HIT Policy Committee
Advanced Health Models & Meaningful Use Workgroup
Final Transcript
April 27, 2015

Presentation

Operator
All lines are now bridged.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Good morning everyone, this is Kimberly Wilson with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Advanced Health Models & Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of the call. Please state your name before speaking as this meeting is being transcribed and recorded. Please also keep your line muted if you are not speaking. I will now take roll. Paul Tang?

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

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Joe Kimura?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Charlene Underwood?

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Frederick Isasi? Shaun Alfreds? Cheryl Damberg?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Arthur Davidson?

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

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Marty Fattig?

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Norma Lang?

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Devin Mann? Lisa Marsch? Ginny Meadows?

Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Sumit Nagpal?

Sumit Nagpal – President & Chief Executive Officer – Alere Accountable Care Solutions
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Terrence O'Malley? Neal Patterson?

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Mark Savage?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Good morning; here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Good morning. Charlene Underwood? Michael Zaroukian?

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
(Indeterminate)

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Thank you, Charlene. Michael Zaroukian?

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

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Amy Zimmerman? Stephan Fihn?

Stephan Fihn, MD, MPH, FACP – Director, Office of Analytics and Business Intelligence – Department of Veterans Affairs
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Robert Flemming? Patrice Holtz? Jessica Kahn? Suma Nair? Lisa Patton? Terry Postma? Shawn Terrell? And do we have Alex Baker from ONC?

Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
And Samantha Meklir?

Samantha Meklir, MPAff – Senior Policy Advisor - Office of the National Coordinator for Health Information Technology
Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
And Kevin Larsen?

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

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Is there anyone else from ONC on the line?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Kim, it's Michelle, thank you.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
Hi, Michelle.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I just made it.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology
And I'll turn it over to you, Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Thank you very much, Kimberly. Welcome everybody and thank you for the great turn out. As you know, we're on a fast timeline so we're going to try to…what we've done is we've broken into subgroups and we are try…of the workgroup and then we're trying to get our act together before the May 7 call when we're going to have…where we're going to be joined by 2 other workgroups that are working on other sections, the Consumer Wor…oh, three actually; Consumer Workgroup, HIE and Privacy & Security. So that's obviously going to be a very full agenda, 2-1/2 hours for that one, so we're hoping that we have this subgroup's reconciliation of all of the input from the various subgroups in preparation for that. Does that make sense to folks and we ready to proceed?

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin
Yes.

M
Yup.

M
Sounds good.

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

Great. Okay, so we're going to go in this order; we'll start out with the overall approach kind of subgroup then go to the CDS, population health and quality measures. And thanks everyone for participating. All right, next slide please. Okay, we'll start with the overall ass…the overall approach assessment; there have been some changes, as you know, in the Meaningful Use Stage 3. Next slide, please. And these are the folks that participated on this subgroup; next slide, please.

And we looked at, in terms of the overall approach, we looked at these three aspects of it; one is there is simplification of the programs to sort of make it easier to understand, hopefully easier to implement, which is the second point, reduce the burden. They've certainly heard a lot of feedback from both the providers and the vendors and their goal, and they really mean this, is to help reduce the burden while maintaining the program and provide more flexibility. Part of reducing the burden is to focus in on just the more advanced EHR…EHR/HIT functionality.

As you know, Stage 1 was sort of get the computer systems out there, get…structure data as much as possible into it. Second is to interoperate or share the information in Stage 2 and three, we're really, now that the tools in place, how can healthcare providers start measuring their outcomes and improving them. And so what are the, in this case now, focus on what are the advanced functionality to do population health and manage your population as we move from pay for volume to pay for value. Next slide, please.

Okay, on the topic of simplification, we had a discussion in our subgroup and here are some positives and challenges. Everyone I think appreciates, and you hear the feedback in the media that having a single stage is simpler. Having to manage some providers coming in at one stage and other providers that may have joined a group or adding a new hospital at a different stage just makes things really complex, hard to understand but very burdensome and costly. So this is much better and basically they said everybody's going to be in the same stage, it will start with Stage 3 by 2018.

And the other side benefit, and it really was…maybe it wasn't that clear until you started implementing let's say Stage 2 is when you want to interoperate or exchange information with other folks, well gosh, if they're not in the same stage and have the same capabilities, it gets hard. So one nice thing about synchronizing everybody to a same stage, even though the stage may increase in its stringency is the way it's termed in the law, then it's just good; so you have equal footing, you know where everybody else is at as well in their system. So we thought that was really a good approach.

The next one, everyone's been calling for is alignment. There are a number of aspects of alignment; one is aligning all the various programs, a lot of it from CMS, you know the biggest payer. And because they have a number of programs, even in the pay for value…the value-based purchasing program that have this, that and the other requirements, quality measures that…and quality measures that even have different definitions, they understand that that wasn't by design, so they are trying to align everything. And you're already seeing that they're trying to align the value-based incentive programs, both on the provider…the EP side as well as the hospital side and Meaningful Use.

So going forward it'll be much more of a uniform program. So that helps everybody; it helps providers in actually working on things, it helps vendors in having consistent definitions. And it helps CMS in receiving the reports. That makes a lot of sense to us. That covers a single definition as well.

The quality measurement program will take time to get one, uniform definitions but they seem to be working diligently on that. And the fact that they can synchronize the quality measures, as you know, some measures change definitions as the evidence changes and there may be new measures that get endorsed that are better. But CMS puts out annual rules, let's say, on the provider side; if you synchronize all of the quality measures to this annual update then their reasoning is that they can one, be synchronized but two, be more frequently than every 2-3 years. Those all seemed positive to the subgroup as we discussed it.

Now the challenges, we still get the same 90-day thing. The theory of the 90 days is to…really what happens is you get up to 9 months of delay if you so choose. So as we go to the third stage, the thought was, well, to try to get everybody to move to Stage 3 or from wherever you are to this single stage does take time and so one of the thoughts is to…for this, I guess this final time, to have a shortened period which essentially gives additional times to the vendors and the providers to implement it.

Now given what I said about interoperability and the need to be synchronous, then the request and it was sort of an interesting one that came from the vendors is, if you make it any 90 days, then you may still have this asynchronous problem. So one thought is this combination of a shorter period, and 90 days had been the period used before, but that it be synchronized. And I don't know how you synchronize it, but you say let's say starting halfway through the year or maybe just the third quarter, if everybody is on the same timeline, that would help with the exchange; that's the thinking that went on in that discussion.

Now, in our subgroup, not everyone wanted to allow the 90 days so we had a split vote in terms of ke…making a shorter timeline for that transition to the third stage or keep it the same, meaning the voluntary in 2017 and required in 2018. Now voluntary was for the providers in deciding whether they wanted to go with Stage 3 in 2017. We all know that when there's an "or," then for the vendor side, it turns into an "and" because the vendors have to implement, if any of their customers wants to go in 2017, that means that they have to have the systems in place in 2017.

And so the challenge becomes the whole time to develop between the final rule and certification requirements and getting the products developed, certified and then out there and then for the providers to implement it. So the quandary there has to do with, do we keep the existing, which is 2017 optional for providers and required for vendors or do we…there are two discussions here, or do we move it all to 90 days and move it into 2018 versus 2017. I guess I'm just going to raise some of these things; I'll go through the rest and then we'll come back, because there are some overlapping issues. Next slide, please.

This is the eases burden; so they reduced it…reduced the total number of objectives to 8, and everybody knows that it has 8 and sub-parts, so I don't know that the actual number is 8 but it certainly is reduced from the 20 whatever, 26 or so, we had recommended…the Policy Committee had recommended cutting that back by 30% and I think it's cut back even more than that. But the goal is to reduce the total number of objectives and focus in on the more advanced objectives thinking that the ones that are already there either have topped out or the market will move it by itself.

