

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
February 8, 2013**

Presentation

Operator

All lines are bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there is time for public comment on the agenda. The call is also being recorded so please make sure you identify yourselves when speaking. I'll go through roll call. Paul Tang?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak?

George Hripcsak, MD, MS – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks George. David Bates? Christine Bechtel?

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Christine. Neil Calman? Art Davidson?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Art. Marty Fattig? Leslie Kelly-Hall? David Lansky? Deven McGraw? Latanya Sweeney? Charlene Underwood?

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Charlene. Amy Zimmerman?

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

Yes.

MacKenzie Robertson – Office of the National Coordinator

Thanks Amy. Excuse me. Tim Cromwell? Joe Francis? Yael Harris? Greg Pace?

Greg Pace – Social Security Administration – Deputy CIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Greg. And Robert Tagalicod? And are there any ONC staff members on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson.

MacKenzie Robertson – Office of the National Coordinator

Hi Michelle. And Neil, are you on?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah, I'm on, but I'm going to have to jump off for a minute, because we're having an emergency weather call with my staff, and I'll be back in about ten minutes.

MacKenzie Robertson – Office of the National Coordinator

Okay. Thanks Neil. With that, I'll turn it back to you Paul.

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

Okay. Good morning everyone and thank you for joining this call. Wanted to first check who all was either present or listening in on yester – was it yester- ... the day before's call of the HIT Policy Committee? Was everyone there or who wasn't there?

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

This is Charlene; I was there.

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

I was not there.

Greg Pace – Social Security Administration – Deputy CIO

This is Greg; I was not there.

George Hripcsak, MD, MS – Columbia University

George, I was listening in.

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

Okay.

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

It's Christine; I was there.

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

Paul, I was on as well; this is Art.

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

Okay. Okay, so I'll try to summarize fairly quickly, because it was sort of an inflection point, I think, in part of our thinking. So, one of the things we – so let me just talk about the agenda for today. One, to sort of cover a little bit a summary of the feedback we received, at least the high-level feedback we received, in particular from Michelle through the RFC. And I thought we would dedicate this call to brainstorming on some new options for ... new options ... new alternative options for Meaningful Use Stage 3. It does not mean we're thinking of ditching any of the work that's been done, just saying other options to explore, as a result of some of the feedback in the sense to address some of the feedback.

As you know, we're having an add-on meeting on the 14th, so next week we have the clinical documentation hearing on the 13th. We're going to spend the first three hours of the 14th, in the morning, with the Certification & Adoption Workgroup to debrief on it and come up with recommendations for Stage 3, based on the Clinical Documentation Hearing. Then we have an add-on face-to-face for the Meaningful Use Workgroup to consider how we want to go forward and what options might we want to explore with Stage 3, based on some of the feedback we heard from the public. So in preparation for that, that's why we moved this call up a little bit early, is wanted to do a little brainstorming on, about the feedback we received and about some of the options we started to discuss at the Policy Committee meeting a couple of days ago. So at the end of this call, like to have two or three of these options that we discuss on this call fleshed out during our face-to-face and at the end of that meeting on the 14th, really target concepts to further do some due diligence and to do some drill-down into the details, to represent to the group on, and I'm going to ask if people can make it March 15th for another face-to-face. The reason for these face-to-face is because it's just a lot more quality time with each other and when we're trying to think of significant changes to the Program, at least explore the possibility of significant changes as we transition from a Stage 2 to a Stage 3. And I'll sort of explain that a little bit more in just a second.

Okay, so for this, let me just try to summarize a little bit of some of the comments or the discussion that happened at the Policy Committee and really, it's to accommodate the responses we had to the RFC, where there was just a lot of support for the concepts that we're after. There's a lot of concern about the rapidity and how much is on people's plate, whether you're a provider organization or a vendor. And so at the same time, this is the time when we had decided, even way back in Stage 1 that Stage 3 would concentrate more on outcomes and less on process. As we all know, even in HITECH, the reason that HITECH was put in to the ARRA legislation was as a preparation for health care reform. And what we wanted to do was drive the capability in EHRs so that providers would have an effective tool to implement a change really in health care delivery system and eventually the payment system. We had always from the start talked about the use of exemplars and not set out to comprehensively specify what an EHR should have, I mean that's an impossible task. So we wanted to concentrate on things that...most of the things that were not already there, that were ... yet were necessary for the new environment under health reform.

So, we always knew about the Stage 1 was getting the data in. Stage 2 is health information exchange and advanced clinical process and by Stage 3, we were intending to focus more on the outcomes you get from use of this tool than actually the actual use of the tool itself. So, it's a good time now to step back and say, well, how would we act on that intent, how would we start moving over towards recognizing people who have already implemented this tool, effectively use it and get good results. And you wouldn't want to say, oh, in addition to good results, let me prove that you did all the process steps that sort of seems a little bit of an anachronism. So, that opens the discussion of, how can we, and we've discussed some of these elements before, but, I want to try to take a step back and more seriously look at how can we sync up with our outcomes-oriented approach to Stage 3.

Let me give some examples, some of which were discussed during the Policy Committee meeting this week, and some are sort of just added on to it. We've talked about in the past deeming for performance, in other words, it's this notion of if people have already implemented, optimized their use and are getting good results, let's not have them point out the steps along the way, let's just recognize they have achieved good results. Now part of this is consistent with our assumption that you really can't be a high performer in this information intensive occupation and do so without having electronic tools, without computer-based tools. So it makes sense that if you have achieved good outcomes, then you ... and you are using a certified EHR, then we'd like to link the two. One – there's a couple of ways to measure good outcomes, one is an absolute threshold, that has a little bit of the concern about well, that looks like a pay for performance program when we're not really trying to be that. We're just trying to say, hey look, if you already established a certain level of performance, that is somewhere above average, then you must be using this tool effectively, maybe not to its optimum, but you're getting some good use out of it. Another way to look at effective use of the tool, if you are significantly improving in your outcome, what's nice is then no matter where you are at the beginning of a reporting year, if at the end of that reporting year you're significantly better. And of course you'd have to define that, then you've probably made use of the tools, both the reporting side, the feedback side, the clinical decision support, etcetera, to get to an improved state. So that's one kind of area, this is sort of deeming qualification for at least some of meaningful use based on your performance.

