine toothed comb to see whether we've been consistent, etcetera. So the notion is though, it's mapping. Here's one of the six domains, Stage 1, this is how we dealt with it, we added to it in Stage 2 and we're proposing to add to it in Stage 3. And you can see things like CDS we had like one, then it went to five and now we're proposing 15, but it's CDS, CDS plus and CDS plus, plus. There are new things that we – what our hope and promise is that they support the ACO models, they support improving outcomes like real-time dynamic dashboards for clinicians, the frontline clinicians on an everyday basis. Like much more robust CDS, like knowing what happens after they leave the office in medication adherence and order tracking. So those were the thoughts we had in support of improved quality of care. Next slide please. I guess we're going to sort of go through then you get a flavor for how this does map out and then get your comments.

Prevention; a lot has to do with public health, so there's immunization from Stage 1, going to registries and reporting in Stage 2, going into pulling in other things like family history and support of more chronic disease management in Stage 3. Obviously that supports PCMH and ACO and public health. It's the prevention side in example. Next slide please. Under patient engagement, we've opened up the records from day one, we have started communication with Stage 2 and we're trying to get much more interpersonalized communication preferences as well as getting data from the home and other places, other than what we get in the office and hospitals. So that's sort of been the progression in patient engagement. Next slide please.

In safety, that's probably a number one job for EHRs, HIT. So CPOE figures – CPOE and CDS figure prominently in that, they get more and more robust over time. And then we, in Stage 3, we're also compensating for hey, what can we – how can we use these systems both to understand adverse events that are occurring in nature and that may be related to our interventions, but also could be related to the systems themselves. Next slide please. And in care coordination, it's – we've been relying on the summary of care, in other words, getting information to other people who need to use it, and that's been a struggle. It relies heavily on this whole interoperability and information exchange. And knowing actually what's even happening, that's in Stage 3, in the health event notification like patients in the ED or got admitted to the hospital, it would be wonderful if the PCP knew; closing the referral loop, because it typically is going to cross-organizational boundaries. So these are things in the care coordination we've had to load up more towards the latter stages than the early ones because every – you got to get the FAX machines out there, I'm using that as a metaphor, sorry. Next slide please.

And affordable care, so one we have to get disparity variables, but we've introduced it formerly checking was one of the things. As I said, we had a couple of other things like expensive imaging and generic substitution. Clearly there's been – we've already had the academic studies that show that if you even know what's been done, you're less likely to order duplicates, for example, so the whole CPOE and CDS and just availability of information out there. I think the – probably this UDI comes probably back into safety, but – and then capturing more information that can affect the overall piece, in terms of disparity. So this one may need some additional work in terms of putting it in disparity channel or however we're going to depict that. I think that's all, next slide please, I think that's all – okay.

So comments on that approach, so one, start with the outcomes, we're going to start with both the National Quality Strategy and map it to that model to try to directly connect well how do these functions we're describing connect back up to the Quality Strategy, outcomes orientation. Does that make sense? And then sort of trace it over time, over stages?

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

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
So I think it's very good, I think it's very clear, I think it's very helpful. A couple of suggestions, one, in some cases we said we would put things in two categories, but I would recommend we not do that. And I don't actually see any examples, other than CDS. CDS is the one exception where I think we have to put it in multiple categories because its covering so many different things. Other than that, are there any we duplicate, because I'm not seeing any?

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

CPOE. CPOE we went from meds to labs and other orders and in Stage 3 we went to referrals.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
Yeah, CPOE we have in both improve quality of care and improve safety. Honestly, I would just pick – other than CDS, I would just pick one for each thing, because the goal is to show in a comprehensible, concise way what this looks like. If we start putting a lot of things twice –

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

Okay.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
– then it just looks like we're doing too much, when in fact it's just the same thing repeated.

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

Got it.

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

But CDS is a little different, so we're allowed to do that, and maybe we've gone even overboard slightly with CDS, but I'm not sure, because I see how that one's a little different. On the one hand we want to show – the tension is, we want to show that it's not overwhelming, on the one hand, but on the other hand we want to show that we're doing something in each of the areas.

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

Right.

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

And so we don't want to leave an area blank if we're actually doing it in CDS, so that's why that one, I think, is a reasonable exception. The other thing, and I wouldn't do it in this – I think for this presentation in September I would leave it like this, but another addition to this is to actually represent what things got carried forward. Like in a separate box underneath, under Stage 2 and under Stage 3, and these are the ones that carried forward, as opposed – so you can see the full picture. I would say for the presentation I would leave it like this with the new stuff, but just for our minds, that's another alternative, so just knowing whether medication allergies got carried forward or it got dropped, so it's no longer under Stage 2, but I would make it a separate box under the blue box, have a gray box which just shows that it just got carried forward, more or less unchanged.

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

Ah, good point.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University
But don't do that for September –

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

Right.

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

– because our goal in September is to show only what's new.

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

Right. Thank you.

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

It's Christine. I agree with George about the carry forward, I think that would be very, very helpful. And I just want to say, coming back to the disparities component, I think that having a slide that's not just conceptually in the pretty slides, if you will, but a slide that is like the ones that we've just gone through where we do with the disparities, you know functionalities, will be very important. Because I think it helps us really focus on how we're doing there, so RELG data collection might be one, population health dashboard might be one and we may have some gaps.

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

That's good point. So we can have a seventh crosscutting –

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

Yeah.