A single set of measures that are a little bit different, this is all sort of the simplification and the unification getting rid of, especially in the modification rules, some of the measures that seemed topped out or that people are already achieving far higher than the threshold. And the rep…aligning the reporting period instead of having the fiscal…the cal…the fiscal year versus the calendar year, just have it all at one, which is the calendar year. And the quality measure, we talked about as well. So that's on the burden side. Next slide, please.

And on the flexibility side, this is, I've already addressed some of this; 2017 or 2018. And so the 2017…the MU NPRM said voluntary 2017, mandatory 2018 and the modification rule proposes or asks for comments about 2018 making that also one thing for everybody. There are some…there is some flexibility in some of the objectives, and that's where there are three measures which you have to report on all three, but you can…you only need to meet the threshold for 2 out of the 3. So that…the 2 out of the 3 is supposed to be the flexibility, but of course that means it adds a little bit of complexity. And same for public health reporting; there's a choice there.

So let me move back, I think, can you go one more slide, just to make sure I've finished…okay, so the comments on that I think I pretty much did that. One more slide…okay. And one more work to do from this group is, if you remember we had for the use cases we presented sort of a matrix of sort of impact, readiness and sort of beneficiaries and program alignment.

So we were proposing to try to set up a matrix not of exactly those columns, but to show, okay look, if these are the new functionalities, not the newer thresholds, and here's the level of effort, let's…we're trying to get some feedback from EHRA. Let's say there are, just for the sake of discussion, there are five new, totally new functions to be developed and they require a lot of effort and maybe they could by the 2018 meet four out the five, well, what we might want to do is propose first show the rest of the committee what's the level of effort for these five new functions and two, maybe give our priority for the four…the four top priority if we want to sort of meet the available time for the effort.

Anyway, we don't have…we asked for that information and EHRA is preparing that information, but we thought we'd provide that as input because most of the folks won't know how much development effort there is in some of the new things being asked. Okay. So let's move backwards to the simplification slide and we'll…thank you; and let me just ask for comments from the group. Do you agree with it? Any comments you have on what the subgroup is suggesting?

W
Well Paul…

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
So Paul…sorry; this is Mike. So I would agree with what I heard. The one piece of feedback I've heard from the field here that's maybe a little bit of an unintended consequence and may be a cautionary tale for CMS and others is with the reporting periods aligned, the burden on those who are responsible for reporting becomes more compressed and the concern about the ability to report on CMS websites in a more compressed timeline needs to be considered to make sure there is enough bandwidth or capacity for everyone to report with an efficient and effective process.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
And what is being compressed, Mike?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
So if the reporting periods for EPs and EHs are all calendar year based…

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

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
…then the reporting periods all come down to the same timeframe, which as you suggest is mostly good. But there just is that concern that the technology that supports that effort and the resources within each organization that are reporting often turn their attention from one task to another because there is time to do that. Whereas now they'll all be in the same timeframe so it may require additional people to do additional work in order to get it all done in that timeframe.

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

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President& Chief Medical Information Officer – Sparrow Health System
Not that it would cause people to not recommend it, but it's just reflective of…

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

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
…the change. Sure.

Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies
Yeah and…

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Altarum, can you please give me the hands up function? Yes, who was trying to speak?

Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies
Hey Paul, it's Ginny Meadows.

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

Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies
So, I was actually going to agree with Mike; I think that is one of the challenges and I think the challenge that Mike was talking about is really on the CMS side because we know they have limited resources right now to support Meaningful Use and so there are a couple of things that will happen with this aligned reporting period. They will get more calls that will have to be answered with questions or issues, so they'll need more people to respond to all of that. As well as they're technical capability to accept the amount of data that's going to be coming in to their systems all at one time.

So those are kind of valid concerns, I think, that we should potentially address and maybe even recommend that they ensure that there is a lot of testing done before hand on the technical side of things as well as thinking about the personnel challenges they may experience.

And I think the other piece that I would agree under challenges that there is…because of the concern around that and then also the concern around the fact that if the first year they could do any 90-day period and someone starting very early, because they're ready to go, then they would have some challenges in a couple of areas, one of which is who's going to also be ready to accept any of their data, if they're trying to show the interoperability pieces as well as will CMS be ready to accept data if they are trying to report some things. So, I think that potentially thinking about saying moving it to the last say 6 months of the year could be an option although I would hesitate to say that people could then just tend to wait again and it could still…we could still have the same roadblocks, but that might be something we would want to think about.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, we certainly can note that. Obviously any time you change there will be a transition time, but…

Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies
Yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
…it's fair to give people a heads up on it. If people could use the hands up so we make sure…so I make sure I get everybody off the lines in order. Anybody else want any comments on the simplification comment? Mark Savage.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Yeah, just it occurred to me when you were talking about the synchronicity as a benefit that that is also something that happens if you stick with calendar year reporting because everybody's on.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
I'm not sure I understand, was that the same…

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
When you were talking about the 90-day periods and trying to pick a common 90-day period so that everybody was…

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

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
…interoperable. You also get that with a calendar year reporting, with a full, I should say a full year reporting because everybody is on the same system.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Yeah, I think that's what Mike and Ginny were saying.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Great.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. Anybody else? Okay next slide, please. Umm, okay, any comments on this? All right, Mike.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Yeah, so this is just, I think, my opportunity to talk about topped out measures. I don't know if CMS or anyone else has done a study or if so, how they could to see whether there's any backsliding on topped out measures that are no longer reported. The literature would suggest that at least for some things like immunizations, if you stop providing reminders or prompts or front of mindness to them, they backslide. And so, I guess I would want to just put that at least in this conversation to decide; for example, even though ePrescribing has become fairly well adopted, that's not going away because it's considered so important. And when we think about widespread adoption and then removing them out because they are adopted, it would be good to at least in the learning health system determine whether or not those backslide when they're no longer required to be measured.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, that's a fair point. I think it's not exactly the same as the reminder in the sense of let's say you're on CPOE, I don't think you're being remin…you know, when something's baked into workflow like CPOE or electronic prescribing, I don't know that people had to be reminded not to do paper so, but, it's a fair point. I do think, and Michelle, you can correct me if I'm wrong, that some of the ONC reports have shown, yeah, I'm pretty sure actually, they showed graphs actually of not only does it not backslide, it just continues to grow. So one big…everybody comes in beating the threshold, some by a huge amount and that it just increases over time. I think that's some of what they use to decide to remove the top down. Any other comments?

Okay next slide, please; Altarum, next slide please. Okay and next one. Oops, sorry; one back, I guess I must…okay. So this is on the flexibility. So I guess what we need to do is let me go with the second point first. I think you understand how they tried to…they wanted to accomplish certain things in these advanced functionality; HIE is not something that's widespread right now, neither is consumer engagement or public health reporting. So they want to keep pushing on this, that's why they have three measures. And the way they get flexibility is to say you only have to meet threshold on 2 out of the 3. Any comments on that approach? Mike?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Sure, so obviously some of us would interpret that as continued sort of core and menu, but I agree the flexibility is in the reality that any of them technically could be menu measures if you choose and others you would then consider core. So, while on the one hand it's not a lot different than what existed for core and menu, I agree the flexibility is helpful and gives people a chance to do what works best for them and what their local environment is most ready for.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. Any other…Charlene?

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Yeah. Am I on?

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

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Okay, just one other point on the flexibility and we spent a lot of time, because I'm on the smaller workgroup talking about this. If there was a way, some of the certification requirements require you to get the new software to meet the measure, for instance CPOE. So if there was a way that they can meet that measure with 2014 and somehow that carries forward, it gives them the flexibility and the incentive to get started. So I would just ask ONC and CMS to work together to make sure that the certification requirements would not preclude them from getting started early, and that would give them flexibility to get started on some of those measures earlier. So where the certification requirements for the other rule and this rule can be the same, the 2014 and this rule can be the same so people can get started early, I think that also gives some flexibility. So it's a tweak to this rule…or to the certification rule probably.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, if I understand you correctly is try to…and is it 2014 or 2015 that you're trying to get it into then?

