



**HIT Policy Committee
Advanced Health Models & Meaningful Use Workgroup
Final Transcript
May 7, 2015**

Presentation

Operator

All lines bridged with the public.

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

Thank you, good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Advanced Health Models and Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded.

Also, as a reminder if you're following along using the webinar we may share your public comment at the end of the comment period at today's meeting. And with that I will take roll and I'll start with the Advanced Health Models Workgroup. So, Paul Tang?

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

Here.

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

Hi, Paul. Joe Kimura?

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

Here.

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

Hi, Joe. Alex...Amy Zimmerman? Art Davidson? Charlene Underwood?

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

Here.

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

Hi, Charlene.

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

Hi.

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

Cheryl Damberg? Devin Mann? Frederick Isasi? Ginny Meadows?

Ginny Meadows, RN – Executive Director – Program Office – McKesson

I'm here.

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

Hi, Ginny. Jessica Kahn? John Pilotte? Lisa Marsch? Lisa Patton?

Lisa Patton, PhD – Branch Chief, Quality, Evaluation and Performance, Center for Behavioral Health Statistics and Quality – Substance Abuse Mental Health Services Administration

Here.

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

Hi, Lisa.

Lisa Patton, PhD – Branch Chief, Quality, Evaluation and Performance, Center for Behavioral Health Statistics and Quality – Substance Abuse Mental Health Services Administration

Hi.

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

Mark Savage? Marty Fattig?

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)

Here.

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

Hi, Marty. Mike Zaroukian?

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

Here.

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

Hi, Mike. Neal Patterson?

Neal Patterson, MBA – Chairman of the Board & Chief Executive Officer & President – Cerner Corporation

Here.

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

Hi, Neal. Norma Lang?

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

Here, good morning.

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

Hi, Norma. Patrice Holtz? Robert Flemming? Shaun Alfreds? Shawn Terrell? Stephan Fihn? Suma Nair? Sumit Nagpal? Terry O'Malley?

Terrence (Terry) O'Malley, MD – Medical Director for Non-Acute Care Services, Partners Healthcare System – Massachusetts General Hospital

Here.

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

Hi, Terry. And Terri Postma? And from the Privacy and Security Workgroup, Deven McGraw?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Here.

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

Hi Deven. Is Stan on?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

He didn't think he'd be able to join until later in the call.

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

Okay.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

So, he's not on yet.

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

Okay, thanks, Deven. From the IO Workgroup, Micky Tripathi?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Here.

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

Hi, Micky and I think Chris wasn't able to join either. I don't think Christine is on yet from the Consumer Workgroup.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes, I'm on.

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

Oh, you are on, okay, good. And Christine is on and then from the Implementation, Usability and Safety Group, Larry Wolf I believe is on?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yes, I'm on.

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

Hi, Larry.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Hi.

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

And I don't think David Bates is on? Okay, so with that I'll turn it to you Paul.

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

Okay.

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

Michelle, this is Art Davidson, sorry to join late.

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

Hi, Art and I forgot about our ONC folks, so is Alex Baker on?

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

Yes.

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

And Sam?

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

Here.

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

And Lauren Wu I heard?

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

I'm here.

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

Anyone else from ONC on the line?

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology

Jim Daniel.

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

Hi, Jim, sorry, Jim, I forgot about you. And I think that's everyone so now back to you Paul.

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

Thank you, very much Michelle and thank you all for attending this Workgroup meeting. The agenda for today is essentially getting all of the input from both the Subgroups in the Advanced Health Model Workgroup as well as the input from the Consumer, Privacy and Security and Interoperability, and Safety and Implementation Workgroups.

And it's essentially sort of a dry run for the presentation to the Policy Committee on the 12th and it's a combination of a dry run and getting the entire Workgroup's consensus of the recommendations that we're going to put forth next week.

There will be a committee discussion of the recommendations that we put forth and then there will be a further phone call meeting of the Policy Committee so that we can turn in the Policy Committee's recommendations before the deadline on the 29th. So, that's our goal it's really...it's somewhat of a dry run and it's somewhat of a discussion of some of the controversial issues, not necessarily controversial but areas where we don't have a consensus so that we can go forward as the Workgroup in our presentation and recommendations to the Policy Committee.

Now we may have multiple opinions that we present in the pros and cons so that the Policy Committee can make its decision in terms of the recommendations but we'd like to hear what we would like to say as a group whether it's consensus or the let's say two options to weigh with the justification behind. Does that make sense to the group?

Okay, so, let's move forward with the next slide, please. And what you're going to hear first, and we sort of curtailed our discussion, it will be 10 minutes for each of these Subgroups of the Advanced Health Model Workgroup and then we're going to give more time, up to a half an hour, for both the presentation and discussion so sort of 50/50 split for each of the Workgroups that are reporting on their discussions. Next slide, please.

And the first Subgroup of our AHM Workgroup talked about sort of the overall approach for the proposed Meaningful Use Stage 3 rule and these are the members of our Subgroup. Next slide, please.

The first thing is we sort of talked about three different things that are part of the approach or somewhat a different approach from Stages 1 and 2, as you know Stage 1 and 2 are sort of get things into the EHR, get it deployed and start sharing the information in Stage 2. And Stage 3 was really the start using this information to know what you do, the outcomes, and so that you can use it to continuously improve and created this learning health system.

So, some of the overarching goals that CMS and ONC had, ONC and the certification rule, proposed rule, is one to simplify the program, two to reduce the burden they've heard loud and clear from the provider groups particularly and to provide more flexibility because between primary care and specialty care there is a lot of diversity and it's hard to make one specific rule fit all. So, they tried to introduce some flexibility both in the kinds of objectives, the kinds of measures and the timing. Next slide, please.

So, first with regard to simplification, our Subgroup, and this is up for discussion for the full Workgroup, was very appreciative of the effort to make it simpler. So, going to a converged stage, it started...once we go to Stage 2 we already had multiple, even multiple providers let's say on the EP side in different stages in one organization and it just gets more and more complicated as the number of stages go up so going down to a single stage we felt was both simpler, making it easier to understand, that's one of the challenges actually, and synchronizes all of the efforts in one area.

And particularly as you get towards, this is part of lessons learned from Stage 2, is that if, you know, one group is in Stage 1 and one group, meaning an entity, is in Stage 2 it's actually hard to do the interoperability when you have multiple stages amongst the trading partners. So, actually one of the benefits for simplification in the single stage is to synchronize the needed functionality and the needed interfaces to achieve interoperability.

We thought that aligning the reporting period, you know, this whole 3 month difference between EPs and EHs was hard and caused this uncoupling or asynchronous nature of where people are at when they try to interoperate with each other. So, the aligned reporting makes it easier to explain to everybody, it streamlines the quality measurement effort so everybody is working on the same thing and the aligned periods also make the integration of systems inside and external partners easier.

When quality measurements are aligned and we really noticed the deliberate attempt by CMS to align the quality measures of its various programs that's all well appreciated and that helps us all whether you're a vendor or a provider be able to get it right for multiple programs, that does reduce the burden as well.

And the other thing is instead of every two or three years updating the quality measures this synchronizes the updates to the annual changes let's say in the payment system they change the quality measures.

The challenges are as we all try to get into one stage fairly quickly that the certification requirements can certainly impact the timeline for development and implementation. Next slide, please.

So, burden, that's heard loud and clear from let's say the provider group and the vendors from a certification point-of-view, so reducing the number of objectives and we know there is a little bit of flexibility there in the sense that they have some multiple measures for one objective but really focusing in on the things that are most important for a specific stage makes a lot of sense to us, removing the duplicates and the topped out measures is also good even though...so the problem was even though you were in the 90% compliance you had to spend the time to document that you were and so that seemed wasteful or we could use that effort elsewhere and so we agree with that.

Removing the notion of having to keep track of what's done on paper also reduces the burden and it advances towards the objectives of electronic interoperability. And the...forcing everything to be electronic while it may be hard initially to get going it provides persistent deficiencies obviously. Next slide, please.

And flexibility, here is one area where we are open to comments from the rest of the Workgroup. The notion in the NPRM for MU 3 it described having 2017 be optional to go to Stage 3 for providers and then everybody should go by 2018. And so the trick was if you make it optional for providers that actually becomes mandatory for vendors and so the question is, do people have enough time to develop, implement, test and deploy the functionality in 2017 if it's optional for providers?

So, on the one hand it makes it a shorter development and implementation timeline but on the other hand it gets the functionality out there and actually this optionality for providers is a flexible...it provides flexibility for providers.

So, we talked about both of these points and ended up taking a vote in our Workgroup, in the AHM Workgroup, and ruling in favor of keeping to the NPRM for MU 3 which is to have the flexibility for providers to go to Stage 3 in 2017.

The other part of flexibility was these three that you see, the objectives for health information exchange, consumer engagement and public health and in that case they provided three measures that you had to report on but the flexibility comes in that you could choose two of the three or three of the four in the public health reporting side.

So, I think in general we were supportive, at least the AHM Workgroup, and open to others comments, were supportive of the flexibility provided and we recommend keeping the MU 3 NPRM statement about 2017 being optional for providers.

And I think that's it for the first Subgroup. Open for discussion and in particular that last point about the optionality for 2017.

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

So, Paul, this is Mike, do you want us to use the raise hand feature or...

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

Why don't we but go ahead Mike.

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

Yeah, so since we discussed this last question that I wanted the group to maybe consider is while we're making it explicit for eligible professionals and hospitals that Stage 3 would be optional in 2017. What do people think about the notion for those vendors who feel it would be too much of a full-court press and too much of a potential for putting on less usable functionality to have it clear to them that their need to support it in 2017 is also optional?

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Paul, this is Ginny Meadows.

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

Go ahead Ginny.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

I could add a little bit to that point and I was also going to express a little bit of concern over this last slide, especially the statement that says, on balance it was reported the vendors could meet the 2017 optional start date, because as you know, because I know that you've been actually having some conversations with Sasha TerMaat from EHRA, we've really been looking at whether, as a whole, our vendor members think that they could do that and it's pretty much determined that this would be very difficult to meet an optional 2017 start date with all of the requirements that are currently in both the CMS proposed rule and the certification rule.

So, we are concerned about being able to do, as Mike said, a really quality job and meet a January 1, 2017 timeline.

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

And thank you Ginny for bringing that up and I wanted to insert some general comments from EHRA as you alluded to. We're trying to get in time for...perhaps actually a little bit more clarity in time for the meeting next week and certainly by the time of our call later in May, but some of the feedback we got from EHRA is one, I think the vendors are interested in going as quickly as they can and having the extra year for 2018 certainly could make a difference as Ginny just pointed out and there is sort of a middle ground in that some of the objectives, so there's eight objectives, some of the objectives can be obtained using the 2014 edition.

So, if...so right now you have to use the 2015 edition for Stage 3 and that causes some of the effort that Ginny just alluded to, in some cases you may be able to achieve the measure with 2014 functionality if that is allowed, and I'm trying to report and correct me if I'm wrong Ginny or anybody else who is familiar with EHRA position, if some of these objectives it's okay to meet with 2014 functionality instead of getting certified to 2015 than that gives the vendors some time to work on either the newer functionality or the modifications that do produce meaningful differences from the 2014 edition in the 2015 edition CEHRT. Did I get that right, Ginny?

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

Yes.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Yeah, I think so, that has been the discussion and of course it gets very complex when you start breaking down all of the different requirements and whether you could use 2014 software or not and that is definitely an activity that I know we've been going through and trying to determine which ones you could do that with and...

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

Right.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

What would not be possible. So, that definitely is something that we're looking at, but, you know, as it stands and especially adding on the certification requirements in the 2015 edition certification proposed rule it would not be possible for most vendors to meet that 2017 date.

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

Okay, so that's the challenge here. Other comments?

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

Paul, this is Amy and I just want to mention I just joined.

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

Okay, thanks Amy. I don't see any other hands...

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

Yeah and Paul, this is Charlene.

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

Go ahead.

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

The one I wanted to emphasize was, you know, again, depending on, you know, the willingness to, you know, make some changes in the certification rule it's hard to debate whether the timeline is doable or not so again we kind of have to see what the final rule is but on the other hand if there is a consideration of, you know, moving the timeline to be more valid we still want to emphasize the need to keep the reporting period synchronous to help with the interoperability that was kind of your second point on there.

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

Right.

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

So we don't really need that.

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

Right.

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

Yes.