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

Paul, this is Art. I just want to comment on this. I think Michelle was trying to point to the last category, the sixth one, it's listed as accessible and affordable care on that ninth slide. And then I think that Christine makes a good point, we need to elevate the disparities issue and I think we probably all agree to that. On the label here for that accessible and affordable, I wonder if we could change that, since all the other areas are about getting to a better state, and this really doesn't say about healthier, improved or something like that, maybe we could say equal care for all or something like that. I don't know if we need a seventh or we have this mislabeled.

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

I agree we have it – I agree with the idea that you're proposing, but I don't think I would put health disparities in there because I do – what I worry about is that it would obscure the – some of the – well, where was the choosing wisely stuff that I saw, because I would put the efficiency, right, you have Stage 2 generics; so I think part of my challenge is this is confusing –

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

Yeah.

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

– some of the affordability pieces with the health disparities, which aren't always about access. So, I think we just need to do some cleaning up there, but I would keep them as separate pieces.

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

Um.. so Christine, this is Michelle, I'm sorry, I just want to clarify. So if we pulled out the affordable, for example, and did the generics and the UDI and then had an accessible one, which – or however we want to – whatever we want to call it related to disparities, would that be okay? Or do you want a disparities that really shows that its covering everything?

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

I think it's –

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

Well – I'm sorry Paul –

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

I think I'm agreeing with Christine that there are two things we don't want to get either mutually obscured or lose focus. So one is affordable, that's the efficiency and cost, and the other is disparities, and it's not just accessibility. So I think there is a seventh one of these slides – this mapping and it's going to be crosscutting, that's represented in the color one, the colorful slide.

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

Okay.

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

So I think it's in a way, it's crosscutting in the color slides, but it is almost as though it's its own –

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

Correct.

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

– what is that – horizontal bar at the same time.

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

Correct.

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

I would – this is George, I would just pick something, I would pick a seventh thing and not make it – I mean yes, it's cross-cutting in a sense, but there's lots of things that are cross-cutting.

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

Yeah.

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

I would just make it a seventh category, so just – split affordable and accessible and rename accessible equal or whatever it – what was it you just said it Christine?

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

Equitable.

M

Equitable is what –

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

Equitable is not bad. Okay, so then –

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

IOM had –

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

– just make that a seventh and then stop there. And if you start doing crosscutting, then people start getting confused and they're like, well what does this –

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

Yeah.

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

– now it's in two places and then it looks like we're doing more than we're really doing. So I would just make it a seventh and be done with it.

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

Okay. We can take care of that. Other comments about this approach and somewhat about the depictions?

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

So this is Mike. I'm trying to imagine the audience or the various audiences. I know the primary, principle first audience is the Health IT Policy Committee, and this may be connecting the dots enough for them. If I imagine a consumer, a provider, a staff member, I would – and then I'm thinking all the way out to outcomes, and I think basically our two major outcomes are quality of care and all the things that go around that and safety. And even some of the MU3 care domains feed into those, accessible and affordable ties into it, care coordination ties into it, etcetera, etcetera. The notion to me is, as I look at them it's still hard to connect the dots in the textual format with the outcomes and I agree that a number of these like CDS, touch on several different areas that matter. And I'm just wondering if, as we think about both stories that would exemplify this, so that it fully connects the dots with people, that is this approach going to be as effective as we need it to, to satisfying the need for connecting the dots. Or might we think of a different approach, visual or otherwise that helps people see the why, and then can see a little bit more with what the recommendations are about the how.

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

That's a really good comment, Mike. What do you think about, and you mentioned this, when we go back and define – when we start putting them in these buckets, if we even had just the one sub-bullet example, e.g. how does CPOE improve safety? How does knowing about race improve overall quality of care? How does generics improve cost? Even – I mean, there's danger always, but that's why I was saying, e.g. like one thing or something so it's clear that it's not comprehensive, but maybe that helps for the various audiences that might talk about – because it's true, we're still like we all know what we mean and we know how that connects. But even putting it in this picture, this graphic doesn't go – connect it for anybody else but someone who's mired in these details.

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

So I like your comment and let me actually carry it another step or two further. What if, for example, we're trying to convince docs, as I do on a daily basis, why they should use our evidence-based order sets instead of one-off CPOE, taking CPOE if you will from the small dot to the bigger dot to the really big dot, advance CPOE. And then saying, well it does help with disparities because if everybody's using the same order set, there's a much better chance that everybody's going to get the same care, or that they're going to have other aspects that deal with efficiency. Because if your order sets are highly efficient, you'll get done faster, you'll be following more evidence-based things, so therefore you'll probably have less overuse and misuse of tests and treatments and you probably are going to be safer because the only things that are in the order sets are things that match that level of safety. So, connecting the dots for providers and patients on this, I think, can be really helpful. And we can also frame, if you will, the difference between one versus five and five versus fifteen and even fifteen versus a future state in which these other various aspects of how they connect to the other domains really matters, and represents a roadmap.

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

That was good – that was a treatise.

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

Sorry.

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

So here's a –

W

Yes, I agree it was a treatise.

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

– yeah, so let me just try to weave these both in. I wonder if we have a simplified, because remember George was saying, very appropriately, we have the tension between not being overwhelming yet being comprehensive. So the not being overwhelming and being able to see the big picture, we need few words. But maybe what we can do is annotate these things, have the superscript and then in the notes section, so that the entire PowerPoint and its notes go along, and that gives you, the presenter, Mike, the ability to say, and what does it mean, CPOE? Or what does it mean, CDS? Or what does it mean, ethnicity? How is it connected? Then this superscript refers to the more elaborate explanation that you just gave, but it's in the "notes" section of the PowerPoint.

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

Yeah, and I apologize for the treatise, but the point was you can imagine the stories you could tell from that –

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

No, I understand.

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

– for the – .

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

I totally understand.

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

Right. Got it.