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
I'd like the four measures such that they ca…like CPOE…

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

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
…if they can make the certification requirements the same between 2014 and 2015, then they can get started earlier on some of those…meeting some of those objectives without depending on the 2015 software. Does that make sense?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Yeah, but isn't that already true?

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
No, there are differences between the two in some cases.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. You might give a…

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Because then they could meet the so…they could meet it with 2014 but then to account for it, they have to wait for the 2015 stuff.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Ah, okay. Would you mind giving us offline some examples so that we can…

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
…sort of point out what that means.

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, that's an interesting…that's a good example of where that helps providers, just as you said. Okay, thanks. Joe?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Yeah so I think this kind of piggybacks on Charlene's comment as well, too. I think when we were going down through public health as well, just the comment that let's make sure that the flexibility truly means flexibility. There are some of the things that we saw that interacted with the standards side where if certain technologies didn't meet the certification, then honestly you don't actually…you can't take advantage of that flexibility. So, and we're going to…well, we'll talk a little bit in our section about some clarifications, but the concept is great, so I think we'd like to…I'd like to sort of encourage the concept, but just making sure that sort of those options don't start to go away when you get into the details of the measures, is the comment I'd like to make.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Thank you. Anybody else? Okay, this is good feedback and some of this maybe either they've already known about or nuances they didn't quite pick up; that's what…that's the whole purpose for an NPRM. Great. Okay, let me turn to bullet number one and ask…this is the question. So in the NPRM for Meaningful Use 3, the proposal was providers could choo…so everybody has to be on Stage 3, and I think it's 2015 certification, let me check, am I right, Michelle?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Restate that Paul, I'm sorry.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
So by 2018 to qualify for Meaningful Use you have to be on sta…on 2015 edition certification?

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

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. Okay, anyway, so that's what was proposed; and if you chose, you the provider chose to go to Stage 3 in 2017, you could. So that's the NPRM for MU3. The modification proposal was to say…was asking us whether we want to make 2018…just go ahead and make 2018 the mandatory or, I guess, leave it as the optional 2017. And so there were…the points on either favor; the point for the 2018 is, as I said, the vendors would have to…if it's an "or," if it's optional for providers, then it's mandatory for vendors, they would have to have developed, certified and providers implement it by 20…no, they would have to divide the…have developed and certified by 2017, in time for providers who choose to do it in 2017, to use. And that leaves, of course, this being 20…middle of 2015, we don't know when the final rule is coming out, it would leave less time for that to take place. And that's one of the reasons we're asking the EHRA to provide us with sort of, what's the new functionality that has to be developed and how long will it take. If we made it 2018, obviously you just add 12 months to that.

So that was the argument in favor of saying, well why don't we try to get the objectives that are proposed for MU3 and make it 2018. And that gives us, well it's less than…somewhere between 2 and 2-1/2 years for vendors to develop and providers to implement the edition for Stage 3. The argument for leaving it at 2017 is just to make the functionality come more quickly. Okay, let me open that up for discussion. Mike.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Yeah, so I'm just going to think this in two ways; one is, can people meet Meaningful Use Stage 3 with 2014 certified technology and if so, I would just be mindful of the fact that every time we've tried to estimate how long it would take for vendors who in good faith are doing the best they can, we haven't yet proven we've been able to do that in the timeframe that would allow 2017 to work for many.

And although I heard what you said and in large part agree that what's optional for EPs is mandatory for vendors, I have certainly seen vendors fail to achieve something that's optional and therefore they simply advise their customers to take the other option, which isn't therefore optional for them. So I don't know that it leaves us with no alternatives if we stay with what we are, but assuming we can achieve Meaningful Use Stage 3 with 2014 technology, I think it would be less pressure on everyone if we just made 2018 the clean cut-off time.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
That's, you said, assuming we could do 2014?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Assum…yeah, assuming we can use 2014 certified EHR technology to meet all of the requirements for Stage 3 Meaningful Use, which I haven't done a deep dive on, so I can't say that for sure, but if others can help with that aspect, then I would recommend that 2018 for everyone be the approach, giving vendors enough time, giving people who need to upgrade their systems enough time and still allowing the goals of Stage 3 to move forward.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
So Michelle and Charlene, do you want to confirm that you need 2015 for Stage 3?

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Right now, there are some measures that you can meet with 2014, but there will be other…in the intricacies of the certification rule, there are certain requirements we have to meet to get to the 2015 edition and get that rolled out. So there are dependencies in there and that providers are going to have to have that software for them to be able to meet those requirements, but there are a good number of them, I think that they could meet with 2014. So we should look at that Paul when we do that analysis across…

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

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Yeah, across the matrix.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
And are you saying that…well let me ask a key question, if vendors…if providers upgrade from 2014 to 2015, recognizing there may be some changes, will there be changes in workflow or is it just sort of reporting stuff?

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Umm, I…it depends…there's a lack of clarity between exactly what they're going to have to implement for 2014 so, if we…if the vendors can make the changes in the standards for instance, the standards for vital signs are going to change, and they have to map to these specific LOINC codes. If we can do that in the background and not impact the workflow, then we're fine. I don't think we may know all that yet, so there are a lot of background standards that have to be put in place that, you know, should be transparent to the end-user, but I'm not sure that that's going to always be the case.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
So that's one of the things we're trying to look into.

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
And Michelle, I think it's true that you have to have 2015 edition in order to qualify for MU3, right?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Yes. And I think there definitely will be workflow changes just based upon the requirements and…

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
…how things will change. Yeah. Yeah.

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

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
So they'll definitely be work, but I think we can look at those particular measures which they should be able to move forward on in 2014 and allow them to do that. So, it'll be some combination.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, so Mike, how does that change things? So it's now, 2015 is required, I assume it doesn't change you're…what you're saying because you were already saying 2018.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Yeah, I think it actually…thanks Paul, I think it actually reinforces my sense that 2018 should be the first year for Stage 3 for everyone. As much as I see some advantages that would make my life easier and that of my fellow providers and IT staff, I just see an important reason to try to do this right and feasibly for everybody by making 2018 the first year.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, other comments please.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Paul, I just want to let you know, this is Amy and I've just joined.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Great, thanks Amy. All right, so in this case, so this is probably our only…well, let me put it another way, Mark do you want say anything and then I think we're going to see if we have consensus around 2018.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Sure, well what I articulated to the small group is; the benefits to patients and families of getting this functionality is also part of the equation. The option of getting that out in 2017 for those who can do it is a significant contribution and for that reason, I would prefer to keep it as optional to the extent that can happen, it does and just leave it with the proposal in the NPRM.

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

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
And Charlene, or this is Charlene again. And Mark, I was thinking about your ask and that was where if there can be fluidity between what's in 20…what they can meet with 2014 in those areas and the 2015 edition of certified software, then that would help providers get moving faster on some of those things that are important to you. So, that's kind of why I was thinking that way.
Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Thank you.

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
You're welcome.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, could I see if there's consensus around require…oh, Cheryl. You might be on mute. Cheryl, are you wanting to make a comment?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yeah, I don't know, my phone keeps going on mute, can you hear me now?

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

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Okay, so for Mark's point, I think I'm sort of on the side with flexibility that if some are ready to move more quickly. Plus, doesn't that provide an opportunity for folks to gain some experience and some lessons learned that will improve the roll out for probably the larger set of providers in 2018?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
I suppose…on the one hand I suppose…

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
So it's almost like the 2017 group are the early adopters and, you know, there's certainly much that could be learned from that sort of early roll out among that subset that could help improve things for 2018.