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

So, Mike has spoken up, Ginny has spoken up, anybody else? I don't see any hands, anybody else have an opinion on this. The default is that we would go with what's on the slide in terms of presenting to the Policy Committee next week. How do people feel about that default position which is to keep the optional 2017?

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

So, Paul, this is Mike, I'll just say would it be possible and would it be helpful to simply reflect not only the majority opinion that happened at the last meeting but...

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

Right.

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

To put in this minority concern and just see how the Health IT Policy Committee wants to address it or...

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

Absolutely.

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

Perfect, thanks.

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

So, one way to do it is to lay out three options, one is as written basically 2017 optional for providers which means it's mandatory for vendors, one is the other extreme of let's just do 2018 period and the third is a bit of what I mentioned which is, and hopefully we'll have a little bit more supporting information from EHRA of, if let's say you do four of the objectives with 2014 edition and move the other four in 2015 that's sort of in the middle and I don't know whether that's how it works out but something like that where we can recognize the additional development time the vendors are asking for and if we have some flexibility in how they meet those maybe that's a way to keep it 2017.

So, we'll work on that kind of wording, anybody else have any either comments or advise on how we can present this?

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

Paul, Marty has his hand up.

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

Oh, I...it's actually not up on my...okay, at any rate, Marty?

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)

Yes, Paul, I just wanted to say that I agree that if we make it optional for providers to participate in 2017 we should make it optional for vendors as well. We don't want less than...less quality software put out there for us to use if it's not up-to-speed I think we ought to be able to wait.

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

I don't know whether that's a...

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

Yeah, that's hard.

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

I don't know whether that's possible because that makes it non-optional for providers. So, I think the way it works...

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)

Yeah, yeah, yeah it does, but by the same token, I mean, if your vendor is ready go ahead and go with it and then, you know, the providers can go ahead and go with it in 2017, but if your vendor is not, you know, you can't force them to move faster.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Yeah.

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

Go ahead.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Paul, this is Ginny, I have, you know, kind of one other comment kind of related to that, you know, I think that not only vendors have to be ready but providers do and I guess the question is how many providers really want to start and if not very many providers do determine that they want to start with the optional start date then that opens us up to some of the issues we saw at the beginning of Stage 2 where there are not enough providers ready to actually start exchanging information and really performing true interoperability which is one of the key objectives that we know we all have in reaching so that would put them and the ones that decided to do the optional start date in potentially a difficult position given the...

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

Okay.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Percentages that we are seeing being required for some of those interoperability provisions.

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

Okay, so let me...because this actually is a really critical point, Charlene did you have a quick one, because I was going to take a break?

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

I haven't figure out how to un-raise my hand, I wanted to just reinforce Ginny's point.

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

Okay.

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

It's the external dependencies that really make this a challenge to get ready in 2017 too.

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

Okay, so may I take advantage of the technology here, in the same place where you raise your hand in the upper left column there is also a way to vote, agree and disagree. So could you please vote agree or disagree with the option which is to present the three, well let me see here, let me first have a vote on what's in front of you which is what the Workgroup minus the other Chairs voted on, let me just get an agree or disagree with the presenting all three and the recommendation that we keep the NPRM proposed option of providers having 2017 be an option for Stage 3.

So, if you vote agree that means you're agreeing to me presenting the three options we've talked about with the reasons and the recommendation from the Workgroup that it be the MU 3 NPRM position. So, go ahead and raise your hand and vote.

Terrence (Terry) O’Malley, MD – Medical Director for Non-Acute Care Services, Partners Healthcare System – Massachusetts General Hospital

Paul, this is Terry, I’m sorry, to a cast a vote are we raising our hand?

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

No you’re casting a vote so in that same pull down list you have an “agree” or “disagree” if you agree you’re voting in favor.

Terrence (Terry) O’Malley, MD – Medical Director for Non-Acute Care Services, Partners Healthcare System – Massachusetts General Hospital

Oh, got it, ain’t technology wonderful, thank you.

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

Okay. Okay, I’m counting now its 1, 2, 3, 4, 5, 6, 7, 8, 9, is it 10, 11 if somebody else is checking my work? So, I think we have 11 in favor and 2 opposed, so just so you all know that we still have a preponderance of folks who would like to move forward with the recommendation that we keep 2017 as an optional.

Okay, so, I’ll present the three options in terms of understanding whether the implications of various positions and the majority voting for keeping that option.

Okay, let’s move onto I think it’s Privacy and Security please, I’m sorry that this took longer than...oh, no, I’m sorry, not Privacy and Security, clinical decision support. Next slide, please.

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

Okay, so are you ready for me Paul?

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

Yes, yes.

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

Okay, great, so, thank you Paul, so, yes the group that I led was charged to look at ePrescribing clinical decision support and CPOE. Next slide, please. So, you can see the participants of the small group. Next slide, please.

Okay, so for the ePrescribing one again the objective being generate and transmit permissible prescriptions electronically the measure threshold has moved to 80% of permissible prescriptions queried for drug formulary and transmitted electronically for EPs and for eligible hospitals and CHs more than 25% of a hospital discharge medication orders for permissible prescriptions, again, queried for a drug formulary and transmitted electronically. Exclusions are the same as in Stage 2. Next slide.

So, there are some significant detail here, let me try to boil it down. So, overall the small group, and then in the meeting last week that we had with the larger AHM Workgroup, the thresholds were generally considered reasonable for most EPs, some field data I've gotten since raised an interesting concern, I'll just share here for discussion, which is there is some concern that the higher threshold might start to effect a significant EP if a significant fraction of patients require the use of a pharmacy that does not accept external ePrescribing even if it does so internally such as VA system or Kaiser for some EPs that I talked with recently.

The 25% threshold was considered probably generally reasonable for eligible hospitals but it was felt that CMS should recognize the frequent uncertainty by patients of which pharmacy they would like to use or when the transmittal to skilled nursing facilities or assisted living facilities do not connect to ePrescribing.

The second one, should we allow for inclusion of scheduled drugs. There was agreement there. There was also, however, the sense that if an organization can implement ePrescribing of scheduled drugs during an implementation period, during a reporting period, especially when it's a yearlong, that one consider being able to declare an effective implementation date and start counting scheduled drugs at that point.

The third point, should we continue to exclude over-the-counter medications in this objective the group felt no that we should allow but not require inclusion of over-the-counter medications, part of the reason for that was the enhanced ability to insure that patients actually are "prescribed" the right medications including their OTCs and that over time getting potentially fill history on whether those were actually dispensed and used, the ability to ensure that they get added to medication lists which may be less of an imperative when one is instructing a patient to use an over-the-counter medicine and drug interactions can be checked, etcetera.

Then for the fourth element, should we limit the measure to only new and changed prescriptions, the group felt that it would be important to continue to include what's described as refill prescriptions, these are actually renewals but certainly the encouragement of the patient centered practice to renew medications at discharge when there is a patient who needs one and a prescriber who is comfortable providing one, particularly those prescribers who will continue to follow the patient outside the hospital. Next slide, please.

So, for objective three, clinical decision support, implementing CDS interventions focused on improving performance on high priority health conditions and the measure one being five clinical decision support interventions related to four or more CQMs for the entire reporting period and as before, absent the four CQMs related to an EP, EH or CH's scope of practice or patient population to focus on those that are related to high priority health conditions.

And then the second measure enabling and implementing functionality for drug-drug and drug-allergy interaction checks and then the CDS encouraged areas that you can see in the section below. Next slide, please.

So, our overall comments of the group for measure one was that it would be helpful if CMS could provide more guidance about the definition of high priority health conditions because there was some feeling that it was not necessarily clearly synonymous what they called their CMS encouraged areas that for measure two it would be helpful to have more guidance about whether there are any restrictions on how providers may calibrate or filter their drug-drug interaction alerts, the goal again being to optimize usability by focusing on high priority alerts while still meeting the measure and making sure that it's clear what's allowable there.

And that also CMS should reiterate its current policy as it relates to CPOE within the CDS, the decision support measure as well to specify what is currently as licensed health professionals can also include credentialed medical assistance where felt appropriate as they can do for CPOE.

And then finally there was a suggestion to add, as an additional priority area, behavioral health. So, the second area, recommendations that providers explore a wide range of potential CDS interventions and determine the best mix there was appreciation for CMS providing these clarifying the examples of physicians appreciate knowing that there is greater flexibility and we certainly supported the exploration of such wider ranges of clinical decision support. Next slide.

So, for the objective four, CPOE, using CPOE for medication, lab and diagnostic orders, again, directly entered by any licensed health professional but also the expansion to credentialed medical assistance or medical staff members credentialed to and performing the equivalent duties of a credentialed MA and then following the regulations of state, local and professional guidelines, the three measures, the increase of medication orders to 80%, laboratory orders to 60% and diagnostic imaging orders to 60% and then the exclusion as listed at the bottom. Next slide, please.

So, overall we agreed with all the proposed measures. In terms of the second question, should we expand the objective to include diagnostic imaging with the examples that you see there. The group agreed with that notion but felt it would also be helpful to provide even more guidance on the issue of whether even more broad definitions of diagnostic imaging should be considered, the examples that you see listed there could be for example a dermatology image where a wound is diagnosed in terms of its stage or severity, if its accompanied by a report or other things that have an image within them that's generally published as part of the report such as an electrocardiogram.

This next item, should we continue to allow but not require providers to limit the measure of the objective to patients whose records are maintained using certified EHR technology. There was agreement with the flexibility. The concern that was raised, and I'm not sure we have a proposed alternative so it may simply be for discussion here, is that it is difficult to count the orders that are never entered into certified EHR technology it's something between far too burdensome, it invites under reporting because it's really impossible to count accurately and to try to count it accurately would require fairly burdensome attempts to try to capture all paper before patients leave the hospital or before they leave a clinic even when systems are in place.

And while it's often considered to be a very small fraction of the totality of orders it's pretty burdensome to try to capture what might be one percent or less of such orders that are never entered into the system and they're simply given to a patient with a paper prescription from someone's legacy prescription pad supply.

The next item is, are there circumstances that might warrant an additional exclusion for an eligible professional such as a situation representing a barrier to successfully implementing the technology to meet the objective. The group felt that there were circumstances that would warrant such an exclusion and on the other hand there needs to be some clarification of whether EPs and EHs could simply attest in this regard or they would need additional qualifying criteria for why they're not able to successfully implement the technology to ensure that the attestation would pass an audit.

And then the last section was are there circumstances where an eligible hospital or a CAH which focuses on a particular patient population or specialty may have an EHR reporting period where the calculation results in a zero denominator for one or more measures. We consider this unlikely but also that if it occurred that the EH or CAH could use the proposed exclusion for fewer than 100 orders. So, we didn't think that was likely to be a concern for most organizations.

So, that is our summary, happy to open it up to questions. Back to you Paul.

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

Great, thank you, Mike. Any questions or comments to Mike? I don't see any hands raised. One last time? Okay, so I think people are in agreement with those comments and answers to the questions. Thank you.

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 & Technology Officer – Palo Alto Medical Foundation

Okay next we're going to go to the population and public health subgroup.

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

Great, thanks, Paul, this is Joe Kimura from Atrius Health and quickly, to the next slide. Just a quick acknowledgment for Amy, Art, Neal and Terry and a big thanks to Jim and Kim in terms of their expertise around a lot of the technical specifications that are required in terms of this objective. Quickly to the next slide.

In the interest of time Jim is going to try to really blast through a lot of our findings in a single summary slide. I'll go ahead and turn it over to him to see if we can sort of catch some time up to get to the next stages or our meeting.

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology

Great, can you hear me okay?

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

Yes.

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology

So, here the proposed objective is on this slide that the EP, critical access hospital or eligible hospital is in active engagement with public health or clinical data to submit electronic health except where prohibited by law and practice.

And there are six measures for them to meet the objective and eligible professionals must meet three of the measures and the hospitals and critical access hospitals must meet four of the measures so that's the objective that we'll be talking about and on the next slide we have all of the comments from the group, if we can go onto the next slide. Great. So, I'm going to try to...

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

Can I just ask somebody to mute their phone or turn off their computer speakers I think we've got some delay? Thank you.

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology

Okay, is that better?

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

I think so.

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology

Great, so I'll walk through the key points here. So, the first comment that was made was on the definition of what active engagement is, there were three options for active engagement the first one that the provider has registered their intent to submit data and is waiting for the public health or CDR to invite them to start the process. We all agreed that this option was reasonable.