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

Just wanted to capture it, but not in PowerPoint.

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

Absolutely, right.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical

So, Paul, this is Charlene. One of the concepts too here is just to have some signposts, where you're giving an example of that, so that might be an approach, too.

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

So explain – signpost? Not sure I fully understood the signpo – how the si – what do you mean? Sounds like she's on mute because there's other noise, but at any rate – so it sounds like we're in the – is the direction good and then we need to find a way of essentially giving the presentation materials. And what I mean by that is it's not only the PowerPoint bullets, but the accompanying information, which we could put in the notes so that it gets carried with this PowerPoint as an example.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Paul, this is Leslie. I just had another comment. I really like this as a way to check our work and it's very helpful, for instance, if we look at the patient engagement and the patient-generated health data that we want to add. As we go forward we say, how does this help the other areas. So if we see that medication adherence is a really big, important concept, then the data we collect perhaps first from patients would have an emphasis on medications that are actually being taken. So I think this is a really great approach for us to also crosscheck our work. Are we enforcing other agendas? Do we get a twofer on things? And – so that we really can show a circle in the way that we're moving forward.

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

Okay. Are we – we're okay with this and then we just need to make further adjustments? And Mike, please contribute your explanations for any number of these things, I think would be helpful. I think Michelle and Elise would appreciate that.

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

So maybe what I'll do is just offline I'll try to create a single example of something simple with the detail behind it and just let you react to it.

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

Well, you can create multiple –

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

I'll see how the first audition goes first.

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

Okay. All right.

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

Mike, this is Michelle, can you make sure you include me on that?

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

Absolutely.

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

Thank you.

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

You're welcome.

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

Let's move forward with the slides then please. Next.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical

Hey Paul, this is Charlene, I had to drop because I had some background noise. Just the other thing that if we can just correlate with this that relates to the conversation is there's the Accountable Care Workgroup that's been working through this accountable care framework. I don't know how that's going to be harmonized at the policy level. I'm not even suggesting that we necessarily harmonize with it, but we at least need to check the box as we're going through this process, okay? Because I mean, that was kind of defined from a process perspective and it is mapped to some of the elements that are in Stage 2, so we just need to make sure that at some level, at the policy level, that gets – there's something that's cross-cutting if we're going to go down this path, would be my only comment. And it doesn't necessarily map into the framework that you've come up with, so, that was just kind of a – because I kind of monitor that workgroup.

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

No, thanks for the comment.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Okay.

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

The intent was one, to – there is a ACO Workgroup, they have not had, I don't think, more than one meeting so it's early, but the intent was for them to give this different perspective you just described. And we even wanted them to weigh in initially on the quality measures, because that's a driver. But yes, we will – maybe this might be something, Michelle, that we float by them and get their comments so we can get more input from that perspective.

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

Charlene, are you talking – it's Christine – are you talking about the ACO framework for HIT that I think came out of a CCHIT Workgroup.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical

CCHIT yes, yes. And I'm not sure to what extent they'll recommend that, but I know it's been discussed pretty extensively in that workgroup. And there's correlation clearly between the functional requirements that we talk about and what's in that framework, and they do map to what we have in Stage 2 in that framework. So, some of that works been done. And again, they try and say, okay each ACO will be different, so it doesn't mean that it's got to be prescriptive, so they're trying to stay away from that, but again, we just need to cross-cut if – as we, I think, move this direction so that we're aligned in some way. I'm not suggesting we adopt –

Multiple speakers

(Indiscernible)

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
– their requirements, but let's just coordinate.

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

Yeah, so this is Michelle, actually when they were walking through the CCHIT framework, I had done a mapping based upon where the Meaningful Use Workgroup was, to identify areas that did align. It was almost too much detail for that group because they just quite weren't ready yet, but I can certainly dig that back up and update it upon where we are now and share that with this workgroup.

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

That would be good.

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

And to the extent that that can be depicted somehow as another way we've coordinated and another way that it's aligned, that would be a good outcome for the presentation in September. Okay, so now moving on to eQMs, Michelle and Elise and probably Jesse helped to put together, in those six domains, how have some of the measures lined up. And this just illustrates this in the next slide. Do you want to go to the next slide please? Okay. So that's an idea, and I think we could improve on it in terms of like getting it crisper and getting, as Mike says, just visually seeing how these dots connect. And anybody who has ideas on how to visually represent that connection, in addition to these examples, would be really – your ideas would be welcome. Number – next slide please.

So the deeming pathway, just to remind you, the assumption – everybody's already not only done Stage 1 and 2, but continue to do 2, and so no object – no functional objectives that we would deem would be new, i.e. new in Stage 3. So that means that this stuff is already implemented, that's part of the constraints. The second – so the main piece is that people who are already performing well in HIT sensitive measures, or improving significantly, they would be satisfying a subset of MU objectives. The whole goal is to reduce the burden, because you're already doing this. This is an optional pathway, it's also to give you more flexibility so that you can innovate within the construct, instead of having prescriptive requirements and it rewards good performance. It hinges on new development of eQMs that – and we're not alone, so all these new CMS programs like ACO and PCMH need better measures that reflect outcomes. So that's another way we're aligned, but we're just saying, we'd like to be in line with all the folks who are requesting and demanding these new measures, so that they could be caused to make happen. Next slide please.