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

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Yeah, so I empathize with all of this and I have my own favorite reasons to go to Stage 3 including the unique device identifiers and so on and so forth. The problem is, and I don't mean to twist the way works mean, but I think this is an important area where providers would say, please don't experiment to see what works before you get to 2018; please try to get it right. And our concerns in the provider world is things get bolted on; when vendors are in a hurry, when they don't have time to innovate, when they have to get functionality put in place, whether it's usable or not in a short period of time. We've seen the natural consequences of that and it is difficult at best and I don't know that it actually serves the patient interest or public good as well as it would be if there was a more thoughtful approach.

So part of what I guess I'm trying to do is get a better pulse of the vendor industry as well as the provider industry to basically say, if we allowed more time for people to get this right, if we could continue with our 2014 certified technology, but let vendors start implementing, I think to Charlene's point, some of these fields and functions such as the unique device identifier, within their current technology that helps them get ready.

I'd rather see that experiment going on in the background, as people get ready to move to it without having to go through the whole process of certification for Stage 3 until they've gotten feedback from their own user groups and user communities to say, for example, you have a UDI in place now, we have a great place to record it. You know how you're going to be implementing it when you upgrade to 2015 certification status; you've thought about usability as you've done it at the same time and now we're truly ready with that 2-2-1/2 year ramp up time to put in place 2015 certified technology with good workflows, good usability and so on.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. So I think you've heard both sides; could I take a vote then and see where we land right now and then we'll…

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
Hey Paul, this is Neal. I tried to put my flag up.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Yeah. Oh, sorry Neal.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
I felt obligated to make a comment. The…so, I mean, I represent that one side, you know, and I may be being referenced in some of these comments but, I mean I think 20…I don't…the 2017…this is a function of priorities, it isn't a…time to do desi…I mean, 2-1/2 years is an eternity in software. So, I mean, I think we throwing longer dates out there just I don't think actually moves the meter; If the meter is important to move then we should be careful not to push the date out.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
I just want to make sure, so you're proposing that we keep the 2017?

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
Or at least keep the flexibility for 2017, so…

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, well that's an important comment. So that must be that you're feeling is that 2014 certification is fairly close to 2015 and so that providers should be able to essentially go with the 2014...well, let's see. Well, let me just take it at face val…so you're saying that at least from Cerner's point of view keeping it 2017, you should be okay to meet that in time for your customers to implement the needed changes for qualifying for MU3.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
I would be comfortable with that yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. That's important feedback. All right, okay, so any other comments? I don't think so. Let's have a vote then for let's see, why don't I state it for making 2018 mandatory, which is sort of the modification rule proposal and let's say who's in favor of that? The alternative of it is going to be, keep it with the MU3 proposal. You know what, since this is on MU3, let me just switch that around. Let's have a vote on whether we keep the NPRM language which is, 2018 mandatory, 2017 optional for providers, which as we all understand means that vendors have to be capable of doing that by 2017. So all those in favor, please let me know.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
Aye.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
That's Neal, so, say your name.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
Neal.

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

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Cheryl, yes.

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

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin
Norma, yes.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)
Marty, yes.

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

Sumit Nagpal – President & Chief Executive Officer – Alere Accountable Care Solutions
Sumit, yes.

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

M
…yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
All right, let me swit…so is there anybody that's opposed to that?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
So this is Mike, I'm opposed.

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

Arthur Davidson, MD, MSPH – Director – Denver Public Health Department
This is Art, I'm opposed.

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

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
And this is Charlene, I'm opposed.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, so I've…I messed up, I should have…

W
Yeah.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
So I got…so, Michelle, do you want…

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
This is Amy and I'm going to abstain since I didn't hear enough of the conversation right now. I came in too late.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
So Paul, this is Mike. There are agree and disagree buttons along with raise hand, would that help if we use those?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Is there? Okay, yeah, it would I was trying to look for that, where is that?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
It's right below the raise hand, it says agree, disagree, step away, etcetera.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, could everybody do that, please?

Arthur Davidson, MD, MSPH – Director – Denver Public Health Department
Paul, I'm unable to connect.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, I'll give you a "no" Art.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
So Paul, agree means agree with the Stage 3 NPRM that it's optional for 2017.

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

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
Okay, thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, anybody else, because we're going to start counting.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
And Paul, if I could say one more thing; so this vote for me is predicated on the assumption that you are…that the group is correct in saying optional for EPs and EHs is required for vendors.

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

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
I'm not sure that's true from the world I live in, at least in terms of what's happening, but to the extent that that's true, that's where my vote is coming from.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. Okay, so I have 1, 2, 3, 4, 5, 6, 7, 8 yesses. And I have 1, 2, 3 nos. Okay. Good, thank you. So that's how we'll reflect back as we present it to the rest of the committee. Thank you. Okay, sorry about the time, I knew this one was going to be a little bit controversial and it's important from a timing point of view. All right, can we go to the next slide, please? And next slide. Great and next slide. Next slide. Okay, so the CDS workgroup…subgroup is going to talk about their discussion.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Okay, so if I can come off mute. So hi everyone, this is Mike. So the…you can see the group 2 participants here. We had ePrescribing, clinical decision support and CPOE to tackle. Next slide, please. So you can see the measure in front of you, the objective for ePrescribing which is very similar to what we've seen before, it's just that now that the thresholds have changed and the exclusions are more or less the same, I think, perhaps precisely the same as you've seen before, so now 80% of permissible prescriptions queried for drug formulary and transmitted electronically using CEHRT by eligible professionals. And then hospitals, more than 25% of discharge medication orders likewise. Next slide, please.

So the comments that we circulated and got comments back from members of the group and so overall objective comments, it was felt that it would be helpful and important to expand the definition of permissible prescriptions to allow for any medication that an eligible professional adds to a patient's medication list and in one way or another conveys to the pharmacy, whether print, fax or ePrescribing. This obviously has implications for the OTC meds that we'll talk about below.

There was probably, I think, a sense that 25% was okay for eligible hospitals, but that the group wanted to recognize the frequent uncertainty about what pharmacy a patient would like to use or at instances when they are being discharged to a skilled nursing facility, which may or may not have a pharmacy that can be connected to electronically. The 25% threshold may still take care of that.

There was also a comment, I'm not sure there is any action we would take on it, but simply the issue…those of us who are out doing this prescribing a lot have trouble with formularies both in terms of making sense of them and whether there are adequate numbers of formularies available to us and whether they're up to date. This seems to tackle the issue of making sure you at least have that technical capability, the degree to which it actually helps eligible professionals is sort of directly proportional to how accurate, up-to-date and complete they are for the patients we see.

And although that's outside the scope of what we're talking about in this rule, it would be great to able to see movement in the industry on getting formularies both complete and correct. Some formularies, for example, don't even put in generics as being on formulary; they make you assume that even though it says not on formulary because it's generic, it is; so very misleading.

The second area, should we allow for inclusion of scheduled drugs the group agreed that that made sense and that sort of related to the earlier comment on the 90-day period, we wondered if, because reporting periods can be so long, a full year, if one can implement ePrescribing of controlled substances effective a specified implementation date. It might be interesting if we could work out an administrative way to say, as long as you've indicated what the effective implementation date is, you can and probably should start reporting it effective that date. So, I'm not sure how that could be administratively implemented, but it seemed to help encourage and reward if you will, those who implement this in mid-year and would like to be able to count it.

The next item is, should we include or exclude OTC medicines? They are currently excluded. The comment was that OTC medicines should be included if desired, so it's allowing but not requiring them of EPs and EHs would be helpful. It has a number of safety and follow up types of benefits so a much better ability to determine that the patient actually gets the right medicine when they get to the pharmacy, even if it happens to be OTC.

And potentially even as fill histories get more sophisticated, to know whether they've actually picked them up, to make sure there's actual check for drug interactions in real time, which is not always the case when a patient is told to go ahead and pick up an OTC medicine and the fidelity with which those get entered into the medication list, at least in real time, may be lower than if they're prescribed. So there is a recommendation, so far at least, and again, the rest of the group can speak up here as we go through this.