The next option is that they're in the process of going through a validation phase before actually sending data and the rule said that they should be responding to requests within 30 days. We did have a change to this that said providers must respond where applicable to the public health or CDR within 30 days through acknowledgment of request and process for investigation to clarify that they didn't actually need to resolve the issue but just that they had to acknowledge it and start addressing it.

Option three was to be in production and the group felt that we did need to have something in option three about addressing issues as well so we proposed to use the same definition as we had for option two about responding to requests and acknowledging it and starting the process for investigation.

The next comment we had was around the proposal for a creation of a centralized registry, that should say centralized registry sorry not clinical repository, where each public health or CDR would need to declare their readiness to accept data in order for that to be a viable option for providers to report to and the criteria here in the rule had said that the public health or CDR must have reported their ability to accept data by the first day of the providers reporting period and we did suggest a change here that we change that to they must report that information 12 months prior to the start of the provider's reporting period so that the provider has some time to get ready, so that was a fairly major shift in the policy there to say that public health and CDRs must report their readiness and register it with that centralized registry a full year ahead of time.

The next thing that we talked about were some of the just attestation mechanics when you are selecting multiple measures to report to. Two of the measures, measure four and five you can actually use that to meet multiple measures within the objective, you can have two measure fours and two measure fives to get up to four and so there was a question about if you're sending the same data if that can still count and we did feel, the group did feel that providers should be able to send the same data to multiple unique registries as long as that data is sent to registries, satisfies the criteria and purpose of each registry it should not matter that the provider is sending the same data. So, the group felt that this needed to be clarified in the regulations that you could actually do that.

Then there were some fairly quick comments on each of the six measures. For measure one the immunization registry reporting some of the comments here were really around the bi-directional component. The Stage 3 rule introduces the immunization information system sending back a forecast and history and there was some concern around the forecast especially whether...

Charlene Underwood, MBA – Senior Expert, Government & Policy for Health IT – Cerner Corporation
I'm not able to...

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology

Oh, Amy, I think we can hear you if you could go on mute?

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

I think that was Charlene.

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

No it's not me I think it's Charlene, but I'll go on mute anyway.

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

James Daniel, MPH – Public Health Coordinator – Office of the National Coordinator for Health Information Technology

Oh, sorry, I thought it was Amy, sorry. So, there was some concern about, you know, forcing the forecast to come from the IIS. The ONC CERHT rule actually certifies display of the history in the forecast but the CMS rule does not require it, so we thought there needed to be a little more clarification there and especially in that display to allow for some flexibility for the EHR products to add on top of or adjust the forecast received from an immunization information system if perhaps they had contraindications to add to that forecast.

There was also the question of what to do with the rule if the state is not ready for bi-directional is the rule clear enough on that...would that mean that the state is not currently ready to accept data per Meaningful Use requirements and the provider could claim an exclusion.

For measure two, syndromic surveillance the general feeling was that the rule as its stated for eligible hospitals and urgent care should be kept as noted but the way it is written for ambulatory syndromic surveillance did not seem to really fit in measure two, it seemed like that was more of a population health measurement and that might be part of measure four as opposed to measure two.

So, definite strong feelings that the eligible hospital data should be kept, this rule did actually start lumping urgent care facilities who are, for the CMS purposes, classified as EPs but they're lumped together with eligible hospitals for the rule because that data is more likely ED data that health departments do collect for syndromic surveillance. So, general feeling here was to keep EH and urgent care as is, but the ambulatory syndromic for other eligible professionals probably was more population and public health measures that fit better in measure four.

For the next measure, this is a new one, case reporting, this is the idea that eligible professionals and hospitals could report the case information as soon as there is a possible or suspect case and to report the clinical information that's not necessarily there in an electronic lab report.

What happens currently is public health does hear about a lot of these cases from electronic lab reports but they get it after the lab is confirmed there is a large delay if there is, for example, a suspect case of measles public health should really know about that as soon as someone presents with the appropriate rash and a test is ordered that is actually reportable to public health, right now as far as any electronic means of getting the information they have to wait for that electronic lab report which often comes in too late for public health to start any intervention.

So, this is really about that immediate case notification from the physician including clinical information that's in the electronic health record and the ONC specification also then allows for a forms management approach that allows the EHR to display a form to collect additional information that public health might need that might not be in the electronic health record so things like outbreak investigation questions. If you think about the recent measles outbreak public health might want to know if people had been on a plane, if they traveled, if they had been to Disney Land those questions could easily be incorporated in that forms approach.

There was a feel from the group that it needs to more specifically address the bi-directional component of the measure around what things need to be reported and the rules around that so there is more sharing of information and rules between public health and the providers, and that the CMS rule might need to actually call out that bi-directionality and requirement for the electronic aspect.

Measure four and measure five are public health registry reporting and clinical data registry reporting. These are the more general registries either on a public health side or from a clinical data registry side. On the public health side there were three specific standards called out for cancer registry reporting, national health safety network reporting of antibiotic utilization and antibiotic resistance data, and reporting at a national level for the national healthcare surveys.

On the clinical data registry side there weren't any standards called out so there was a feeling from this group that we need to regulate better what is eligible and if there are other standards that are part of the ONC rule that might be okay for reporting these measures and there is also a note that...measure three, the concept of bi-directionality that sharing of information between public health and the providers probably needs to be called out and also in the exclusions acknowledge the existence of national registries independent of jurisdiction for those exclusions.

Measure six was electronic lab reporting which is pretty much the same as in previous years and there was a comment in this one that we do need to make sure that we're clearly defining the difference between electronic lab reporting and syndromic surveillance data.

The new syndromic surveillance implementation guide for hospitals does include some lab data but there was a comment that we need to make sure that this is clear that this syndromic surveillance data does not count toward ELR. ELR is really about the lab data coming from the eligible hospital to public health.

And there was also the notion that some of the knowledge management and bi-directionality that could be useful in measure three should be thought about for measure six as well, there is a lot of work on the laboratory side to figure out the triggers for what's reportable within each public health jurisdiction and if public health is doing some work on that to help operationalize measure three case reporting that should be repurposed for measure six.

So, I think I covered everything; hopefully I did that in the time allotted.

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

Thanks, Jim. Paul turn it back over to you. Paul?

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

If Paul is not here is group four ready?

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

Sorry, I was on mute.

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

Sorry, go ahead Paul.

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

No, thank you very Jim anyone want to...you did a great job of expanding on some of the points you were making in verbal form. I wonder if you could put some of that let's say on case reporting since it's new, some of the things you talked about the forms, if you could put that in the summary. I'm going to propose that we actually...it will be in the presentation but not necessarily verbalized, but if you could include some of those things. Any other comments from the group?

Okay, let's move onto quality measures please.

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

Okay, this is Cheryl Damberg, and if we go to the next slide, I want to thank my fellow Quality Measure Workgroup Team members and also to acknowledge Samantha Meklir from ONC who provided tremendous support throughout this process. So, if we go to the next slide.

Much of what I'm going to share with you we had talked about on the last phone call although there were a variety of comments that came up during our last discussion with you where we went back revisited and tweaked the set of comments in our section. So, I'm going to try to highlight those for you, but the two areas that we were specifically asked to address were the number of measures vendors must certify to and also issues related to alignment with what is on the ONC side with the rest of CMS quality reporting programs. So, next slide, please.

So, as a reminder, one of the things that the team did when we approached the task was to step back and say, you know, are there some overarching issues that need to be addressed to try to advance quality measurement and nothing has really changed for the most part on this slide with the exception of the last sentence in that second paragraph, but as a reminder, what we were trying to convey here is that it is going to be important to improve the availability of standards to further interoperability.

And the idea here is that we need to really advance quality measurement to allow measurement across settings in time for a patient and the standards that are being worked on via the clinical quality framework focus on CDS and do not yet pilot the effectiveness of these standards to advance quality measurement. So, that was language that we added here.

If we move to the next slide, some of the other overarching comments that we made, so the current set of electronic quality measures are essentially retooled clinical process measures that largely derive from manual chart abstraction or claims and they tend to focus on sort of single providers and single silos and again the idea here is really to try to advance measurement to cut across settings to follow the patient longitudinally across all the possible settings in which they might receive care and that these types of functionalities are going to be critical to support not only quality improvement for patients but many of the new value-based payment models that are really trying to derive those kinds of changes. Next slide.

So, as we get into our specific recommendations, this was a new...an addition from the last presentation that we provided and this was in response to a comment that came up in the last call about disparities and we went back and reviewed the language in the Notice of Proposed Rulemaking and the language that's there in quotations is what is contained and our group reviewed this and thought that this was an important addition and that we support this proposed language and believe that the collection of disparity sensitive data elements would help to advance improvements in closing the disparities gap for many populations.

However, to do this requires collecting this information in a structured data format as well as using standardized variable definitions and I can't underscore enough having worked on disparities work myself that, you know, there are varying definitions out there related to how people categorize race, ethnicity, etcetera, so those two words, structured data format and standardized variable definitions are critical parts of our recommendation. Next slide, please.

Turning to the alignment piece, so, again here we support alignment across the different federal quality measurement efforts. We continue to support, where feasible, alignment with the work that's going on in the private sector as well to try to help produce burden on providers. The alignment should focus not only on using the same measure specifications where people are measuring the same things, but also the alignment of reporting formats, the standards utilized and the reporting periods. So, those are important components of alignment as well.

The other thing that we flagged, and I want to acknowledge Ginny's expertise in this area, was calling out sort of the continued issues related to misalignment around data elements between ONC and CMS programs and we call out several examples here in terms of how say age is represented, so in one it's birth date, the next it could be age at admission, how gender is represented, vital signs and there is a larger list, we certainly could provide that information, but again, I think CMS and ONC have to get on the same page about data elements and the definitions for them, again, to reduce provider burden and to help vendors out as well. Next slide.

So, now turning to one of the key areas that they asked for comments about, again our recommendation has not changed from the last call although we did clarify some of the language. So, there were three options presented that vendors certify to all clinical quality measures, that there be a phased approach is option two and then option three was certifying to more than the minimum but not all and we continued to stick with conditionally supporting option one provided several things are met which are contained on the next slide. Can we move to the next slide? Thanks.

So, there is concern that there is, you know, the compressed time between the release of these annual electronic clinical quality measure updates and the required use in the EHR and so we tried to go in here based on comments that we received last time about trying to clarify some of the language and really it's about significant impact on clinical workflow as well as requiring extensive software code changes, those are the two areas that are most problematic and generally I think the consensus among the group was is to the extent that a clinical quality measure requires more extensive modification or for any new clinical quality measures being introduced the scheduling of these changes should allow sufficient or ample time to accommodate these activities because inevitably they're going to take longer not only for the vendor to get coded up and tested, and ensure that they work before they take them out into the field, but also for providers to understand, you know, and get a vessel with the change required on the operational end.

There are a couple of other things we added in this slide, so one thing that was flagged was CMS's efforts to work with stakeholders regarding the 2015 annual measures update to get feedback on changes and we wanted to acknowledge that we appreciated the opportunity to provide that feedback and hope that this process will be continued as measures evolve.

The other thing that we added was, you know, we noted and we support the provision in the 2016 IPPS Notice of Proposed Rulemaking where CMS acknowledges the need to determine a predictable cycle for the introduction and certification of new measures, and we know that CMS is going to publish an RFI to gain better insight and recommendations on this and we certainly support that because I think as we have amply heard, at least in the context of these calls that we've had, there are lots of thoughts about how these processes should play out and what could be done to strengthen them. The next slide, please. I guess that's it for me.

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

I think there is one slide, fast forward.

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

Yeah, did we miss one?

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

Slide 30.

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

Okay, sorry. So, this one, going back to the number of measures that vendors would need to certify to, so, again, the idea was that vendors face a lot of different clients who have varying needs and vendors found themselves needing to certify to all which is partly why we were supporting recommendation one, but this was predicated on the specifications and the certification tools being accurate, complete and fully tested, and allowing at least 18 months for that implementation process to occur.

And then the last bullet point, which we did not change, was that, you know, clinical quality measures, the full set, are not relevant to all providers or all practice settings and that there should be flexibility to allow the EHR vendors to certify specialty EHRs really customized in a way that are relevant to a particular specialty. So, that was it, any questions or additional comments from my team members?

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

Okay, thanks Cheryl. I do have a question, this last point in a sense of our...if I can catenae these conditions you said for option one it looks like you're saying option one only if there's no change required in a sense because you said anything that requires development or change in workflow needs an 18 month notice and sort of we're caught a little bit if it goes with 2017...we're caught a little bit of saying, we can't do anything. But I have a...is that what you're saying?