So to get away from saying – getting criticized on any one measure, which we already acknowledge right in this last slide that are not there. The point of the framework is to say, it's high performance, we said top quartile, improved performance, 20% closing of the gap between you and the top quartile, and, what we added last call, reduction in disparities. So we're giving only an example of two things that match up with the Quality Strategy, one is a bucket, prevention and another is a bucket of control of chronic diseases. And an end-condition is that you should demonstrate improvement, narrowing the gap bet – a disparity population and your mean population on one of those four selected populations. This is for EPs. Next slide please. And for EHS, same thing, same framework, pick from two buckets so you have flexibility and pick ones – things that are important to your population and also do disparity reduction.

So we're reducing this to be less prescriptive and basically just presenting the framework really. Pick – give some flexibility in picking what's important to you and tie it to reduction in disparity. So that's the goal for the deeming alternative pathway. Any comments on that?

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

Paul, it's Christine. This is the one that I'm a little more challenged by because I think the presentation is right, I mean, it's fine. But I don't think anybody's ever had issue with let's say the complexity or whatever, it's really the piece of – folks that I've heard take issue with is the substantive detail about well which measures and are they really HIT enabled and da, da, da. So I guess what I'm a little bit worried about at the end of the day here is nobody disagrees with the concept. And if we just keep sort of putting it out at such a high level, and there's lots of support for it, well what happens if we really can't get agreement on making it work, because of its complexity or the lack of measures. I don't know the answer to that.

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

We are say –

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

Paul, let me say –

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

Yeah, go ahead.

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

– Paul, this is George. I think though there's a difference between coming up with alternative measures versus true deeming. I mean, so the first question is, do we believe in deeming or not? In other words, it's one thing to go through and say, well we have these functional measures and if we do these CQMs, in fact, in order to do the CQM, you have to literally do this one because you couldn't report the denominator without it. All you're doing there is coming up with a different set of measures for the same set of functions. That's the one-to-one mapping from each CQM to each function gets deemed. So that's different from the idea of truly deeming where if you're achieving outcomes as an organization, and we come up with criteria that actually mean your organization is truly doing well and not gaming the system, let's say we could do that. Then we say, you don't need to report on functional measures anymore. And the purpose of the functional measures is to get the nation using the same standards, so we need to – we want to do Stage 1 and Stage 2 because we want everyone to be doing CPOE in a way that we could share the data using VDT or something, right? We don't want to skip over Stage 1 and Stage 2, we do want to get through that part.

But once you're at Stage 3, already proving you can do it, already set up the standards, everyone uses the same basic standards say for CPOE, not the same user interface necessarily, but the same standards for sharing for the VDT. So we can act – and for care coordination, to actually share, then you actually get deemed and you don't have to do one-to-one mapping from the CQM to functions that can be deemed by the CQM. Because it's the whole concept of achieving good performance and therefore not having to continue to prove that you're good. So that would be – and the things that get deemed, it's not that they have to map back to the CQM, they just have to prove that they were adequately covered in the prior stages.

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

Well I think George that's where there's a little bit of disagreement or maybe it's in – at the nuance level, which is that this is an EHR Incentive Program, Stage 1 was supposed to be about data capture, Stage 2 about data exchange, Stage 3 about outcomes, yes. But, we've always said EHR-enabled outcomes and so the challenge here is these are – many of these are measures that have long been out there, that providers have been working on in the absence of EHRs, so just because you've got a high influenza-screening rate doesn't necessarily mean that you're using your EHR to get to that outcome. And that's where I think we're – the real challenge is here. So conceptually, sure, but when you get down to how to operationalize that, for example, does it really mean that if you are – even with some of the better measures, if you are focused on HBA1C control, does it really mean that you're also still giving your patients an after visit summary or giving them online access, because we're deeming those. And I don't think you –

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

Okay, well I think that the program – well, where we agree is that it shouldn't be easy to game the system. So, I mean if someone is doing one particular measure in some very inefficient way, that's not our – that's not what either of us wants to accomplish. However, if they're really proving that they're – I mean, the MU Program is not going to go on forever. We're out of – we're going out of the Incentive Stage soon, into the Penalty Stage and I think the goal is high – is improved outcomes and we just presume if they've been using CPOE for three years, they're not going to shut off CPOE, and even if they did shut off CPOE and achieved legitimate, perfect outcomes, maybe we needed to learn something there.

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

Well – so – but, I think the caveat is, you use the example of CPOE, we've also said there are certain areas that the market isn't thriving, patient engagement, health disparities, things like that. And so, you know, I think when it comes to those measures, it's a different story, number one. And number two, I think from a fiscal responsibility point of view, this is an EHR Incentive Program. And so if you sort of make too large of assumptions about the connection between the use of the EHR and the achievement of a measure, then we may as well be the Hospital Value-Based Purchasing Program, do you know what I'm saying? There's no difference between this program and others if we use the same measures and that's not, I think, statutorily what Congress was aiming for.

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

This is Mike –

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

So it really gets down to the HI – what are the measures and are they – can they really give us some confidence that the outcomes are at least in part driven by the effective use of technology.

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

No, but I think that what's different, Christine, is that in Stage 3 and Stage "N," we'd be adding some new objectives, and that would be the part that would be truly EHR-based, we would be deeming the ones that we think the nation satisfies, because again, the program's not going to go on forever. At some point, things are going to be going off, and so just look at it as a staged – it's a staging of the program going off, these things were achieved, these are high outcomes organizations, they don't need to report any more, but they will need to report on the ones that we think remain important. And for me, it was patient engagement and health information exchange, right now I think patient engagement is actually going better than I would have thought, but health information exchange is going a little slower, so that would be how I look at it. But those – remember in January, those were the ones we were talking about being the ones that we really hadn't achieved yet. And disparities, too, I guess.

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

Yup. But you can make the argument then, that all we should do is focus on those areas and to forget everything else, and make the assumption that they're using it, but just focus on disparities, care coordination and patient engagement. I mean, so the challenge is in how you link the measures back to some tie to the EHR, I think that's the point that David Lansky's often raised.