And then fourth, should we limit the measure to only new and changed prescriptions? The opinion was that it also makes sense to encourage the use of what they are calling refill, but they're really renewals of medications at discharge, remembering that it's more than occasionally the case that a provider who's seeing a patient in the hospital also takes care of the patient in the office and whenever it is time to renew a medication and both the provider and the patient are comfortable with that, including that in a numerator is important and, I think, helpful and patient-centered. So, that was our opinion on those.

Paul, would you like me to stop at each one or go through them all and come back? Paul, are you on mute?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
I was, yes, please go ahead, go through it and then come back.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Will do. All right, so we're going to go on then to the next slide, please, to the oh, you're already there. No, okay, so thank you. I'm looking at two different slide decks. So the second one is clinical decision support and you can see the objective here. The five clinical interventions related to four or more CQMs that at a relevant point in care. The drug-drug, drug-allergy, interaction checks, the encouragement of the following areas; preventive care, chronic condition management, heart disease, hypertension, appropriateness of testing, advanced medication related decision support, as you can see. Next slide, please.

So the comments from the group on this overall were perhaps focused mostly on clarity; so more guidance on the definition of high priority health conditions. Some assumption that the earlier comment on CDS encouraged areas, but that is not synonymous, we thought, with high priority health conditions, per se; so if it is, that could and should be clearer and even if it is, there was a recommendation on adding behavioral health as an additional priority area. It also was felt helpful for two other things to take place; one is guidance about any constraint, if any, on how providers may calibrate or filter drug-drug interaction alerts. That's an area of huge interest, but some debate within organizations with regard to whether filtering these alerts continues to keep them compliant with Meaningful Use. So there are those who feel that if you filter any of them out to the higher priority ones, severity, likelihood, etcetera, that you're no longer meeting the measure and so it would be helpful if CMS was simply clearer about whether this measure is met if filters are put in place.

The other one was related more really to CPOE, but since it's brought up in this instance, the issue of licensed health professionals. So the current wording says that the clinical decision support must be visible to and reviewed by a licensed health professional whereas in CPOE it actually is…includes credentialed medical assistants or others with similar training. It would be helpful to include that wording in this objective as well.

As to the second item, that providers explore a wide range of potential CDS interventions, the group supported this. It is very helpful, I think, particularly for my own organizations to be able to be clear and explicit in this regard that a lot of the things that we have argued are clinical decision support , CMS would actually agree; so they do not have to be interruptive alerts or any particular single way of doing it.

Okay, so the last couple of slides, next slide is on objective for CPOE. Again, the issue here is the three thresholds that you see and increasing thresholds for them, so medication orders, lab orders and diagnostic imaging orders are now at a higher level for the totality. It is clear at the top, as you can see, that credentialed medical assistants or staff members credentialed to that level are allowed, and that's the point we're making about CDS. So the next slide.

So in this one we agreed with all the proposed measures. In terms of 4.2, should we expand the objective to include diagnostic imaging as a broader category, including other imaging such as ultrasound, etcetera? We agreed. We thought it would also be helpful to provide even additional guidance on things beyond those types of diagnostic imaging studies and whether providers have flexibility to define the diagnostic imaging process more broadly. Some, for example, might say that a dermatology image such as a wound which is diagnosis and staging, if it's accompanied by a report might be an example. Others would say an EKG or EEG, which contains images that are used to make a diagnosis should also or could also count. So just clarification on this would be helpful.

The next item, 4.3, should we allow…should we continue to allow but not require providers to limit the measure to those patients whose records are maintained using CEHRT? The group agreed with flexibility and the comments we got, the bigger question again may or may not be out…within the scope of our feedback, but the issue that organizations that I've worked with and colleagues I've spoken with is, the process of trying to count orders that are never entered into CEHRT is really, really hard and it's almost never done well. And so the question becomes how to operationalize the task of getting those into a denominator or whether we're doing well enough with CPOE that we can both acknowledge the difficulty of that and not worry about it so much.

So where it's possible we do that, but the example I was giving back to the group myself is, literally somehow being able to capture handouts from patients when they leave to see if a surgeon, for example, has given them a paper prescription from their office as part of their discharge. And that's literally the extent to which we would have to do this to truly capture the denominator. So anyway, we'll leave it at that for now, unless other people have comments.

The next item is whether there are circumstances that may warrant additional exclusions such as barriers to successfully implementing the technology required to meet the objective? Comment back, and again my experience has been that part of the comments that providers have made is the…either the bolted on functionality or incredible burden of trying to build out the CPOE in a method that actually works within the system is difficult and that although the vendor may be certified for CPOE, the task of getting that implemented has been large enough that organizations haven't been able to do it. So, the question of how you'd operationalize that into an exclusion would, I think, be the challenge.

The last one is circumstances in which a hospital or CAH focuses on a particular population and would that mean that they would get a zero denominator for one of the measures. It was felt that that was probably unlikely, but certainly not unimaginable and if so, then they could use the existing proposed exclusion for less than 100 orders in that regard. So that is our report. Any comments from any of the other members of the subgroup?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Great. Well thank you very much, Mike. Let's go back to the first one, okay, so the ePrescribing, why don't you to the next slide, please. Okay, any comments from the group about their comments back in answer to the questions posed?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Paul, this is Mark Savage.

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

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Just an observation that when we've talked with members of the Consumer Partnership for eHealth, they on 2.3, they too have appreciated having over the counter medicines included.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, thank you. Okay, it sounds like there's no disagreement with these comments. Two slides forward, please. How about on this? Okay. Sounds like agreement. Two slides forward, please. Okay, how about this? All right, and a couple of slides again. Oops…I think…

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
Yeah, I think that's our last one.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Oh, okay. So any…is there agreement with all the comments that Mike summarized?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
This is Cheryl, yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, any disagreement from anybody? Okay, thank you very much, Mike. Let's move on.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System
You're welcome.

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

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
I think it's going to be Jim; this is Joe, Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
It's going to be, you?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Jim Daniel.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Jim Daniel, okay. Jim?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Are you on mute, Jim?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Jim, are you still with us?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I can see that he's on the webinar, but I'm not sure that he's dialed in.

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

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Well, I can start in the interest of time.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. Sure, thank you, Joe.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
No problem. So we had objective 8 and this is sort of just the overall outline and the commentary structure. We're going to go ahead and do a quick overview and then comments on three elements of the overall objectives and then just go line by line in terms of the 6 measures and give commentary. Next slide, please. This was our workgroup; thanks to everyone for putting in a lot of time over the past couple of weeks. Next slide.

So the overall sort of objective here around public health and clinical data registry reporting, essentially around EPs, eligible hospitals, critical access and active engagement with a public health agency or a clinical data repos…registry to submit public health data in a meaningful way using certified EHR technology, except where prohibited and in accordance with applicable law and practice. There are 6 possible measures that were included in the objectives with the theme of flexibility, eligible professionals were required to meet 3 of these; eligible hospital and critical access hospitals must meet 4. Some of the difference with respect to that is the electronic laboratory reporting is only relevant for the hospitals and critical access hospitals. Next slide, please.

And I think one of the things that we had found pretty quickly when we dove into the overall measures within our objectives, there's a lot of sort of cross-talk with the standards and within our objective I think there were a lot of references around these new capabilities and new requirements, particularly around how things are being measured, assessed and submitted. This is just the table that kind of reviews all of them. I think as a workgroup we were a little bit overwhelmed to try to get into the nitty gritty detail and Jim was fantastic in terms of helping summarize the major points for us with respect to all the additional documentation that was there. And I think that becomes relevant to some of the questions and clarifications that we're going to point out as we go through the measures had to do with some of the details of some of these standards across. Next slide.