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

So, I think the idea is there is the introduction of new measures which requires a certain timeline for the vendors to code up and to get those tested so that there are no glitches once, you know, providers have to actually use them on the ground. You know Ginny you might want to weigh in here because I know you had thoughts about the 18 month period.

You know I think the idea was, you know, anything that's sort of ready to go could get out there but it's more, you know, when there are significant changes in existing measure specs or something, you know, comes up new, you know, sort of six months prior to launch that's when problems start to emerge.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Yes, Cheryl that's a good analysis and I think, you know, when we're talking about option one certifying to all the measures and if we think about the set that we have now, you know, as long as when new measures are introduced then that really gets into the whole timeline consideration and the RFI that CMS will be putting out, you know, there does need to be ample time given to do the implementation both on the vendor and the provider side especially.

I think we've heard a lot from providers about the amount of time it takes them sometimes to implement these measures and change workflows and, you know, it affects their policies sometimes and a whole lot of things that take time for them to do as well. So, I think it...you know those kind of go hand-and-hand. Does that make sense Paul?

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

It does make sense, but then we get into the quandary of well then how do we move forward?

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Yes.

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

So, the constraints are everybody complains about the current measures...

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Yes.

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

And that it is not good enough to do the alternative payment models.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Right.

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

And then we can't say we...and yet we can't do anything for "x" amount of delay time and I know those are two fairly hard constraints but if the group can somehow think of how do we get past...how do we move forward, because it's sort of saying we can't do anything for Stage 3 even though we don't have measures that are good enough.

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

Right, no, I think that that's an important consideration and we can certainly go back and try to, you know, tweak some of the text, but I guess, you know, my...and this is outside of doing e-Measures, but, you know, kind of how I watch this on the ground in the context of value-based purchasing programs is that the providers need, you know, some amount of lead time to be able to code up the measures and also to signal to providers what the new expected practice is if the measure is, you know, suggesting a new practice and so generally they'd like to have these things locked down, you know, 6 to 12 months in advance of when everything begins.

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

Yeah, I understand the constraints.

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

Yeah.

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

If Stage 1 was to really get the systems deployed, which I think it did a fantastically successful job at, Stage 2 is interoperability and you know that we're still struggling, I would say Stage 3 plus is all about measurement of how we do and getting it in front of the right people. So, I'm just saying that this is going to...this is Stage 3's interoperability quandary.

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

Right.

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

And it's probably worth our time as the FACA to do a lot of brainstorming and figure out how to break through the log jam.

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

Yes.

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

I understand it's a really hard...we all understand it's really hard on all sides, but somehow...let's say the Secretary's movement for 2016 30% and in 2018 50% we can't do that without better measures.

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

Yeah, I agree.

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

So, what are the breakthroughs there? It's not something we need to talk about now and we actually don't have time to talk about it now, but I would sort of...we as a Workgroup and as a Subgroup need to try to brainstorm something about this that's my only plea.

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

Yeah, so Paul, I think that's a really good point and my question back to you is, will we have time on future calls to address this and what's our timeline for, you know, providing that input?

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

I think we're going to have to create some time for future calls and to try to get it in as quick as possible because it's not just "Meaningful Use" it's really the delivery system reform that's the Secretary's initiative and her timeline, and we need to, as sort of advisors on the HIT support of that, I think we have to find a way to come up with some suggestions and advice. So, we'll take that off line but I'm just teasing that up as its next year's black. Next year's black so we have to deal with that.

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

Yes.

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

I'm going to move us along because I know we're so far behind. Any other...Terry you have a quick one?

Terrence (Terry) O'Malley, MD – Medical Director for Non-Acute Care Services, Partners Healthcare System – Massachusetts General Hospital

Yeah, just a comment, the issue of having creating your new own measures and testing them within your system as an option for certification, there is a...way around such a log jam, let those places that are able to move, move forward with measures that they think are important as long as we figure out the framework within which those measures get constructed but that might be...

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

No that's an excellent point and Cheryl if your group could think...we've had that on the agenda and spoken about it and recommended it as part of our HITPC recommendations in anticipation of MU 3. So, maybe that's one of the comments we provide back to remind them.

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

Okay.

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

Thanks, Terry, because that is something we thought about a long time ago as one of the ways to break log jam. So that can speed up essentially everything from the development testing and accreditation, and you may know that NQF has an incubator model, but at any rate...

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

Yes.

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

So, those are just food for thought. We somehow have to break through this log jam.

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

Okay.

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

Thank you, thank you very much.

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

Yeah.

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

Okay. Let's move onto the Privacy and Security Workgroup, please, Deven.

Deven McGraw, JD, MPH, LL.M – Partner – Manatt, Phelps & Phillips, LLP

Okay, great, thanks, Paul. So, next slide please, here we all are, next slide. We took on two issues with respect to the NPRM one being the first proposed objective around protecting patient health information but we also took on the question of what privacy and security issues arise related to increase patient access to data whether through the view, download and transmit that's been available since Stage 2 or through the newly proposed API infrastructure. Next slide, please.

So, with respect to this first objective here is what's been proposed protecting ePHI which is electronic protected or identifiable health information that is created or maintained by the certified EHR technology through implementation of appropriate technical, administrative and physical safeguards and what's new here is to be clear that this is not just a technical assessment exercise that this really is sort of a slice of the HIPAA security rule risk assessment applied to CEHRT and that it includes an assessment also of administrative and physical safeguards in addition to the technical piece for which the capabilities are usually inherent in the technology.

And this recommendation is quite consistent with recommendations that the Tiger Team put before the Health IT Policy Committee that were endorsed by the committee, we didn't get everything that we asked for, but to be honest I think we got the spirit of what we asked for and probably the most important aspect of what we asked for. Next slide.

So, we essentially say in response to this that we support what's been proposed and believe it should be incorporated into the final rule. Next slide.

So, on the issue of increased privacy and security issues related to increasing patient access to data, yes there are increased risks associated with this. There are risks for which the provider has a responsibility to address that include increased security risk from connectivity to the EHR not sort of fully understanding what legal requirements might be attaching to those connections, you know, keeping in mind that this security risk assessment applies to these types of connections and technologies as well as it does to any other part of the certified electronic health record technology when the provider is using it.

But there are also risks for which the patient takes on responsibility and patients frankly may not be aware of that. If a patient chooses to use a device in order to transmit information using VDT or to connect to a provider's EHR through an API it might have weak security controls, it might be an App that either has no policy on privacy or is unclear on privacy, or that allows data sharing liberally with the third-party or other broad uses for some patients that's perfectly fine for others it's not, they may not necessarily know that they should be checking the privacy policy and again they might not necessarily be able to understand that that's what's happening. Next slide.

So, in general we support, really without reservation, the increased opportunities for patient access to information through the use of these technologies but acknowledging that these privacy and security risks do exist and that the law, HIPAA, certainly on the provider's side provides one set of responses for the provider managing their responsibilities for managing their risk, you know, HIPAA doesn't apply to the patient-facing space and the Federal Trade Commission has the ability to crack down on unfair and deceptive trade practices for vendors in the consumer marketplace, but it's not exactly the same as having the full complement of HIPAA and that's just the reality of what we're facing here. Next slide, please.

So, we recommend a lot of guidance and best practices. We previously, as a Tiger Team and as a Policy Committee, actually opined on these increased risks when we first took on this issue when view and download were all that was proposed and we dug those back out and took a look at them and they are equally as relevant today and just need to be sort of brushed up to apply to the transmit functionality where again what the patient does is not just viewing and downloading for her own safekeeping in her computer on her desk, but sending it to an App or having a direct connection to an App.

We did have recommendations involving transparency to patients about risks and making sure that they understood them and making sure that they understood that they were responsible for managing those risks and we believe that all of those recommendations are equally applicable here and frankly to the best of our knowledge nothing was done with them in the first round, although, I will say, recommendation number two, ONC is currently working with the Federal Trade Commission and with OCR to develop guidance for key stakeholders around use of mobile IT Apps and APIs including on the patient-facing side. So, there is work being done it's just we haven't seen the results of it and we think it's important to endorse that effort and maybe urge it to be released promptly.

ONC and OCR, which oversees HIPAA, should produce educational materials for both patients and providers on the safe use of App and APIs, but there is also a role for the agencies to play in educating private industry App developers about how to best communicate privacy policies and security practices, you know, not too long ago ONC had a compare tool on its website that allowed vendors to sort of put in the details of their privacy policies that would enable a consumer to compare those policies across different vendors but not very many vendors took advantage of it and so it's not really a tool that's been widely used. If they were to dust that off and maybe be more upfront about publicizing it's availability it might get more widespread use.

We also want to take the opportunity to remind ONC of the prior recommendations that the committee has done on the issue of identity proofing and authenticating patients as well as family member, friends and personal representative access at the patient's request. Next slide.

We also think it's important to issue guidance and this one is really going to come mostly from the Office for Civil Rights about the intersection between what's required for Meaningful Use, for patient engagement and the certification requirements and HIPAA's patient access rights. How do those intersect? How can providers make sure they are in compliance with both?

And then we also think that there is probably a role to play in a voluntary but yet meaningful and robust effort to sort of certify patient-facing health Apps which could help patients choose Apps and help providers to counsel their patients about what might be the best Apps for them to use and of course the agencies could play a role in advising such an initiative but we think it's best to come from the private sector. I think that was it.

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

Okay, thank you, Deven. We're going to open up to comments.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

You know one thing we will be able to show also, in the Policy Committee if there are questions from the committee since we have so many new members, is what where in those recommendations that we approved way back in August of 2011 on transparency to patients about risks of view and download.

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

Right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And Paul it's Christine, I'm on and I wonder if...I'm not sure what you're thinking for the order of the agenda, but our...the first part of the Consumer Workgroup comments relate directly to this, to these things as well so we might want to give people more context for how this applies in that way.

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

Right. I don't see any hands right now so I'll go ahead and volunteer some comments.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Sure.

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

One, I completely agree with you that a lot of the work that, you know, your Workgroup has done over the years are applicable here. I think the challenge here, and a lot of the recommendations really are guidance and education, the challenge here is once we do "free the data" and liberate the data through APIs in the portal sense the people who are operating these things were covered under HIPAA and were accountable numbers, you know, the healthcare providers, as we free the data which can obviously be used for a lot of good we increase the risk as well and you alluded to that.

So, I think I'm focusing in on your recommendation number seven of this "certify" is there some way to, at the same time, educate consumers about the possible risks, I mean, one possible way of educating is to provide almost a template or a check list, a voluntary check list that consumers should consider as they sign up for Apps and have the FTC backing on, okay if you say that you do these things, you agree to these things, then if you do not then FTC can step in.

Another example that's come up since our discussion of the whole VDT kinds of implications on privacy is the Apple HealthKit where that...so a single vendor has made, in a sense, they've declared an API for this HealthKit, and I don't really mean...I'm just using it as an example, I don't mean to be endorsing it or anything, but as part of using their interface, their API all of these business partners have to agree to certain terms.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right.

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

Now Apple has a way to say or you're not going to be on the, you know, their platform, but I wonder if it almost requires something as strong as that for the protection of consumers who, as you pointed out, not everybody keeps up with all this stuff and I'd say like the vast majority of people don't understand the possible implications or the policy considerations as we all hit "I agree" buttons.

So, I really like the seven and how strong could or should we make it and the analogy there is this "Apple HealthKit" where they make it a condition on connecting.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Well, that's right and, you know, it is already the case that any sort of terms that are set by vendors can already be enforced by the Federal Trade Commission. Again, you know, any entity that says "yes, I agree" and then turns around and does the opposite could be subject to an action from the FTC and their consent decrees are almost always 20 years in length. So, you know, any company that's been subject to one of them will tell you that it can be quite onerous.

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

That's right.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

So, it's not an empty threat, you know, but it's one agency, right, so that's why we have, you know, the endorsement of the continued guidance that the FTC and ONC are currently working on that is going to be directed toward patients to help them to understand and to let them know what to look for.

But, you know, an effort where somebody does some of the hard work for people, which, you know, a platform vendor like Apple or any other could do or that patients could do with guidance or check lists on what to look for is clear.