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

So this is Mike, if I could jump in. So I understand these arguments. I think part of the way we framed it here is to say we have been able to achieve excellence in some areas through brute force and high vigilance and persistence and effort and that the EHR technology and the requirements, the measures have helped hardwire for us, a more efficient, effective, demonstrable way of achieving the goal. And I think one thing that could be considered is not only just performance against a target that could conceivably be achieved without Health IT, but is enabled by Health IT. And at least at some point in the program, actually looked for evidence that there were structured data with regard to either entry of an order, completion of task, etcetera, etcetera. And the expectation over time that all reasonable players in the field will continue to use their hardwired EHR-enabled technology to fulfill that, and if they do otherwise that's not only unlikely, but obviously probably not a great business choice. So I think one of the things I'm wondering about from Christine's point of view is, is there a place where you need to also be able to say, in addition to having a high score with regard, for example, to immunizations, that you've also continued to capture that in the system in a structured manner, so there's every reason to believe that it is enabled by it and it will continue to be so.

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

I think that's a fair question.

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

This is George, just one last thing to consider. If we're too – if we're not careful, there could be a backlash and there would be no program. So what we want to do is not provoke a backlash where they say, okay, enough is enough, we've done Stage 1 and 2, we're set.

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

Yeah, I get that George, but I'm also thinking about the public backlash for what happens when patients no longer get reminders, no longer do online access or have secure messaging. Because frankly you can – it's – if you didn't build it into your workflow in a way that created efficiencies for you, the provider, well it's just easier not to do those things and now we don't have to. And so when I think about like the HCAHPS experience of care measure in care coordination for EHs, they've been working on that for years, and we're going to give them credit under meaningful use. I don't – I'm not sure that's a good call. Now disparities, I think there – as I've said before, it is much harder to reduce the gap when you don't have IT, like significantly harder, but you can work on HCAHPS pretty easily without IT. That's what I'm –

Paul Egerman – Businessman/Software Entrepreneur

Christine, this is Paul. I just want to comment on one part where you said you're worried about the public's backlash if they no longer get reminders or visit summaries. I would think that healthcare providers would be responsive if their patients were unhappy about stopping something, that they would restart it.

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

I don't know that that's the case. I think there are plenty of examples where that's not been the case and there are some examples where there are, but from a tax – I mean, right, taxpayer's funding this, I'm not speaking to the global level, right? I agree with everybody and we all agree together that conceptually this is a great approach. The devil is in the details and that's what I'm worried about, and so I'm giving the example of something like HCAHPS, umm, where there's a much more tenuous link to IT. That's what I'm concerned about.

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

Christine, I think HCAHPS now has, or maybe it's GCAHPS has a comment about your access – timely access to inform – something that's related, it's HIT sensitive, is that not true?

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

I will look at HCAHPS, I don't think so, but I think it is – what you may be thinking of is the CG-CAHPS module on HIT, which would be for the ambulatory setting only –

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

Yeah. Okay, and I think –

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

– and that –

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

But in a sense, that's where we'd like to go, so if HCAHPS could go in that same direction, that's the real – it doesn't matter how much is turned on, it's how much – where people perceive in our taking advantage of these things. So in some – that's a much better "outcome."

Paul Egerman – Businessman/Software Entrepreneur

So you're –

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

– this was an HIT CAHPS module for hospitals, this is a different conversation, I think that gets much more to...a stronger indication that the incentive dollars are being used to – for the HIT to enable care improvements. That's all I'm saying.

Paul Egerman – Businessman/Software Entrepreneur

So your concern, Christine, is somebody could get a good HCAHPS score by having like good food service.

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

Correct.

Paul Egerman – Businessman/Software Entrepreneur

It does not necessarily have anything to do with their IT activity.

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

Correct. And somebody could be achieving immunization rates based on a file and postcard box system that doesn't have anything to do with IT, because it was in place, and it works for them, which is great. And I think that's a valid outcome, but it's not an HIT sensitive measure.

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

So I think that's the phrase I'll try to introduce in these slides is ideally, we are looking for outcomes-oriented, HIT sensitive measures, so that we would focus attention on what's been accomplished rather than in these later stages, how you got there, so...

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

Yeah.

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

– being prescriptive on how you got there using this technology.

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

Yeah, I'm raising two concerns. That's one and then the other, and we can get to it when we go potentially into more of the deeming stuff, is that there are some things that – some functions that we're deeming that I think there isn't a strong tie between the ability to perform on a measure, which gets to the HIT sensitivity, and the functionality. So, VDT, reminders, the patient-facing stuff, that's the second concern.

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

Well, but if it's in CG-CAHPS HIT module, I think that's covered.

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

Yeah. Yeah, if it's in CG-CAHPS HIT module, I totally agree with that. I think if you don't get the clinical summary, and I'm not sure you get to reminders in that, but I could check.

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

Right. I don't think we have to do each and every – that's the whole point about not being prescriptive. If your patients feel you're communicating and they have a way to get to you, regardless of how you did that, I think –

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

Yeah, no, I agree with that, but – except in the areas – on principle, but again, except in the areas that are not particularly market driven. So in the after visit summary, which I didn't recall deeming, but it's on slide 23, the after visit summary is really essential, not driven by the market. It wasn't happening to the level it was – it is now, previous to meaningful use and there are many published studies that show that patients forget about two-thirds of the information that occurs in the office visit. So, just because my LDL is under control doesn't mean that I'm getting all of the information I need. It means that the people with that particular condition are doing what they need to do, but I don't think that in those areas like disparities, care coordination and patient engagement that deeming is a good plan, until potentially everybody's part of an ACO or a PCMH or something like that, and we won't be there for Stage 3.