I should pause, I'm not sure if Jim has joined yet.

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services
Can you hear me?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Oh yeah.

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services
Okay.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Jim, try to catch up. So…

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services
Yeah, sorry, my mic was not live there, but I got turned on. That was a little frustrating, but okay; great. So I think we're into some of the places where we're looking for comments now. And within this measure, there were 3…sorry; within this objective there were 3 ways to meet each of the measures.

You could be an active engagement with the public health agency or clinical data repository, which means that you have registered your in…the first…option one for active engagement is that you've completed your registration which means you've signed up within 60 days of the start of your reporting period but the public health agency or clinical data registry has not yet started the testing process with you. So you…it's…that is where you are, you've actually met the measure.

The second way to meet each of the measures is to be in the testing and validation phase, which is option 2. And in option 2, you are sending data, fixing issues back and forth with the public health or CDR. You must respond within 30 days to any issue that comes up. And the third option to meet the measure is to be in production actually submitting data.

The comments here were pretty much that we agreed with option 1. For option 2 we thought that we needed a better definition of what responding to requests from public health or CDR was and so we had some language here, providers must respond to PHA or where applicable to CDR within 30 days of request through acknowledgment of request and process for investigation; so to clarify that the problem doesn't have to be solved within 30 days, but they've responded and they've started to investigate and come up with a process for how to address the issue.

For option 3 we also…the recommendation was that we had a similar phrase in there about responding to issues, because when in production, issues might arise as well. So the suggestion is to include the same language in option 3 about responding to requests within 30 days. Next slide.

So the next place that the rule was asking for comment was the concept of CMS having a centralized repository of national, state and local public health and clinical data registry readiness so that there's a single place for everyone to look to see where they can actually submit data for each of the measures. The idea around this registry was that on the first day of the reporting period of a provider, the readiness of the public health or CDR would have to have been declared on the first day; if not, then the provider could exclude that measure.

We…this group did come up with a change that says that the public health and CDR should submit their readiness to that centralized repository one year prior to the start of the reporting period. So, this is a fairly significant change, but it's not that the readiness is declared on day 1 of the reporting period, but one year ahead of it. That allows the providers to plan and implement the software and the vendors to develop the appropriate systems. Public health would need to commit to develop the system once it's placed on the list and the CMS repository would need to be ready in 2017.

We did talk about some potential consequences there if public health declared readiness, but weren't ready to actually start accepting data on the first day of the reporting period, that they could actually still put providers into the register of intent process and if they were two or three months behind, could start moving them into the validation phase two or three months later. So, we did walk through some of the consequences of this and felt that it would still work. Next slide.

The next issue for comments was the number of measures that providers would have to meet. The rule says that EPs would choose from measures 1-5 and meet any combination of 3 while EHs and critical access hospitals would choose from measures 1-6 and meet 4. There was general agreement that this number was reasonable, but we did want to call out that if the same data is being sent to or used to more than one registry, that it should be called out that that could actually meet multiple measures; that the same type of data could be sent to multiple registries and count more than once. So, there was a feeling that that was not clear in the current rule. Next slide.

So now we're going to go into the specific measures. The first measure is about immunization registry reporting. We tried to frame all these within the clinical goal; the clinical goal of this measure being to improve overall immunization rates for the public. There was general agreement about the concept of this staying in Meaningful Use and general agreement about the bi-directionality that's called out here. However, there were concerns about the forecast.

Part of the rule says that the provider should be able to receive a forecast and history from the IIS and there was some concern about the language around the forecast being received and what has to be done with that information. The ONC rule does certify for display of it; CMS does not require display and there's concern about…there was some concern expressed around displaying of information where additional information from the EHR might override a recommendation. For example, someone might be recommended a flu shot, but they might be allergic to eggs so that forecast of needing to get a flu shot should not necessarily be presented if there's information that the EHR has that overrides that. There was also a need to call out what to do if a state is not ready for bi-directional that clarified that that would allow a provider to take an exclusion. Next slide.

For syndromic surveillance reporting, here the clinical goal was to better enable public health agencies to detect early indicators of new public health threats. There was general agreement, especially around the eligible hospitals and critical access hospitals to continue to participate in this with the updated implementation guide. However, on the ambulatory side for urgent care, it was noted that they really do fit in with the eligible hospital model of submitting data when they're acting more like an emergency department and urgent care centers fit in with that model, but other ambulatory syndromic surveillance did not seem to fit as much. And the things that public health is really trying to do with ambulatory surveillance sounds more like Population Health measures and put Population Health with a big "P" to indicate the more public health oriented population measures and that should probably be part of measure 4 as opposed to measure 2. Next slide.

Measure 3 was the new measure for case reporting. This is very different than electronic lab reporting, this is actually when a condition is reportable by a physician currently they're required in all states to fill out paper case reports. So for things like measles, STDs, that's currently required for physicians to fill out paper case reports; it does not always happen and for something like measles, it might…the way the response of a public health agency to that event. So here the clinical and regulatory goal is to enable public health agencies to reliably receive case reports of reportable conditions in a timely manner to better protect the community.

There was general agreement that this is a good thing to have, but we need to call out the bi-directional component of this that in order to really operationalize this, there needs to be a bi-directional component such as knowing what is reportable within each jurisdiction. And there was a note that both the Centers for Disease Control along with the Association for State and Territorial Health Officers and NACCHO are working on a public health community platform to operationalize this in a shared environment that does include some of that bi-directionality as well as the case reporting. And the question was still there if the CMS needs to include the bi-directionality requirement for the electronic aspect. The implementation guide that's referenced does address some of that bi-directionality, but not all of the pieces this group brought up; specifically the knowledge management for triggers. Next slide.

Measure 4 is the public health registry reporting. Here the clinical goal is to enable public health agencies to comprehensively report on community determined measures based on local capacity in order to better understand community health needs. There was agreement that measure 4 and measure 5 are a good idea. Measure 5 is very similar, it's just measure 5 is the clinical data registry. For both measure 4 and measure 5 I'm going to kind of talk about them together here.

There were some questions about how to regulate what is eligible. For measure 4 on the ONC side, there are 3 specific implementation guides called out for antibiotic utilization, antibiotic resistance reporting, cancer registry reporting and hospital survey reporting.

For the clinical data registries there are no standards called out so there is a question of, should other standards such as conditions of care that are part of CEHRT be okay for reporting to for measure 4 and measure 5. And they're…currently the way the rule is written, there is a concern that many Stage 2 what we called specialized registries may not count because there were not standards called out specifically for those. So, some of those previous specialized registries that people have done work for might not work.

There are lots of examples for things like smoking cessation, prescription drug monitoring program where states have put into place those to count as specialized registries that seem to not count under the current wording of the CMS and ONC rule. And again, the concept of bi-directionality is discussed, such as prescription drug monitoring program where it might be appropriate and to make sure it's appropriate, we called out for other options.

And there's also a note that we need to make sure that the exclusions specifically call out the existence of national registries for both the public health registry reporting and the clinical data registry reporting; two of the public health registry options there are national programs, the antibiotic utilization and antibiotic resistance which are part of the National Health Safety Network as well as the National Hospital Surveys are both CDC run at a national level.

So we can go on to measure 5, the next slide. And really, all of our comments here are pretty much the same. There are just some specifics here about some of the clinical data repositories that might fit in, such as Mini-sentinel or PCORI, if they would be accessible and the standards there for clinical data registries. But again, overall for measure 4 and measure 5, there was a concern called out to regulate better what is actually eligible for these two measures and to note the exclusions need to acknowledge the existence of national registries. And next slide.