What we would not, I think, endorse as a Workgroup is the sort of default position of all Apps...were all App platforms must adopt a particular rule about no third-party use of data, because I think we want consumers to be able to choose which options work for them and, you know, certain constraints around data use by third-parties will have an impact on the price point for these Apps and how they're made available to consumers. So, if a consumer wants an App for free and wants to trade off data access in order to get it as long as it's clear to the consumer that that's the deal that they're making we didn't think it was our job to stand in front of that.

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

Maybe the...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

This is Christine...

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

The question is on that last statement you made is as long as it's clear and as you know the standard of practice for Apps is the "I agree" that everybody does it, I'm sure it's in the five nines...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right.

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

All of us including me, click the "I agree" and you may have agreed to give away all your data for any purpose that the App developer wants to use.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right, right, no, absolutely and we make...

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

That's the difference.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

The point that it's got to be clear. Frankly the Federal Trade Commission has made that point in previous reports. The extent to which they could use their unfairness jurisdiction to hold companies accountable for hiding the ball in privacy notices with respect to what they're doing is a little bit unclear, but that what's out there in terms of authority.

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

Well, that's interesting, so maybe making it clear, you said it's unclear, so maybe making it clearer so that people do have an understanding and a lot of this is just not having the understanding...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yes.

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

Of what's required, what does clear mean?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah.

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

At any rate, okay, thank you. Christine you had something?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, so I just have a couple of questions on this, you know, the Consumer Workgroup has the same, I think, position Deven in that they were supportive of the sort of technical solution that an API offers but really worried about the privacy and security components and so we basically made a recommendation that was sort of, this is what we recommend pending hearing from you guys, so this is really helpful.

A couple of questions that I have, you know, we definitely talked about the PatientsLikeMe kind of approach where a consumer, you know, the value that they get out of using the PatientsLikeMe website is really worth it to them, it's very clear not just in their notice but in other pieces of their website that they will resell data to pharmaceutical companies and I may want them to do that in fact not just for a business model but because I want my data used in ALS research or whatever it is, right?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yes, yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, your right to say that it wouldn't be a smart idea to require the App developer to say we won't resell your data, but I just...I'm a little bit worried about a couple of things, one is, can you make the requirement to be clear about secondary uses of data part of the certification process number one.

Number two, how difficult would it be to get this voluntary certification process up and running, because, you know, my concern is that it would need to really be transparently in play by the time Stage 3 kicks off, that really needs to be in play now in many ways because the view, download and transmit functionality is supposed to allow people to transmit their data, we've been told it's not exactly doing that it's more of the download feature but even then I might download my C-CDA and put it in an App.

So, I feel like there is...my concern about it is great idea that you have a voluntary certification approach and kind of a marketplace that creates some transparency but I just don't know how even a federally facilitation one could get off the ground fast enough so I don't know if you guys have thoughts on that?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah, no, we recognize that this is one of those recommendations that is the "gee, it would very nice to have" and to sort of put out there that it would be great if this were to happen, we think it would be incredibly valuable, but we do not...it wouldn't be available in a timely way since the FTC and ONC guidance is already underway I think that has a better shot of being...of getting out there for people to use.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, but, so it's the guidance for consumers on how to select it, can you say which guidance you meant?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Can we go back a slide? Can we...yeah, thank you. Number two...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

ONC continue to work with FTC to develop guidance for key stakeholders, I mean, and this is a summary slide, what's in the transmittal letter, what's in the comment template is a lot more detail, those key stakeholders include App developers, I mean, patients number one, patients and consumers and number two App developers probably less healthcare providers because this is really aimed at the consumer-facing marketplace. OCR really should be developing the guidance around security risks for the providers.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, actually, one of the things we said was...we went back to the April 2011 transmittal letter which was the work you guys did on view, download and one of the requirements or one of the sort of fundamental principles was that a lot of trust is really rooted in the patient provider relationship...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And the implications...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

We're re-endorsing them here that's exactly right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, so the other, you know, concern that we had is that it would be great to have the guidance, it would be great to have voluntary certification, but if all ONC and OCR do is publish the guidance on their website and ONC doesn't really get it out into the hands of providers and really help them understand it and use it in a very practical way then it's just going to be a...like the letter from, you know, Mr. Rodriguez sitting on the website that, you know, you hope somebody stumbles into and looks at and that's not realistic.

So, if we...I'm sure we'll get a copy of your more detailed recommendations but that's certainly one of ours and I'm wondering if the two Workgroups might kind of come together around some of these things and...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Well, we're not meeting again, Christine.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

But, I'm happy to engage in this discussion at the committee level, absolutely. I mean, if this is just a...is this just a making sure it's clear to ONC that they should be both developing it an actively disseminating it?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, yeah.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay.

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

Is one...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes?

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

Is one of the "asks" Christine that recommendation be teased out and made more explicit like what do we want to be...what's the guidance for developers; what's the guidance for consumers. I was very intrigued by your comment about how FTC is working on trying to help vendors decide what they need to do to comply with FTC guidance. I think that it's just like a lot of these things, being more explicit maybe helpful.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay, we'll definitely work with the slides because we tried to...the comments in the transmittal letters are much more detailed and we just tried to lift it up a little bit in the slides, but we can provide some more detail.

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

I think so and I think that ties into your recommendation seven, what does that mean, you know, how do we...your comment was it should be done in the private sector I think.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yes.

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

So, how...shouldn't some of the...how does the FTC work with that with your recommendation seven. Just maybe...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

So...

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

Just making it more...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Making it more clear, okay.

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

Yeah.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And quick question, Deven, when you talk about FTC putting out guidance is there a requirement that App developers would comply with that guidance or it is just...

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

Right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

We hope you do this? I mean, that's where I'm confused.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Well, so what...so FTC has no regulatory authority, isn't that interesting. They cannot issue Regs. What they have is very broad authority from congress to crack down on unfair and deceptive trade practices.

So, when the FTC puts out guidance for App developers on consumer privacy issues it is an indication of what they're thinking is with respect to how they...what they believe is fair and transparent to consumers with respect to privacy and security issues. And so most of the vendors that I know take a look at that guidance and use it like a regulatory tool even though it doesn't have the force of regulation technically.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, that's helpful.

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

Yeah that's helpful. Other comments? I think this is one of the big issues related to...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay, well we'll...well on that note Chairman Tang we will add more stuff to our slides.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yay.

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

Thank you, as Christine mentioned it's going to be front and center of the Consumer Workgroup recommendations too.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right.

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

So, it's really, really, you know, important. It's how do we safely liberate this data so that it can be made to good use while decreasing the probability of it's causing harm.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right.

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

Okay, speaking of consumer, you're up Christine.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great, we did not do slides because we just finished our meeting yesterday and didn't know you guys were doing slides, so what we did do was a letter where we are in the process and I think you guys actually got that e-mailed out to you during the call, but we are not...it's not a final letter, the Workgroup is looking at it based on our discussion yesterday and will turn around their, you know, comments or questions or whatever by Friday. So, just so you are aware.

So, here's basically what our letter says, I'm going to take it in two chunks so I'm not talking at you for too long before you have a chance to weigh in.

So, the first is that we looked at objective five, which is electronic access to health information for patients. The proposal is that 80% of unique patients are offered access to their electronic health information so this is a continuation of something that was in Stage 2 with an increase in the threshold and it's that they would also get access within 24 hours of the data becoming available.

So the Workgroup supports the proposal in the rule that we also looked at the question of do you do...you know, the view, download, transmit function which in practice today is really pretty much just view and download right now or do you, you know, really go VDT plus this API.

And so what the Workgroup said was we believe that in Stage 3 providers should be able to do both, which is the view, download and the ONC certified API. We did raise...and we basically said we support both, however, we need to resolve a number of questions before, you know, we would really recommend that APIs go forward.

And so the issues that we are outlining with APIs are as follows; one is the privacy and security components that Deven did a great job of outlining. The Workgroup was, you know, one the hand really likes the possibility of a technical solution that could break down a lot of silos in healthcare, would address the portal proliferation problem, would allow me to put my data in one place and use it in different ways that are really appropriate to me, so we'll talk about precision medicine, etcetera.

On the other hand, we wanted to make sure that doing this and getting the data into third-party applications and making an API interface available wouldn't just sort of unleash this huge, you know, market for the sale of health information.

The group was in particular concerned that health information, because it is no longer protected under HIPAA once it gets into an App, could be used in identifiable ways, could be used to discriminate against patients in health insurance or in employment practices things like that. So, there was just lots of concern there and happy to have some really good work now from the Privacy and Security Workgroup.

The second concern we outlined was again this idea of how is a small practice or a rural hospital really going to do a good job of saying, here's what this means for you, these are the applications I recommend, you know, etcetera, so making sure they have the tools to do that.

The third concern and recommendation around APIs is the only function of the API that has been proposed to be certified by ONC is the ability to download and transmit the data, but that leaves out a lot of functions that consumers currently have mostly via portals today like secure messaging, patient specific education resources, you know, lots of other things that aren't part of Meaningful Use like medication refills and appointment scheduling that could go away if a provider were to decide only to offer an API which is just an interface to help you get your data but that's it.

So, in order for the API idea to really work and continue to deliver value for both patients and providers we're suggesting CMS and ONC look at certifying some additional functions that really relate more to inbound data functionality.

And then finally, that ONC in particular that the rule needs to be clarified that these APIs are publically available. We want to make sure they're not proprietary APIs so that, you know, Cerner has their own that's different from EPIC and that they only work with certain applications because that would mean basically the same portal proliferation problem would apply to the App's market. So, if they're published and publically available that solves that problem and so that's really essential.

So, the rationale and then I'll stop and invite questions or comments. The rationale here is both in order to continue delivering that value and in order to give the marketplace time to suss out well what's working out there, what is it that works best for providers and for patients.

The other rationale is the way the Stage 3 rules are proposed providers would still have to maintain a portal anyway because you can't do secure messaging and some of the other functionality around patient specific education resources without it. So, that's why our suggestion is both. Any comments on that or questions?

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

Let's see, I see Norma.

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

No you don't.

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

And instantly it went away, okay. Anybody else?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, do you want me to keep going Paul?

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

Sure, keep going, thank you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

All right, so very briefly...

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

So, Joe is this on this? Did you want to...

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

Yeah, just a quick question, Christine, so is there any guidance around as the APIs become available and sort of data becomes more liberated...I mean, what we're seeing a lot of challenges are, in terms of even from the provider's side of the system side, sort of those third-party applications that drop on top of data and start to recalculate things in different ways and how that information can then begin to conflict with how the delivery systems or insurance companies, or the government is also calculating things that...is there any guidance around what happens next after that data is extracted to try to make sure that there is less informational discontinuity or conflicts?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

We didn't really dive into this. There are two places that I think or two things I think are relevant, one is there is a patient generated health data component in the next objective that I'm going to talk about that could potentially be used in that regard.

There is also a requirement in the HIE objective around information reconciliation, but really I think the essential piece, and we as a Workgroup made this comment, in the interoperability roadmap, the essential piece is going to be making it easy for providers to do that information reconciliation and to digest and ingest only what they need at more of a summary or an aggregate level. So, that's not really been proposed in the rule though so we didn't comment on that.

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

Got it, okay, thank you.

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

Charlene?

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

Christine I just wanted to ask a clarifying question and you might come back to this one, this is backing up a little, when you looked at this particular measure you're recommending that it should be an "and" and not an "or" for this particular measure?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Correct.

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

I support that, thank you.

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

Okay, take it away Christine, care coordination.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so two other quick things on objective five and then I'll jump into objective six. So one is the Workgroup was supportive of the proposal to provide 35% of patients access, electronic access to patient specific education resources, so that's the changeover Stage 2 is it become electronic offering only, so I think that does make it easier for providers.

And then the other piece is an exclusion criteria around broadband. So, CMS did ask for comment. Right now if a provider is practicing in an area that doesn't have more than half of its housing units with a certain level of broadband available then they are excluded from the view, download and transmit measure entirely. CMS is asking for comment.

Our comment was essentially, first of all don't forget that consumers are increasingly using cellular to download it's not always broadband.

Second of all they still might want the access to their health information and they might be using that access either on their cell phone or churches, or libraries, or other places and so our suggestion was rather than carving out a big huge exclusion that says, you know, you don't have to do this at all, why don't you allow the providers to do objective five, which is, you know, make a proactive offer to patients that they can go on line and their data is available, but exclude them from the objective six measure of having to get a certain percentage of patients on line. So, that takes me to objective six.

So, objective six is interesting its care coordination through patient engagement and the proposal from CMS is that providers have to meet two out of three measures. The three measures they propose were first that 25% of patient's view, download or transmit their health information or use the API.