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

Okay, I think we are making the transition to the next slide please. So I think this, like everything, it's a balancing act. If we have too few things, then it's just not worth doing and I think in the spirit of keeping the eye on the prize, we do want people to be high performers on things that matter to patients and consumers. And to the extent that we have better tools, let's call it HIT sensitive tools, it could be CG-CAHPS HIT module, it could be HIT sensitive quality measures, whatever we rely on, and they may not have been developed yet. But we're asking for them to be developed in time for use in Stage 3, there has to be some assumption that the folks who are performing well are using it. And I think that's part of the – that really underlies this whole deeming process. So, to the extent that we require them to do each and every thing, we've sort of, at the same time, dismantled this whole alternative pathway.

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

Yeah, and I agree with that Paul and I don't want to do that, because like I said, I do particularly agree with the approach in concept. I think my approach would be to look at the right hand column of remaining items, look for things that were core in previous stages, look at things where performance was high. And then look at things where potentially the infrastructure – if the performance wasn't particularly high, or there are a lot of exclusions, it's because the infrastructure weren't there, and move them into certification only, which is what the deemed and satisfaction left-hand column is.

So, I might think about things like advanced directive, because it's presence or absence only, it's not content. It's very high performance, its core, it was a highly selected core to a highly selected menu item in Stage 1, should that or potentially some of the public health things if the infrastructure isn't there yet, really be part of deeming. But not so for some of the ones where the market hasn't driven them successfully. I mean reminders, for example, was the number two opted out of thing for menu items, after care summary. So I don't think there's the evidence that would support that that should be deemed, for example. I'd rather look at the right side and maybe other – even some of the new items that we're putting in Stage 2 that could be certification only, because there is a direct tie to improving health outcomes and expand the list on the left that way.

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

eMAR might be another high prevalence thing that's already done.

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

Sure.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul. I hear what you're saying Christine, I'm just a little bit worried about undermining what we're trying to accomplish with deeming. I mean, is it adequate simply to say as part of the deeming process, the person attests that they're continuing to do, in Stage 3 at least, the same level of these activities as they did in Stage 2, so it's not like they're eliminating anything?

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

So you're saying take something like EH –

Paul Egerman – Businessman/Software Entrepreneur

Take something like care summary, and if you deem, you also say you're going to attest that you're continuing to do care summaries, at least at the Stage 2 level.

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

But the difference being you wouldn't have to do the denominator and numerator calculation, you'd just –

Paul Egerman – Businessman/Software Entrepreneur

Yeah, you wouldn't have to do any of that other stuff. You wouldn't have to figure out your denominator and numerator. You're just saying, I'm doing it – I continue to do it, I haven't – I'm not backsliding on care summaries, if I did it before, I'm doing it at least as well as I used to. But you don't have to recalculate everything, because again, part of the complaint is that – I mean, the fact that the complaint exists is actually a good thing, it says that people are really working hard to make sure that they meet the criteria.

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

Yup.

Paul Eggerman – Businessman/Software Entrepreneur

And so, it seems to me if they're going to go through all the work to make sure that they meet the criteria for deeming, we ought to be – make it – give them a fast lane – a fast pass lane or something on some of these other things, to either say they don't have to do it or they can simply say, yeah, I'm still doing it, not to worry.

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

Yeah, I mean I think that's an approach worth considering. I would – I will probably make it the second tier approach, only because when we've done some things like that before, we've been really well intentioned but then it turns out that the providers get really worried about audits and then they – they're like oh well, I better really, really do it. So, I think we should look at that and see if there are other fast pass ways. I think the first approach that I would consider is, what about advanced directive, eMAR, some of the immunization – particularly immunization registry if you're reporting on immunization screening measures, or pieces where – the public health, where the infrastructure isn't there for every state, but where it is, it's probably going to be used and move those over first. And really kind of take a good scalpel to what we can deem outside of the three or four areas that we've said the market isn't driving.

Paul Eggerman – Businessman/Software Entrepreneur

That's fine, maybe – we also just have to keep in mind that there are some reasons why people don't do this, don't do advanced directives or don't do clinical summaries. So advanced directives may not work if you're like – for certain specialties, if you're an ophthalmic specialty –

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

Right, but we're deeming it so you wouldn't have to –

Paul Eggerman – Businessman/Software Entrepreneur

That's right, and so it doesn't work, and care summaries may not work for other specialties and so, that's just – it's just an observation.

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

Yup.

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

So can I take as a summary from this, if we still believe in the concept, and I think we're moving in the direction of look, we've got to back off and we need to align with what's pulling people, which are the new models of care. Then let's try to get as much from the right side over to the left side, with the presumption – I mean, that's the whole approach of deeming, and the contingency, which is a major one, is that we do get HIT sensitive measures to deem with, and we can describe that. So like CG-CAHPS HIT module is a really good way – a good outcomes oriented basis to deem things. And we can list some other examples, and that's the whole – so we're not actually going to propose deeming program, the deeming alternate pathway, if there aren't good measures. So we have to assume that, and we cannot predict what's going to be present in 2016, 2017, whatever, but we're saying, if you can get – if the good measures, and some of them are going to be recommended by the Tiger Team, do become available, this is a program that would help point us – keep us aligned with the direction we wanted to go and reduce the burden of the program – of administering the program and complying with it. Is that a fair summary of where we are?