And finally measure 6, electronic lab reporting where the regulatory goal is for public health to receive laboratory results consistent with local regulations; agreement here that this is an important measure that should stay. There is some confusion now that the updated implementation guide for syndromic surveillance does include laboratory data, to make sure that everyone is clear how ELR is different from syndromic and also calling out that if there are some bi-directional components of measure 3 that are implemented around the knowledge management system of what's reportable, that perhaps that should help with electronic lab reporting as well and those participating in that measure 6 for ELR should also benefit from that knowledge management system. Next slide.

So here I think, and hopefully we've got all of our comments summarized so we don't have to go back through every slide as we walk through and see if there's agreement. But this slide just summarizes all of the current comments and recommendations for each of the overall objective topics and measures. So I think I'll stop there.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Great. Thank you Jim, thank you Joe; open for comments. Okay, anyone disagree with the comments proposed here? Okay, so I think we have consensus around this. Well thank you very much, appreciate that.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Thanks, Jim.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
That was a lot of work.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Yeah, it was a lot of work. All right, next slide, please. And finally we're going to turn over to the Quality Measure subgroup and Cheryl.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Great, thanks. So the last group is going to make our task look light in comparison. So, I just want to thank my team members, Ginny, Norma and Sumit, as well as Samantha, who helped out; if we move to the next slide. Okay, so the two things that we were asked to review and comment on are these two questions related to the number of measures that vendors must certify to and in the notice of proposed rulemaking there is language that indicates that EHRs should be certified to more than the minimum number of CQMs required by one or more CMS quality reporting programs.

The second broad area that we were asked to comment on are considerations related to alignment with the rest of CMS quality programs. And so we provide comments on that as well. So if we could go to the next slide.

So our group, before we jumped into commenting on those two specific areas, really started out by identifying a number of areas where we thought there needs to be renewed attention to try to help advance quality measurement overall. And in particular, on this slide and the next, we lay out a couple of these areas, but first starting with improving the availability of standards to further interoperability. And I think the underlying issue here is that quality measurement still remains sort of this exercise of assessing quality at single points in time in single provider settings as opposed to really tracking what happens to the patient across settings and across time and so renewed attention or focus on trying to improve interoperability to enable quality measurement across settings in time is a priority.

And while there are pilots for new standards being worked on via the quality…the clinical quality framework related to CDS, there really isn't anything yet that's working to advance quality measurement in that same vein. If we go to the next slide; the other things that we highlighted that would be important are, as I mentioned, trying to look across longer periods of time, but also utilizing more data sources and considering care…behavioral health and palliative care. Again really representing sort of the various types of care that patients receive as opposed to what currently is the focus in measurement in a very narrow swath.

So I think there was recognition in our group that trying to advance these capabilities are essential in the world in which quality measures are being used related to new payment models where people are being held accountable for care delivered to a patient across longitudinal episodes and how this type of measure capability would help support and enable value-based payment models. The other thing to note on this slide is that again it's important to broaden the focus beyond eligible providers and eligible hospitals and recognize the other providers, as well as individuals and family for accessing information systems for information that's both input, these through-puts as well as outputs as part of this quality measurement process. Next slide, please.

So now I'm going to turn to the specific areas where we're asked to comment. So just as a reminder, there were three options in the notice of proposed rulemaking. Option 1 that eligible providers…I'm sorry, the sender certified to all clinical quality measures. The second option was a phased in approach over time until the EHR is certified to all applicable clinical quality measures and then option 3 is that the EHR would be certified to more than the minimum number but not to all. And our group recommended that, conditionally, so that word is italicized for a purpose, that we support option 1 requiring EHRs to be certified to all clinical quality measures. And if you go to the next slide, this lays out our reasoning for that conditional endorsement.

So our group, after much discussion, noted that many EHR vendors eventually implemented to all clinical quality measures because they were required to meet the varied needs of the different users. So in essence they already went there. So having a phased in approach really doesn't reduce burden on their end. However, in order for EHR vendors to do that, there need to be certain things in place to make that possible, and this is sort of the conditional part.

So clinical quality measure specification and certification tools need to be accurate, complete and fully tested when released. And this group felt as though there needed to be at least 18 months between that release and when there would be full implementation because there are lots of things that need to happen in this process and rolling out measures and tools that providers find to be inaccurate risks losing trust and creates a lot of complexities in the process. And I think there were a lot of lessons learned at earlier stages in this process that really highlighted the need for accurate specifications as well as this full testing.

And the other thing that came up in our discussion was that CMS engages in annual updates of the clinical quality measures, but the team felt that these annual updates should be limited to changes that do not have substantial impact on the clinicians' workflow or the provider implementation time or that require excessive code changes. And if a measure sort of dramatically changes its specifications, then that's going to require a different avenue for scheduling that kind of update and allowing ample time to accommodate these changes.

The other thing that was highlighted in our group, and I think it's an important reminder that the full list of clinical quality measures are not relevant to all providers or practice settings and so there should be flexibility to allow the EHR vendors to certify specialty EHRs to those measures that are relevant to that particular specialty. So we wanted to make sure that the role of specialists and their particular measurement needs should be a key consideration in weighing the CQM requirements. Next slide.

Related to alignment, we were very supportive of the language around improving alignment and the requirements across the different CMS quality measurement and reporting programs. We also support alignment beyond the CMS quality reporting programs to include other public payer initiatives as well as private payer initiatives to reduce burden on providers.

The other area of alignment that we wanted to call out above and beyond similar measures is in terms of the reporting back or the reporting out of these measures, we believe that there should be alignment related to the data collection requirements for measures looking at the same concept in terms of alignment of reporting formats, the standards utilized and the reporting periods and data submission timelines. So there are lots of areas for alignment here above and beyond picking the same measures and the same measure specifications. So, that was the set of our comments and I guess I'd like to open it up to my fellow team members to see if I missed anything and then Paul and the rest of the group.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Great, any fellow t…subgroup members want to make a comment?

Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies
Hi, this is Ginny. Cheryl, you did a great job summarizing that. I think there is one more thing I would add on the earlier slide about annual measure updates, especially thinking about adding new measures, which we know new measures were not specified in the CMS rule, but will be coming out in subsequent payment rules; we probably should include that in the comment around thinking about how those would be introduced and what the timeframe and the timing. Because I know CMS is also highly interested in thinking about that timeline issue of new measures.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yeah Ginny, that's a great reminder.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, Charlene, did you have a comment? Her hand went away. Anybody else have a comment? On slide 41, if you could…Alt…yes; so, just like we were asking CMS for "clarification" on certain things, for bullet 3, certainly understand the intent behind it. How would you determine whether it has a significant impact on workflow or implementation time?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Ginny, do you want to weigh in on this? I know that this was an issue that you had flagged for the team.

Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies
Sorry, I was on mute. So I think that what we really have to think about is how we would do potentially a better job of testing some of those capabilities and really being able to look at the feasibility of what's going to be updated ahead of time. Right now I don't think there's a lot of time allotted to that process so I think we need to think about how we could better do an evaluation of what the updates are going to include before they're finalized.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Yeah, that certainly sounds reasonable. Is there a way you could word it so that, because everything's going…most things will require some kind of change. Let's say you even change…try to align all the definitions and where you get this data appears now in a different spot, well that of course is going to change the workflow. How do we make…word this so that just because it changes workflow…that there's a balance between changing workflow for something important; how do you do that? Or maybe you can think about how to reword that before we present to the rest of the group at the next call on how to specify how you would assess whether it has a significant "impact," or how do you do the trade-off?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Sure, I think we can go back and talk through this and come up with clearer language. Yup.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
That would be helpful. Thank you. Mark.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
This may be out of scope but in the Stage 3 transmittal letter from the Policy Committee there was a recommendation about filtering quality measures by disparity variables. It doesn't show up in the Stage 3 NPRM, but does show up in the 2015 edition CEHRT and I'm just wondering if this small group discussed using…at all using quality measures for the purposes of identifying and reducing health disparities and any comments to share with us as the larger group.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
We did not take that topic on. I guess I did not see language anywhere that referenced that. We certainly could provide comment on that. I think there are lots of opportunities, particularly since the variables I believe to do a lot of the disparities analyses will be embedded in EHRs. So, certainly there is an important role here for that, both monitoring as well as providers better understanding where disparities exist within their own practice.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families
Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Good catch, thank you. Any other comments? Charlene.