The second was that for 35% of unique patients a message is sent by the provider to the patient or it's sent in response to a message sent by the patient, or it's in conversation with other providers and the patient is sort of cc'd. That's a change, a big change over Stage 2 because it's not patients sending the message it's converted to providers send and that's why the threshold is significantly higher.

And then the third one is for 15% of unique patients they are either incorporating patient generated health data into the record or they're getting data from what CMS unfortunately called a non-clinical setting, which essentially means a non-Meaningful Use eligible provider so it's physical therapists and nutritionists, and long-term care which are clearly clinical settings but they just mean a non-eligible provider. So, those are the three measures they proposed.

The challenge...so the Workgroup is highly, highly supportive of both patient engagement and care coordination, but putting the concepts together and then saying you can just do two out of three opens the door for providers to do two out of three things that actually don't engage patients. In other words they could send a secure message to another provider or they could get data from another provider from a clinical setting. Those are really important measures but they're care coordination.

And so our suggestion is that we need to separate those concepts and we've provided three options for doing so in a way that would get to both patient engagement and care coordination.

So, all three options that we're proposing involve some level of view, download and transmit but I want to say that the Workgroup believes that getting 25% of patient population to go on line is too high. The rule does state that attestations to date tell us that the median percentage achieved is well above the current 5% requirement it's at 31% but we still felt like people would game the system a lot and they would be very, very worried about trying to get a quarter of their patients on line in that one year, remember it's a 12 month reporting period. So, we're suggesting that this be dropped back pretty significantly to 10% instead.

So, the Option A would be essentially require all three measures but change that threshold in measure one from 25% of patients to 10% so that makes it more achievable, otherwise, you know, do all three as proposed.

The one caveat is we, on the patient generated health data, it's really essential that CMS clarify that patient generated health data should be provider requested that was the recommendation the Policy Committee made, well I don't know, whatever a year or plus ago, and if the PGHD is provider requested than it takes care of, you know, the liability of like we turned on a fire hose of data and we didn't even know it was coming in. It takes care of the need to like validate and confirm. So, we just really need to make sure it's provider requested. So, that's Option A.

Option B would require all three measures, but again, reduce the measure for VDT to 10% and revise the patient generated health data measure and this by the way is the measure I feel like the Workgroup might be leaning towards. So, all three measures, so 10% VDT, the secure messaging as proposed where you can send out to...a provider can send out to 35% of patients but modify the PGHD measure to take the data from a non-clinical setting and move that to the health information exchange objective so that people would be getting credit for health information exchange if they were either sending a summary of care document or they were getting clinical information from a non-eligible MU provider and by the way they can use secure messaging to do that which would be a twofer. So that's Option B.

Option C is a little bit more complicated, it is basically really separating out care coordination and patient and family engagement entirely. So measure one would still be the revised 10% of patient's VDT.

Measure two would move completely to health information exchange, as I just outlined, and be replaced by a continuation of the current Stage 2 measure or 5% of patients send a secure message at some point during the 12 month reporting period.

And then measure number three would be as I just mentioned your having providers focus only on truly patient generated health data and moving the non-clinical setting piece down to the HIE objective. So, I'm going to stop there. I'm happy to walk you through what the changes would be to the HIE objective I think it's fairly obvious from what I said but I'm happy to clarify that if anybody would like to.

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

Okay, thanks, Christine. Comments about this and I see Joe, I think I see Joe.

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

No it's not me.

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

Okay, so the hands raise, I don't know how you clear it, but any other comments, questions? I'll wait just a little while because it seems like there is a delay. So, you're saying, Christine, that Option B is the group's preferred approach and each...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

We don't...

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

Go ahead.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Sorry, we don't know that totally for sure yet that seemed to be how people were leaning, but I'd say, you know, they needed some more time to discuss, but I think it's probably B or C. Option A was just sort of if CMS doesn't listen and keep everything then, you know, here's how we would change that.

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

And Option B differentiates itself from A by is it the measure two?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No it is the measure three...

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

Measure three.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Around patient generated health data and it's basically saying you're not going to count the care coordination aspect of getting health information from another provider, you're not going to count that as patient generated health data you can get credit for it under information exchange but that you would do something so that you could get patient generated health data into your EHR for 10% of your patients. I did forget to mention that threshold was also reduced in our recommendations because, you know, obviously we've kind of changed the denominator...

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

Right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, it made sense to reduce that.

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

Okay, I see it now. Okay, now we have Mark?

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Yeah, thanks so much Christine, could you just quickly summarize again the reason on VDT for going from 25% to 10% I missed some of that?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Sure the Workgroup felt that while the Stage 2 attestations are at 31%, at least they were at the time that the rule was proposed, that's the median threshold that providers are achieving. They also were concerned that it is the early attestors, it's the kind of, you know, more tend to be the leading edge providers and we felt like going...since there was such a concern about even the 5% in Stage 2 that jumping to 25% would lead to providers out of fear really gaming the system and that would have a really negative impact on patients, you know, people getting locked in an exam room and told you have to log into the portal before you can leave today, you know, stuff like that. So, we just wanted to avoid the gaming and the impact that this might have on consumers but still double the requirement from Stage 2.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Okay.

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

Next, Norma?

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

No, sorry, not me.

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

Okay, so, all right, anybody else? Okay, so when you present to the committee are you going to outline the three options or are you going to somehow figure out which one your preferred one is?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

We're going to figure out what the preferred one is and then we may still outline the three options.

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

Sure.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

In fact, I think, I'm sure we will. But we will know by then, we'll know by Friday, tomorrow what the committee's preferred option is.

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

Great, thank you. Okay. Thank you very much.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Paul can I just...

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

Sure?

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

Say that this is really helpful. As somebody who works on these issues to see it all lined out like this I really appreciate it.

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

It is very helpful.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families

I meant to say the same thing for the Privacy and Security Workgroup but and didn't jump in then, but just want to say it.

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

Yeah, I'll reinforce that it's just been so helpful to have this written down and have it delineated like this. Thank you both.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Thank you.

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

Okay, let's...we're going to conclude with the Interoperability Workgroup, well actually do we have...yeah, Interoperability Workgroup and then the...then I'd like to give some suggestions on how we present, since obviously we don't have the same amount of time in front of the Policy Committee. So, go ahead Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, hi, everyone. Why don't we jump ahead to the next slide, Chris Lehmann can't make it today. So, we were asked to look at objective seven which is health information exchange and there is some selected questions in there that were asked by CMS in the NPRM as well and we address a few of those.

And I should at the outset say that, you know, the comments reflect where the Workgroup deliberations are to date, we still have one more day of getting feedback from the Workgroup. So, there could be some changes here. I will try to point out the particular areas where there is still, you know, sort of open Workgroup discussion just to give you a sense of where the boundaries of that discussion is right now. Next slide, please. Next slide.

So, the objective seven comprises three measures and I can already see that there is some garbling of some language here, so for measure one it's to...and I tried to boil this down without, you know, putting in all of the text from the NPRM itself just to try to simplify it and hopefully didn't over simplify it.

But measure one is send electronic summary of care records for 50% of outgoing transitions or referrals. The garbling is in the next two where it says "new patients" it shouldn't be for just new patients.

Measure two is to receive and incorporate electronic summary of care records for 40% of incoming transitions or referrals.

And then measure three is to reconcile clinical information for 80% of transitions or referrals.

The one thing that we'd note at a high-level before diving in is that, you know, these three while, you know, you have to report or attest to all three you're only held to the thresholds on two out of three, but that there is some inter-relationship between these three and, you know, that comes up later as you start to think about a recommendation with respect to one it could affect the other.

So, in particular, for example, the ability to receive is related to the volume of the sending, so, you know, that connects measure one and measure two in some way. The availability of clinical information to reconcile is related to the volume of information sent and received. So, you know, if you have too much of a disparity between what you're requiring people to send then, you know, your ability to expect good robust reconciliation maybe somewhat hampered.

And then finally, the ability to streamline and automate information reconciliation as related to the quality of the information you receive, you know, again just pointing to what...how much information you're getting and how structured is it and how high quality is it. So, we just note those as background considerations as we were thinking about some of the tradeoffs here. Next slide, please.

So, in general the Workgroup agrees with the direction and the goals of objective seven measures. We, you know, completely agree that they're very important for quality and safety. HIE functions are gaining traction in the market and these objectives are good impetus to keep progressing.

We are concerned about setting thresholds that are unrealistically high that's just sort of a general concern, you know, we agree with setting higher thresholds from Stage 2 so it's not about that, it's not about the directional, you know, setting of higher thresholds, but, you know, we did have, you know, a lot of conversation about not wanting to be in a position where there is a need felt to backtrack on the threshold as has happened with the VDT announcement this year and, you know, we certainly want to motivate providers to, you know "own the problem" but not penalize them for factors that are genuinely out of their control and interoperability more than almost every other, you know, type of objective has this component of their being, you know, sort of the need for an ecosystem in order for someone to perform well against some of these measures. So, that's just, you know, again just background considerations as we work our way through this.

The Stage 3 rule also changes exclusions and we'll talk about that, but, you know, and part of what we discussed was the consideration of tradeoffs between thresholds and exclusions for example keeping a threshold high if you're allowing exclusions or conversely lowering a threshold if you're taking some exclusion's off the table. Next slide, please.

So, the first thing that we asked ourselves is what's the current experience with Stage 2 because two of the three measures, you know, are directly, you know, sort of extensions of measures that were in Stage 2. So, as we think about the threshold question we wanted to ask the question of, you know, what's going on, on the ground right now?

So, one of the things that we uncovered first off is that among those who have attested to Stage 2 the rates are generally higher...are generally below the proposed rates for measure one but well above the proposed rates for measure three and we note that measure three for Stage 2 was medication reconciliation only as, you know, we'll talk about in a second, but, so in particular you can see that for measure one for eligible providers they're at 40% and eligible hospitals are at 30% sorry 36% for measure one, which is to send a summary of care versus the proposed threshold of 50%.

And then for measure three, I'm sorry that says measure two, it should say measure three, EPs are at 93% and EHs are at 87% versus the proposed threshold of 80%.

We do note that...and this will be, you know, a point of conversation later that Stage 2 only required medication reconciliation. Stage 3, the proposal increases, expands the scope to include medication allergies and problems as well as medications and it also raises the threshold on all three to 80% from the 50% for medication reconciliation in Stage 2. So, it's a significant expansion in the threshold as well as an expansion of the scope.

One thing that we note though before going on to the question of thresholds is that there is a very strong selection bias in the numbers on Stage 2 so far so in particular, you know, as we dug into this one of the things we wanted to ask ourselves is, well, how many people have actually attested.

It turns out that a high percent of providers, 76% of qualifying EPs and 35% of qualifying EHs, are either taking hardship exemptions, leveraging the flex rule or they haven't yet attested in 2014. So, when you look at those who are scheduled to attest for Stage 2, so, you know, we're taking out the ones who are not, you know, scheduled to attest, these are the ones who are scheduled to attest three quarters of the qualifying EPs are actually not attesting to Stage 2.

Furthermore, when you look at measure one the transition of care a very high percent, specifically 86%, of the eligible providers have taken the exclusion from the send measure that allowed them to get an exclusion for fewer than 100 transitions or referrals in a reporting period. So, you've got three quarters of them who are not attesting even though they're scheduled to attest and then 86% of those who took the exclusion.

So, the reduction and the reason so many took the exclusion is that there was a reduction in the reporting period, many of you may remember in 2014 where it was first 12 months but then reduced to 90 days, but CMS didn't correspondingly adjust the exclusion. So, what you have...the adjustment would have said, well, wait a minute we're going to prorate this so it should be, you know, 25 or something like that, instead they left it at 100 that allowed a lot of people to get the exclusion many more than I think was anticipated.

So, the result is that only about 8000 EPs have attested to Stage 2 in 2014 and I think it's, you know, probably fair to say that they are probably the ringers in terms of their probably better position for successful achievement of the measures than the average provider.

We just provide that as background, you know, just to recognize that though these numbers, for example 40%, 36%, for the ToC measure, for measure one you are probably looking at one end of the distribution here and the average performance against that, you know, could be much different.

So, Stage 2 experience suggests that the Stage 3 thresholds are higher compared with performance to date and perhaps significantly higher given the small sample results, but, you know, you have to weigh in the impact of exclusions as well and that's what we'll talk about in the next set of slides. Next slide, please.