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

Yup. Yes, just with the small caveat that I really – that we need to move columns from the right to the left, but there are a couple of the patient engagement pieces on the left that I think need to go to the right, because they fall under the criteria of not being driven by the market; same thing with care coordination, disparities.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

An example – this is Leslie – on the – for instance, on patient education, we’re just starting to talk about new languages. That’s going to be an important part, so we don’t want to deem patient education because we really want to drive other languages as we go forward.

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

That’s correct and that’s new to Stage 3, so if we use that criteria on that element of it, would not be deemed.

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

That’s true. So, things that are new – we don’t deem new things, because there’s no evidence that it’s been done, so, agree with that. Okay, so we’ll try to – would it be reasonable to ask the leads of the categories to try to come up with more things on the right to push over to the left?

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

Yup.

Paul Eggerman – Businessman/Software Entrepreneur

Yes.

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

And give an example of the kind of measure, if you can point to one, like CG-CAHPS HIT module, that would be fabulous. If there’s the concept you can identify with to make this contingent on, that would be great, too. That just gives us additional support for why we need measures of this sort, that would be good, actually, we could actually put that right in, here’s the things that we think we need. Great. Thank you. Next slide please.

Okay, so just to fill out. We got feedback from CMS it can’t be a six-month rotating performance. So, one of the strategies the providers would have to think about as they move towards deeming is you’ve got to have a comparison, so you will have – will need – if you’re going to improve or test out of something, then you have to have measured it before, in the year before. That this is an optional pathway and it is true that if we don’t have performance measures for every specialty, they may not be eligible, and of course, the underlying incentive is for you to work in your professional society to get these outcome-oriented measures through that process and get NQF endorsed. And finally, the reminder that we want to tie this – we’d like it to almost be bi-directional. So, just like we might want to take some ACO measures and put them in here as really good examples and they could even be deeming examples, we would like to have the kinds of quality measures that can be picked up by CMS programs as being deemed over there. So we’d really like to align, that way whatever efforts people do put into reporting, and that is one of the high cost things of this, that you can reuse it. So that’s part of this program. Next slide please.

So where we are, I think we’re doing pretty well. I think we need to revise our presentation, and really ideas are welcome. So Mike, your idea about these stories – the connect-the-dots stories, as many as you can get us are good. We need to think about a visual way of making sure that it’s seen, probably almost on a continuing basis rather than switching over to the row basis. Anyway, some way of visually connecting the dots and through stories, connecting the concepts to the outcomes that we’re shooting for. That we’ll review that in our next call, before we present that to the HIT Policy Committee for approval of the framework, the outcomes framework and the direction we’re going and with that approval, we would continue to relook at the details we had worked out. And some of them might survive, some might be new and some might no longer be relevant with this perspective.

And we’d be shooting – and we’d get the input, hopefully, from the new Tiger Team on what are some of the recommendations. They’re not going to be there already, but again, this example of the HIT CAHPS could be one of the recommendations that come out of it, use that, to help input both to our MU recommendations, as well as our deeming recommendations, with additional recommendations. And I probably shouldn’t have put November there, what makes sense for what we get from the Tiger Team and if we can get some early information from the Stage 2 experience, those would all feed into us coming up with our detailed recommendations back to the Policy Committee on its way to CMS and ONC.

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

In October, you're saying?

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

No, so we're – September is the date that we're going to try to get our approval for the framework, and the way we're presenting the linkage to outcome. And then we would like other pieces of information, the Tiger Team recommendations on –

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

Actually Paul, Paul, I think in September we're trying to get not just the framework, but actually – but we don't have the details, the objectives. In other words, like we're presenting the framework for their buy-in that this is a reasonable number of objectives, this is a reasonable mapping. Like it's not just we should do a framework –

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

– yeah.

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

– because that's what we want approval on so that we can go and do the details next.

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

I agree with you. So those – like CDS, that – they're buying into the framework and the way we've placed and linked these objectives. I agree with that. We may not have a complete set or we may – yeah, we may not have a complete set at that point, but they agree with where we're headed and the things we've done so far.

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

Um hmm.

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

And that's not binding, for example, this doesn't bind them to accept our detailed recommendations, but yes, that's where we're headed for September. And then based on this other input, we might target something like November to come back with the details.

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

Right.

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

Does that make sense?

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

Yup.

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

It does and I think at least November, maybe potentially October, because we have been working on these for so long, I think there's very little that's new, with the exception of potentially re-looking at ACO functionality and health disparities functionality, we've been – this has been going on for more than a year, I think, at this point. So, it might even be great to think about some elements that we could do in October.

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

Except that we won't have the Tiger Team –

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

Ah, the Tiger Team – well, right, that's for deeming. Right, but doesn't that only affect deeming pretty much?

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

Well it affects certainly the CQM reporting of meaningful use, but also the other thing we'd love to have information on, because the public's been asking for this, is how's it going with Stage 2, because that certainly affects Stage 3. And then the separate topic we want to talk on – talk about is timing of Stage 3.

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

Right. So two questions, one, so the Tiger Team is not just looking at eCQMs for deeming, they're looking at the whole eCQM process for meaningful use? I thought that was the Quality Measures Workgroup did that.

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

So it's a combination. We're trying to fit into the timing, and I know that we don't have a specific timing that's been given to us, but we're trying to get the recommendations in as early as possible, partly because we want to trigger the filling the gaps that are identified.

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

Right. Okay, that's –

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

So that's the timeline.

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

The other – second thing is, I guess it's a comment not a question. I don't think we're going to have any really meaningful information about Stage 2 until probably three to six months into next year, because it doesn't even start for EPs until January 1.

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

Yeah.