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
This is just a clarification point. As you went…there are a lot of new standards that are putting in place in the certification rule, are those standards aligned with the measurement standards so that we've got the end-to-end capture? And do you want to reinforce that point at all? So, for instance, as we change the data capture for vital signs, for race, ethnicity, for other aspects that…are those things aligned in your view because we've got the data element catalog, etcetera, etcetera.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
I actually…that's a good question and I'm not sure I know that and I guess I'm wondering whether someone from the ONC might be able to or some other team members on this call would be able to work with us to better understand that, because I do think that would be an important thing to comment on.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Thank you. Any other comments? Okay, are we ready for a vote to accept this, it's primarily…the recommendation is on one, ensuring that vendors certify to all quality measures with a little bit of a caveat. And then the second one was aligning quality measures ideally with not only the public, but the private sector payers as well. Did I state that correctly Cheryl?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yes. But again, within that alignment it is beyond just the measure specifications, it's how the data gets transmitted; there's sort of a sub-layer in there…

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

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
…which is what that second bullet referenced?

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

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
This is Amy and I fully agree with that. The question I have is do the private payers on a national basis have aligned measures themselves across all their providers? It's just more of a question for my knowledge, or does it vary by private payers regionally?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yeah, it varies regionally. So I live in an environment where the providers or the private payers are trying to align, but I would say they're not 100% aligned. But then you go to other markets where there's a lot of misalignment and you can get one payer doing different things in different markets. So there's a huge amount of variation out there.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
So, one of…the reason I raise that is more, while I fully support it and I think any state that has SIM grants and stuff is trying to do measure harmonization as well and that's part of a requirement of that. How would you see this playing out operationally if…I mean, the federal government can control its measure alignment across its own programs, but when you get…we have no control over the private market to say they have to align their measures.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yeah, it gets really…

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
So the practicality of that is what…is just what I'm sort of asking about. While I fully support it and want it to happen and it needs to happen, there's no question there, I'm just trying to think about by putting that in, what does that…is there any way to make that really happen?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Right5. I guess how I've been seeing this happen in practice is that generally when performance measurement is used in a community, there's a multi-stakeholder group who sits around the table and they usually try to ensure that either state payers are at the table, and in some cases, the feds, to try to better align things; or at least have the conversation about where alignment occurs, or could occur, I should say. I know that CMS has an inter-agency workgroup that is working toward better alignment and they continue to try to identify where they are aligned or misaligned with the private sector and I would say that some of these regional collaboratives have been in active discussions with CMS around better alignment. But how you kind of enforce that, I'm not sure other than sort of the marketplace urges it to happen.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Right.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
…a question, could I piggyback on that and we know that CMS wants to align its programs. Is the same true of…do the privates want to align with each other?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
I think part of it is what I'm going to call a forcing function within a region. So it partly depends on how active say purchasers are with their payers to try to force that. But I have seen that payers often want to differentiate themselves and maybe go beyond what I would call the lowest common denominator. So they might have a core set, but then they often want to measure things that they think are priority areas and so that has been the tension on the street.

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

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
And I would…this is Amy again, I would say that there is significant pressure, I think, from states especially those that have SIM dollars to move in this direction and to do alignment. I just was really trying to unders…you know, so I mean I know some states have done it better than others, some states are starting and certainly in the context of SIM test states and even design states there's a requirement to try to start to harmonize measures, public with private and so, I know we'll be working on that here. My question was more that if we try to put this in to say that the measure harmoniza…certification has to go to the, you know, to the alignment on the private side, I…it's okay, but I don't think we have any control or enforcement over that. So I'm not objecting to putting it in, I'm just trying to figure out how it would actually work.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Right.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Because I actually think we need it to happen and it's a big burden to providers and there are a lot of people singing this tune and I don't…I would say yes, there are still payers that like to try to make some things unique and whatever. But I was just really trying to think about okay, so then how do we assure that it happens if it's in there or what's the, you know, what's the downside to making that happen if there's no control over what the private payers do?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yeah and I guess, that's a really good point and I guess what I've seen private payers moving toward is, where they're actually measuring the same thing, they try to get that aligned. But, in some cases, because they're populations are different, they need to measure it in a different way. So I don't think one should expect that there would be 100% alignment in the future, but in the areas where there is overlap, the question is how to make that happen.

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

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin
This is…

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

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin
Yes, this is Norma. I'd just like to speak almost from a consumer point of view for the alignment. For those of us who have private and public payers and try to sort out our records and our payments and our cost, I would certainly push a whole lot for alignment, speaking as a consumer.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, any other comments?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Does this do that? Can we do this is my question? I mean, I want it to happen, is this the right driver to get that to happen, I guess is my question? What does it do to the providers and to the payers by putting that in there or it doesn't really matter?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
I think this is a common aspirational goal that's put in a lot of things, and I think Cheryl explained that this is a direct endorsement of CMS's goals and that we're encouraging what the statement's trying do saying encouraging the private sector. And as I say, this is an encouragement that's put in a lot of goals from a lot of different venues.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yeah and I guess I've seen CMS engage in conversations with private payers wanting to have that alignment occur. But I would agree, I think that they're struggling with how to actually make it happen.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Yeah, so if it's aspirational and a goal, that's one thing; if there's actually certification requirements or something for vendors, that's a different story. So I'm…that's all I'm asking. I'll be quiet now…

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Yeah…

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
…but I mean, I fully support it, need it, want it to happen, working on it in my own state, so this is not a…whatever drivers we can do to move this, I'm all for. I just am sort of questioning the practicality of how far this goes that's all.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
Right, I don't…I can't imagine how to make it a certification requirement.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Okay.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation
So, unless others can think of ways, but I can't imagine that that's the driver that's going to make this happen.

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
Yeah.

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

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin
Can we keep it in?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Well I think we're keeping it in.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
Yeah, I mean I think it's…we're keeping it in because it's a statement of our endorsement and our desire and our goal. I just was trying to understand…

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin
Okay.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services
…if it was going any further and how that would happen; so, I'm fine.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay. Any disagreement with the summary on slides 41 and 42? Any of the workgroup members? Okay. Okay, so our next topic, I think you can go to the next slide, the final slide, which is our call on May 7 where we're gathering together this workgroup with the 3 other workgroups, Privacy & Security, HIE and Consumer Workgroup. They also will have fairly meaty topics that may generate some discussion. So I think we want to allow as much time; we've schedule 2-1/2 hours, want to allow as much time for those folks to present their conclusions for discussion by this, the wider group here before we present it back to the committee on the following week.

So may I suggest that we all try to summarize where we are, the four subgroup leads, within…well hopefully like in five minutes; in other words, have a total of 10 minutes for presentation and discussion at that call from the subgroups that just presented today? And then we'll dedicate the majority of the time for hearing and discussing the work of the other workgroups. Think that's doable? Subgroup leads?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
I think so, Paul; that's 10 minutes for each subgroup, right?

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

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health
Yup.

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

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Okay, so that's a combination of presentation and discussion; so we're going to try to limit it to 10 minutes each. All right, well I think we're well prepared and thank you so much for attending this call and for all of the work that you did in between. I think this is very impressive and it really helps digest the material for everybody else. Are we going to open for public comment, Michelle?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Yup. Lonnie or Caitlin, can you please open the lines?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute
Yes. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the telephone and would like to make a public comment, please press *1 at this time.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
We have no public comment.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
All righty, well thanks again everybody and talk to you on May 7.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thanks Paul, thank you everyone.