So, what we've done for each of these you'll see for measure one, measure two, measure three the way we've structured it is first just try to boil down the measure itself into the fundamental components just to give some clarity on what are the specific things that we're talking about here and then we give the recommendation that we make on each of these and then finally a set of slides that discusses, you know, some of the background and some of the thoughts we had behind each of the recommendations. So, you'll see that for each of the three measures.

So, first for measure one for send, as I described it increases the threshold from 10% in Stage 2 to 50% in Stage 3. It requires electronic transport but it does not specify use of a standard. So, it no longer requires that Direct be used as a transport standard, it allows any electronic means.

It allows the inclusion of patient self-referrals so I'm sending, remember this is a send, it allows a means to count a patient who has self-referred, basically they just show up and nothing has appeared in terms of information and I don't know where they come from, but it allows a provider under certain terms to include those self-referrals.

It allows inclusion of transition and referrals to providers who are on the same EHR, the so called "selfies" many of you may recall that during Stage 2 there was a big question that arose about whether these selfies would count, it was unclear in the Stage 2 rule, CMS did in an FAQ say that they would count and so all of a sudden, you know, that was an option that was available.

It turns out, based on our informal querying of different vendors some of whom were on the Workgroup, that the selfies ended up probably not being a large percentage of the counted transitions that were reported by those who attested recognizing that it was just a small number so it maybe that the selfie issue isn't that big, but we just note that they did in the rule formally allow that.

It does require a summary of care that includes the CCDS data elements. You may recall that we no longer have the Meaningful Use common dataset, it's now being called the CCDS which is the Meaningful Use common dataset plus a few other new data elements.

There is an exclusion if there are zero transitions, referrals in the reporting period, so as I noted before there were many providers in Stage 2 who were able to get in under the, you know, fewer than 100 transitions or referrals perhaps in response to that CMS has said we're going to take away the exclusion so you only get the exclusion if there are zero transitions or referrals in the reporting period. And then finally, they include an exclusion for providers who are in counties with low broadband penetration. Next slide, please. So, that's just a description of the measure itself.

Our recommendation just ticking the down the same, you know, along the same categories, is our recommendation is to lower the threshold to 40% from 50% to we agree with the NPRM to allow any electronic transport.

We disagree with the NPRM on allowing patient self-referrals, I'll discuss...some of these are still in conversation in the Workgroup, I'll get to that when I go into the discussion of each of these.

We disagree with the NPRM on allowing selfies.

We disagree with the NPRM in terms of the summary of care and what's required in terms of the data that's required to be sent.

We actually disagree with the NPRM on allowing the...on removing the exclusion.

And then finally, we disagree with the NRPM on the exclusion for low broadband penetration. Next slide, please.

Now, I'll go into describing each of these in a little bit more detail. So, in terms of, you know, lowering the threshold to 40%, you know, the Stage 2 data suggests that the average provider will probably be below the 50% target. So, a number of people on the Workgroup were concerned that, you know, 50% is probably a bigger leap for most providers than would be indicated by the Stage 2 data and the 2014 exclusion allowance has slowed adoption of those functions.

So, you have a whole number of providers who if they hadn't gotten the exclusion they would have, you know, been forced to move forward but because of the exclusion they're now in essence one year behind. We could, you know, agree or disagree on whose fault that is but the fact of it is that, you know, for a large group of providers that adoption that we were hoping would take place in this year just hasn't taken place.

However, we do very much want to keep the rate high to motivate forward movement. This is a topic that is under discussion at the Workgroup right now there is a range, there are some providers who feel that it should be more on the 25% line and there are some, I shouldn't say some providers, some members of the Workgroup who believe that and there are some members who are saying we should stick with the 50%.

I think, you know, there seems to be a consensus building around the 40% because it, you know, doesn't seem right to have a number that's below what the current attestation rate is even though it is, you know, for those lead providers and recognizing that we're looking ahead to enforcement only starting in 2017, so we have, you know, a little bit of time behind us, but, you know, that's kind of where we are right now, but this number is one that's a little bit in play right now in the Workgroup.

The second one about allowing any electronic transport, we do agree with the NPRM on this because there are ongoing industry challenges with Direct that could still be a barrier to achievement in many markets and we do like the idea of giving credit to those who have other types of HIE capabilities. So, it allows for that kind of flexibility, allows the ability to use APIs in the future for example for write types of capabilities once those are available through an API. Sorry, my computer just went blank, I'm okay now.

On the third on not allowing patient self-referrals this is also one that is still under discussion with the Workgroup. So, let me just describe here, you know, the current thinking but there are some, you know, there is still some discussion on this.

The thinking that would suggest that we shouldn't allow patient self-referrals is not because we don't think that there important, you know, important in general except that, you know, there seems to be a small number of cases where it would be clinically meaningful to incorporate them.

So, the intent certainly is to allow more transactions to qualify for the measure, right, that's what is written in the NPRM. It seems that the benefit to the patient would be relatively small because the information is arriving post-encounter.

So, the idea would be that for those who haven't read this section in detail, someone sends something and then it's after the fact, well this would be where someone appears and it's after the fact that I can go and get something sent, I think I'm saying that right, but it would add a large workflow burden to meet the measure requirements that seems to be out of proportion with the benefit to the patient or the provider.

So, that's basically the concern with that is that information is basically being said to be sent after the encounter has happened but that the workflow requirements that would be placed on the provider with a relatively small benefit to the patient as well as from a technology perspective the complexity of having to program how to count such circumstances seemed to be, you know, sort of...seemed to outweigh the benefit there.

Those who are arguing that we should probably still include those, and this starts to bleed over into measure two as well, is in cases where some of these functions are automated. So, for example there is a practice group in Worcester, Massachusetts that has automated ADTs that are sent from the hospital, for example a patient appears in an ED an ADT is automatically sent to this practice group and this practice group does a real-time patient match and sends a summary of care back to the ED in real-time.

And allowing the self-referrals and for the next one for, you know, patients who you haven't seen before, would actually allow them to get credit for that kind of capability. That, you know, probably only happens in certain rarified markets right now but it certainly happens and the argument would be that we ought to be encouraging that and therefore allowing these. Next slide, please.

Number four, do not allow selfies. It was, you know, a pretty strong sense of the Workgroup that these disproportionately favor large integrated delivery networks and that they also don't add, you know, very much if anything to patient care. This is a circumstance, for those who aren't familiar with this issue, where you could have an integrated delivery network hospital and their employed ambulatory providers are on the same EHR, so they literally are on the same database but they have different NPIs, maybe have different billing identities, so this sort of allowance allowed them to send a CCD from the hospital to the ambulatory provider for example and get credit for it as a transition of care even though that ambulatory provider is on the same EHR.

This would say, and CMS is proposing allowing that, we're actually suggesting the opposite that they should not allow that, it disproportionately favors large integrated delivery networks and by taking this away it would force those IDNs to be reaching out more into the care continuum where they don't have people on the same EHR in order to meet this measure. And again, it just doesn't seem to add to patient care, the information is already available in the EHR and by the accounts of those in the Workgroup in the vast majority of cases that's how the provider actually accesses the information, you know, as anyone would if it's already in your EHR.

So, the next one, slide five is a proposal that we would recommend allowing flexibility in the CCDS payload. Right now the way the NPRM reads it says that you need to send everything that's available of the CCDS data elements and in many transition or referral use cases it just may not make sense to provide the entire CCDS and so...and one concern is that this contributes to so called C-CDA bloat which many providers note makes C-CDAs unusable.

So part of the conversation we had and some concern among providers is not that they don't want more information to flow those who are concerned of, you know, moving this up to 50% from the 10%, but, you know, as one provider said, you know, I'm getting 10% now of things that I find unreadable in terms of bloated C-CDAs that are difficult to navigate and I don't like the idea of having 50% of things that are unreadable. I would get more clinical benefit and my patients will get more clinical benefit by having a lower percentage of things that are useable.

So that's sort of the background to this recommendation to allow some flexibility so that those who are sending can tailor it to what they believe is appropriate for those on the receiving end. And it allows the same provider discretion that's allowed for measure two. The NPRM in measure two they do allow...the NPRM does allow some discretion for saying, well you don't have to incorporate anything just incorporate things that matter most to you. Next slide, please.

So, recommendations six, allowing the exclusion for fewer than 100 transitions, referrals, you may be surprised that we're recommending this since, as I pointed out, it was, you know, this exclusion that allowed 86% of EPs in 2014 to get around having to do the measure one transition of care summary send.

The reason that we brought this back in is that we believe that this was a unique circumstance because of that adjustment of the reporting period without a commensurate change in the inclusion, exclusion threshold. So, we would certainly recommend that any changes in reporting periods going forward also appropriately adjust any inclusion or exclusion thresholds.

But we think that it's important to maintain this low level kind of exclusion because there are...you know, the cost of implementing electronic capabilities when you really have very, very few transitions or referrals is pretty high and probably outweighs the clinical and efficiency benefits to patients at the end of the day if you're having to invest, you know, more time and labor in relatively few transitions or referrals that could be better spent in actually, you know, dealing with faxes or whatever it is you deal with, but focusing more on patient care.

So, that's really, you know, sort of the argument here is to say if you're really at a low volume, you know, it may not make sense to invest in this kind of technology and we want to be able to accommodate that.

And then finally, the final point is related the exclusion for low broadband penetration. I think that this was just brought over from Stage 2 this was an exclusion for patient engagement which, you know, seems to completely make sense that, you know, in the patient engagement model you're dealing with retail commercial customers, you know, and their ability to get broadband, you know, capability in their homes, but it doesn't seem to make sense, we don't think, for measures of provider-to-provider exchange.

Providers can get business level broadband and that doesn't seem to be a barrier in most places. There certainly, you know, may be circumstances where electronic exchange is not dense enough to allow a provider to meet measure thresholds but that, you know, usually doesn't seem to be about broadband capability its more about ecosystem considerations of there aren't enough of the people who I transact with who are on CEHRT for example or who actually are connected to a Direct, you know, capability that I'm connected to and all of the issues related to that.

We did consider recommending an ecosystem solution to address such cases but at the end of the day we weren't able to come up with an approach that, you know, didn't add more complexity than it solved. Every kind of approach that we started to work our way through it just seemed like it was just making it more complex at the end of the day.

You know we do recommend that CMS monitor this issue carefully and consider such an exclusion in the future if the problem appears significant and beyond the control of EPs and EHs, but at the end of the day we ended up, you know, deciding to leave that alone.

So, let me, I know I've thrown a lot out there and this is just measure one. Let me pause and see if there are any questions or comments on it so far.

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

The issue is I think we're going to run out of time so you may want to go ahead...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Finish up.

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

And then finish, yeah.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, okay, next slide, please. So on measure two this is to receive and incorporate electronic summary of care records for 40% of incoming transitions or referrals of new patients. So, you know, obviously it's a new...this is a brand new measure, remember, you know, 40% threshold. I think that in general the Workgroup, you know, sort of actually liked this approach and it was somewhat of a clever approach to try to get a toehold into the query kind of capability that, you know, all of us want to get to but still, you know, taking account of the fact that we don't have a ubiquitous homogenous universally available query ecosystem out in the market and from what we've seen with Stage 2 just the difficulty of getting a push ecosystem out there and the challenges that still are...you know they're in the market suggest that a query ecosystem will be, you know, complex as well. This seemed like a good way of, you know, of starting to move in that direction and providing a toehold for that.

So, what it does is it gives you credit for incorporating a summary of care record and however you get that summary of care record so whether it's active meaning you asked for it or it just came to you as a part of measure one, which is someone just sending it during a transition or referral, it gives you credit for that and it allows any type of query, meaning that I can call someone and say, hey a patient, you know, I see that next week I'm going to see this patient could you please push something to me if it doesn't get pushed to you or an ED calling, you know, a primary care provider for example. It allows any type of query it doesn't have to be electronic but it does require that you get it electronically and that you incorporate it.

It allows an inclusion of patients never before encountered for whom an electronic summary of care is available. There is an exclusion for encounters where information is unavailable meaning that you requested it manually and didn't get anything or you tried through an HIE and it wasn't fulfilled or the provider has no access to an HIE with query capability.

And then there was also a question that CMS asked about whether utilization alerts, that are becoming more common in certain places, be allowed to count against this measure. So, next slide, please.

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

So, Micky, just want to give you a head's up we have about six minutes for this.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, so what I could do is just...okay, why don't I just walk through this one quickly and then I can jump to measure three.