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

And, if the provider community is right, and I'm not saying they're not, and there are fewer completely certified EHR products available on the market, we're not going to have information about the stages until well into next year. Because even the EHs won't be attesting starting October 1, unless they happen to have one of the updated EHRs, which I think will – sounds like, will be sort of few and far between. But, I think keeping our process moving so that even during the whole – the rulemaking cycle, which they need to receive our recommendations, have time to write, put it out, 60-day public comment, da, da, da. That's a several month long process at which point there will be more information from the second stage, so I don't think the Policy Committee necessarily has to wait on that.

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

No, that's a fair comment. I mean, we get more information about the availability of 2014 certified EHRs, for example. But that's a fair comment, so we may not be – we may not be able to get that experience, but they will definitely have it for the NPRM, so, that's fair.

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

Yeah, so all I'm saying is the more we could do in October, the better, so that we don't inadvertently hamper a timeline.

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

Right. I think it's unlikely that we'll present our final in October because of the quality measures stuff –

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

Sure.

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

– but, we can – we're trying to shoot for this Fall. And it might work out from a face – I do think we need face-to-face, we are face-to-face September, that means we probably will be virtual in October and so maybe November is a face-to-face, when we can present our final. So we'll work on that piece. Let's see how September goes and if we can get by on the connection with the outcomes. Any other comments? Some very helpful discussion.

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

Paul, this is Art, I had a question. I had to step away, so you may have discussed this, so if so, just let me know. Earlier in the call there was a mention by Farzad, and I think even on one of your early slides, you had a piece that talked about using data that might not be collected yet –

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

Not yet.

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

– and I just wondered, in that slide where we're talking about things on the left, things on the right, is there a third column now of things that were not in Stage 1 and Stage 2, but are part of deeming, like claims. So I don't know whether that's something we need to return to or, I wasn't at the Policy Committee, so I don't know what that fuller discussion might have been there or the challenge of should we be including other types of data.

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

That's a really good point, and thanks for reminding us of that, and I think Michelle, we might want to have a section laid out in our next call about deeming and include this notion of, does it only have to be data in a certified EHR? So that's bridging and – that's broaching another boundary, but we certainly can talk about it. So the example was readmissions, which is a claims-based measure, then – but is that something important that if you're doing well on that, that deems you certain things. So that's a question to ask, but you're right. So we raised the question but we need to schedule some time to discuss the implications of that.

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

Well what was the measure, I missed it, sorry.

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

Readmission, that's a claims –

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

Ah, great. Thank you.

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

– and yet that's very important, it does contribute to quality care, it does contribute to cost, what do we have to say about that? Clearly there's lots of processes that you put in place to try to address that problem that don't have to rely on the EHR, but there's certainly a lot of contribution of the EHR that are required probably to achieve a good result. So that's something we have to think through. Any other comments, questions on what was talked about today? Okay, now let me ask a question. What's the impact of my mistake on the next call scheduling? So Christine says she's not going to be able to make it.

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

Right.

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

Others who can't make it?

M

What's the date and time again please?

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

I think it's the – Michelle, you have it, 29th I think.

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

Yes.

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

This is Mike, I have clinic then, I won't be able to make it either.

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

I will not be able to be there. This is Dave Bates.

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

Okay, so I've sort of botched up. Would it make sense to do a Monkey Survey, just in this special case, would that be okay? Michelle? Caitlin?

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

Sure, we can work with Altarum to see who's going to be available.

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

Thank you Paul.

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

Thank you, it's possible that we could deal with – what we're doing is we're revising the slide set, it's possible we could get signoff and comment electronically, in this special case, but, in general, of course, talking is much more productive.

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

I thought that was the call where we were going to talk about the timing – the sort of policy implications of timing, pros, cons, etcetera.

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

Yeah, I think we have time – that was the original schedule, since we are delaying our final recommendations, I think we have more time, we could have in September, and I certainly would want to have as many people as possible on that discussion. So, partly because I messed up, that we can defer and also, we're not making our final next month. All right, so we'll work with Monkey Survey, if we can find a time great, and if not, we'll try to work the revisions of these slides through email, recognizing we're just getting feedback on the framework and the objectives and then we'll still be deliberating further in September.

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

Paul, this is Michelle. I know a number of people had a few ideas of how to...so Mike Zaroukian had some ideas and Charlene had mentioned something, if people can send what they were thinking, I think that would be helpful.

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

That would be really helpful, yes, that would be really helpful. All right, thank you, and then we'll open up to public comment please.

Public Comment

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

Operator, can you please open the lines?

Rebecca Armendariz – 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 are listening via your telephone, you may press *1 at this time to be entered into the queue. We do have a comment from Carol Bickford.

Carol Bickford, PhD, RN-BC – American Nurses Association

This is Carol Bickford at the American Nurses Association. One, I wanted to say thank you for those slide presentations at the very beginning, it was very helpful appreciating the flow and understanding how it all fits together. There is a question I have on improved quality care slide and it was in Stage 3 where you're recommending medication adherence. Has there been conversation about being it bigger than medication adherence? For example, if they are talking about nutrition for the obesity problem, is there consideration and that it's other things besides medication for the patient engagement and – measures. And the last thing is, if you select a new data for the next call, because it's being rescheduled, please get it posted as quickly as you can on the calendar for those of us who are trying to track what's going on. We don't want to miss the opportunity to hear the thinking and also provide public comment. Thank you.

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

We'll definitely be posting the change.

Rebecca Armendariz – Altarum Institute

We have no further comment at this time.

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

Okay, thank you. Thanks for attending and your participation in this call and for working through as we get in the final stages of Stage 3 recommendations. So, appreciate all your help. Thanks.

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

Thank you Paul.