So, on this one we are recommending lower the threshold to 25% out of a concern really that this is a brand new measure, you know, more than anything else the concern of it being a brand new measure and all of the issues that we know will be confronted with a brand new measure, you know, have people, you know, being somewhat concerned about, you know, the ability to hit 40% right out of the gate.

We believe that we ought to allow some provider discretion in what to incorporate, you remember the second point was that you have to incorporate the question is what does incorporate mean and so we, you know, there was...in the NPRM it says, you know, you basically have to incorporate almost everything. We believe that, you know, you ought to have a little bit more discretion in what you incorporate because some things really may not be relevant and you don't want to, you know, sort of keep passing on and increasing to, you know, sort of CCD bloat or record bloat just for the sake of meeting a measure.

We agree with allowing active or passive receipt meaning that I can either query it or it just came to me.

We think that you should remove the never before encountered in the measure denominator and that's the same issue of a new patient. We just think that the cost of trying to figure out how to do that both from a provider workflow as well as a technology perspective outweigh any benefit that would come to the patient where this is all going to be coming after the fact and any benefit to the provider in terms of making it easier for them to, you know, count more of their transactions in this.

We agree with allowing the exclusion for information being unavailable although we do think that it needs to be specified what would constitute my being a part of an HIE, you may recall there was something there that said something like if I'm not a part of an HIE I get an exclusion, well sometimes your sort of half in/half out because you're not fully, you know, sort of on-boarded. We think that needs to be further specified.

We don't agree with allowing utilization alerts because there is just a lot of complexity there and there is relatively little clinical information contained in the utilization alert. It alerts you to an event but it doesn't tell you anything more than that in most cases. So we don't think that this is really doing the same thing as the spirit of this measure is going forth. And by the same logic that we used in measure one we think that they should remove the exclusion for low broadband penetration.

Why don't we jump ahead now to medication reconciliation, it's a few slides in. Okay, so on this one the recommendation is to reconcile clinical information for 80% of transitions or referrals of new patients and as I said it increases the level from 50% to 80% and it also increases the scope so not to just medication but to include medication allergies and problems. It also applies to any transitions or referrals there are no exclusions allowed on this.

There is a question about whether it ought to specify automated versus manual and whether credentialed medical assistants ought to be able to perform medication reconciliation like they are with certain CPOE functions and then it asks a couple of other questions as well. Why don't we jump to the recommendation slide here.

So, the Workgroup recommends the following, setting the threshold at 80% for medication and medication allergies, so agreeing with the NPRM on those two but there was a lot of concern, this is point number two, about problems and in particular because it's new, it's something that's being introduced.

But a number of the clinicians and indeed I think it was all the clinicians on the Workgroup had just grave concerns that problems are, you know, kind of wide open territory in terms of conventions that clinicians used to document problems and there was a concern that those are, you know, still widely disparate and it would be, you know, very difficult and cumbersome to have, you know, sort of standardized conventions about how to reconcile problems when you have such variability in the landscape.

On the other hand we do agree that problems are important and we think that because it's new we ought to, you know, start people on a glide path or on a ramp to be able to accelerate it. We were concerned that because Stage 3 is the last stage that not including something on problems might make it more difficult for CMS to include problems later so we wanted to include something there with a low threshold but then that gives CMS the opportunity in, you know, Stage 3 plus to up that threshold over time.

So, the rest of it I think is relatively self-explanatory, why don't I just jump to the last one which is about HIE governance it's the last topic. This one that's still in discussion with the Workgroup but a question that was asked, if you keep going I think it's three slides more, a question that was asked by CMS is about whether there ought to be a link between a governance mechanism established by ONC and EHR incentive programs, that was really, you know, sort of the general question. Next slide, please.

And it's not there now but this was the question of whether it should be, right now, and I should say this is also one of the recommendations that is still under discussion with the Workgroup, but in general right now the Workgroup seems to be falling into, you know, sort of a consensus or majority that providers really ought to be responsible for this and they should be allowed to use any electronic means that meets federal and state privacy and security laws.

We certainly recognize that a more assertive government rule maybe required at some future date but we point to the JASON Task Force recommendations that were unanimously approved by the policy and the Standards Committee that pointed to a series of specific non-regulatory steps that the federal government could do to encourage market-based governance with, you know, sort of more direct intervention and perhaps top down governance levers being pulled but only after clear thresholds and benchmarks have been defined and those seem to not be happening at an appropriate pace based on market-based activity. I'll stop here.

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

Okay, thank you. Thank you, Micky. I'm sure for the folks that are new to this Workgroup or the Policy Committee I can appreciate and I'll just single out Micky and Deven, and Christine the presentations and the digestion assimilation are really outstanding and it shows the talent and the experience of these folks, these presenters. I'm not excluding the Subgroup leads, but it's just amazing how much can be communicated so clearly by all three and the rationale. So, really, really thank you.

Any...I'll ask it this way, any disagreement with what was presented by Micky? Charlene?

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

Paul, this is...

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

And Terry, just short comments, please, we're towards the end of time.

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

Yes, this is Charlene, Micky did you look at the relationships of the three measures and, you know, like they might opt out of doing like for instance measure three because it was too hard in favor of one and two and maybe it's more benefit to do measure three, anything like that in your thought process?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

You know we didn't. I mean, we thought that it was appropriate to have flexibility here because there are so many different things going on, you know, there's a big jump up in measure three for example in reconciliation, on the other hand measure two is genuinely new and it could be more difficult, it could be easier for people who are, you know, in a query-based kind of ecosystem versus those who aren't. So, we didn't specifically, you know, think about that except there seemed to be enough variation and enough difficulty in any one of the dimensions that it seemed appropriate to allow a little bit of flexibility there.

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

Yeah, okay, but I definitely support your recommendation on that third measure on the problems because I...just a lot, thank you.

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

All right, Terry?

Terrence (Terry) O'Malley, MD – Medical Director for Non-Acute Care Services, Partners Healthcare System – Massachusetts General Hospital

Quick question or comment on episode. I think we're moving away from episodes as the unit of care and particularly as we get to value-based payment. So, you might want to rethink using that as a reason to exclude patient generated data coming in because it really is a process now as sort of ongoing surveillance of continuous information streaming into the practice about an individual rather than just what happens face-to-face. That's my only comment.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, it's Christine, can I make a comment?

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

Yes, go ahead, Christine.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, Micky, we...it's actually a request, so the Consumer Workgroup has an objective, and I guess also to Terry's point based on what you just said, there's a measure, two measures in what they're calling patient generated health data but only one of them is actually patient generated the other is information received from what they're calling a non-clinical setting meaning like long-term care or...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so our recommendation is to take...one of our recommendations is to take that information from a non-clinical setting and move it into your objectives around HIE because it's not patient generated. So, I'm wondering if you could look at how that might impact any of your recommendations if we, you know, what we were saying was make it so you could either send or receive the summary of care and then send or receive, you know, whatever this information is which won't be a summary of care but it might impact some of your recommendations around like the threshold because obviously this is expanding the trading partner universe so you could facilitate more exchange and, you know, I just want to make sure there aren't unintended consequences, but...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

It would be great for you to look at that and give us some feedback on whether that works.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, yeah, no I'd be...yeah, we're happy to look at that. I should point out that there was this question with respect to measure one versus measure two, whether measure two should actually, this is where I receive, should actually be...whether the denominator should be limited to I guess within that crude CMS parlance would be called clinical settings, because my ability to receive something requires that the person on the other end actually have CEHRT.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, because they have to generate a C-CDA to send it to me. So, it may not be appropriate to say, well the denominator is everyone who I traded with because LTPAC providers for example very few of them are going to have CEHRT.

So, the last point is, I think that there is little confusion in that the patient self-referral stuff for objective seven doesn't include patient generated data.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So, in that case it was the weird circumstance of a patient shows up in my office and I didn't get anything from the referring provider, they leave but I'm allowed to go and ask the referring provider, hey could you send me a CCD and then they send it, I'm allowed to count that even though it's post encounter, that struck as just being, you know, sort of odd and complex and probably not adding a whole lot to patient care.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, I agree with that.

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

Okay. At the end of time, let me try to summarize here in terms of instructions for the presentation on the 12th. I have to tell you I really enjoyed, literally enjoyed listening to this discussion and the presentation because it so clearly articulated the issues and the background and rationale, so one, thank you.

Two, I think what was nice, and I'll just pick on Micky's the last presentation, how a lot of this information is so well written in the slides or let's say like Christine's letter, I wonder if what we should do is let's, for the committee, we only have two hours to present everything. If we can highlight a little bit like Micky did the agree or disagree, if we can, you know, put in bold or Caps agree and then an annotation, so, in the committee we'll just say we agree with this and for the committee to read it they'll be annotation on why you agree.

Then focus really on the disagree, recommend the following changes and then work through the annotation...and have the annotation and rationale for the changes listed on the slide for reading but also in the presentation you can focus your time more on that.

So, you know, I agree, blah, blah, blah and then say, but focus your time on the recommend changes and annotate and what's the...and then talk about why in the rationale much the way you did in the presentation here but that's where we'll spend most of our time so that the committee can focus in on the agreements.

I don't think people are going to disagree with where you agreed and Micky also took the time to do the, here's what we discussed and then we don't have a full agreement that kind of thing. So, if we could focus on that I think that's the way we...the only chance we have of really containing this within two hours that we have. Does that make sense to folks and was I sort of clear?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Paul if we can also get the materials out to the committee like this week.

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

Correct.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Or as soon as they're finalized, because I know Micky and my groups aren't totally final and Deven's probably got some revisions, but I think the key is just making sure everybody reads this ahead of time and has a...

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

Exactly right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Chance to do that otherwise there is no hope.

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

Exactly right. So, that's the tradeoff. It would be nice if people had the weekend if they're going to read but that also means that we have to get it in, you know, by the end of Friday, but really tremendous job both the assimilation and discussion, deliberations, your recommendations and the rationale. So, let's just find a way to concisely present it even though the information will be available to everybody.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay.

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

Okay, any further comments and then we'll open to public comment? Okay, open to public comment please.

Public Comment

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

Lonnie or Caitlin, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

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

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

So, we have shared that we will start to share the public comments that come in through the comment box, there are quite a few and knowing that we're already over time I think I'll just e-mail those out to the Workgroup members so that you can see them, because I don't think we'll have time to walk through them all now.

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

Okay. So, I didn't know...so there is some public...

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

There is a comment box that people can put comments into.

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

Okay.

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

And we have been just making them a part of the transcript but I think it is appropriate to start to share them as part of the public comment.

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

Okay.

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

We just don't have time today.

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

Okay.

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

But there is no one calling in for public comment today. So, we're good.

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

Okay. Well, once again it's really a joy to work with you all and thank you so much for putting in this amount of time. So, we'll tighten up our presentation materials, keep the full set available to the committee and we will see you next week. Thank you now.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Thank you, Paul.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Thank you.

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

Thank you, everyone.

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

Thanks.

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

Thanks.

Public Comment Received During the Meeting

1. We have decided as a vendor with 2014 Edition certified EHRs for the Inpatient, ED and Perioperative settings that it will not be possible to have our products updated to the MU3 certification criteria for a 2017 start date. The reduction in burden has been focused on the EP/EH/CAH, but the burden on the EHR vendors has been increased.
2. Also, add that our planned development time will be dependent on the content of the final rules and that the development period must be constrained by the needed deployment time to hundreds of hospitals. We must allow enough time for each facility to upgrade to the new release, test in their unique environments and to train their employees on the new software and workflows. All of this must be done with a need that all providers are starting a full year's reporting period on Jan. 1, 2018. This is going to be a huge task for a 2018 start date and thus a 2017 availability is not possible with the current requirements for certification.
3. Need clarification of what "credentialed" means - is this an internal institutional definition or defined by state level regulations as defined by scope and standard of practice - reconciliation requires the clinician have the ability to add, modify, or delete the content e.g., medication, allergies, and problems - this is distinctly different that reviewing the content and making notations of discrepancies for the appropriate provider to "reconcile."
4. Recommendation # 7 certifying patient facing health apps, consider making distinctions between mHealth apps, devices and sensors, many are combined for diagnosis, treatment, monitoring for self and provider-directed care.
5. There a number of industry efforts to certify patient facing health apps, for providers, researchers, pharma and for consumers. Encourage public private partnerships.
6. I may have missed this - has there been discussion about explicit requirements for 2 factor authentication?