Another idea, and again it's something that we've talked about in the past, but this is the time we step back and we look at is clustering or consolidation of objectives. We've tried to do some of this as we move either to clinical quality measures or like what we did with VDT, sort of subsumes the work we did with electronic access to information in the earlier stages. So that kind of clustering and consolidation has the effect of, one, it sort of reduces the overall number of things you have to adhere to and prove that you complied with. And it also sort of – it can have the effect of relieving some of the prescriptive nature of an individual process measure. So, if you give patients, for example in that last example, the ability to view, download and transmit, well that certainly is guaranteeing them access ... electronic access to their information, and yet VDT is so much more powerful in terms of what they can do with that information going forward. So that's a good example of essentially consolidating some of the objectives in future stages and subsuming some of the more tedious process work in earlier stages. The reason for the process work in earlier stages was sort of the guardrails of sort of guiding a lot of folks who are just getting into this on how to get good use out of their EHR. So that's another kind of approach and these are not mutually exclusive.

A third way is, we talked about this as well, is sort of a partial deeming. So once – let's say in category 1, where we're saying you've got to have your problems, your meds, order, drug-drug interactions and saying you've got to have all that stuff. After a couple of stages, you know, many of our stages they're 60% or 80% thresholds, it's really incorporated into standard of practice and that's what we had thought, anticipated, that's what we intended. And the graph that Steve Posnack showed, or someone showed some people refer to it as the heat map and Rob Anthony talks about this as well, once you pass ... once you've implemented a certain functionality and you've incorporated into your workflow, people sort of blow past that threshold and they're much more on the high side of implementation, which is what we, as we said, what we anticipated and what we expected would happen. And it's not as if – so it's not as if they stop at 30%, say ohh, let's not do any more of that, and it's also not as if they say, ohh, we qualified for this, let's turn off vital signs, right, it just doesn't seem reasonable. So from that stand ... once they've done this process, like in Stage 1 or Stage 2, maybe we focus on the outcome measures, the CQMs of what they're achieving on the care side and spend more of our time concentrating on the things that are still hard and that still need sort of a level playing field and still need the standards worked out, etcetera, such as interoperability, or even patient engagement, population reporting and management. Those kinds of things where we know that the functionality and the use is still emerging, let's concentrate on those functions in the meaningful use objectives, and really play down or have CQM subsume the process functions in say category 1 kinds of function. So that's the third kind of way we can approach Stage 3 and beyond.

And a fourth – it's not necessarily an option, but it's a way of thinking about things, we've always tied certification criteria with meaningful use objective. They need to be linked, there's a reason to link them but we've linked them coincident on the timeline. So when we have a certification criteria, in other words, when we put functionality in the EHR, we insist that people use it instantly in a sense, which has created part of this timing problem. We have where we need lead time for the development and testing side part for the vendors, and we need lead time for the implementation and effective use of these new functionalities on the provider side and that's where you have to add them together in that sequence. What if we decouple the timeline of certification criteria from the kinds of use or the kinds of objectives we have for meaningful use of the software.

And by that I mean you could start working on the certification criteria for concept, for functions that we need at one point, let's say even on Stage 3, and yet not insist that at the same time, providers have to already implement and use that in the same year, let's say 2016 in our current Stage 3. That sort of decouples the development time and the capability from the use, and one could imagine the – one of the concerns people have is we're trying to write meaningful use objectives across the board when people don't have the same patients and the same needs across the board. Well if we use more menu functionality, that addresses that the diversity problem, the diversity issue in the types of practices and scope of practices and scope of patients, yet it still gives us the ability to specify certification criteria for EHRs. And as you know, in 2014, EHRs are much more modular, there's this concept of a basic EHR and then you then add on things that your customers need, and you don't make customers pay for things that they don't need.

So, these are just some thoughts in terms of other ways we can approach meaningful use. It does not apply to Stage 1 and Stage 2. We had in mind much more of a process or a function-oriented approach for good reason, because before meaningful use, basically only 3% of physician practices, for example, had a comprehensive EHR system. Now, a quarter of physicians already have qualified for meaningful use payment and there's obviously more that are already implementing. So, we may be at a point where we're beyond some of the process measures and we can start working more on the, what good are you doing with this inf- ... this tool. And if you are doing good, whether it's an absolute threshold or improving, then let's recognize that, that you must have been using your certified EHR in a productive way. That's sort of a long introduction, so let me open it up now for other comments, either about the discussion we had at the Committee meeting or comments about just this notion of looking at different ways ... different approaches to Stage 3 and beyond.

Marty Fattig, MHA – Nemaha County Hospital

Paul.

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

Yup.

Marty Fattig, MHA – Nemaha County Hospital

This is Marty; I just wanted to let you know I'm on the call. Thank you.

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

Yeah; thanks Marty.

George Hripcsak, MD, MS – Columbia University

Paul.

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

Yup.

George Hripcsak, MD, MS – Columbia University

This is George. This kind of echoes Neil's comments yesterday, or the other day, I'm wondering if for quality we shouldn't be focusing on certification to create infrastructure, just because so many groups are working on quality, and that what's unique to ONC and the Meaningful Use Program is health information exchange. No one else is pushing that forward really and patient engagement, and those are the two where we need doctor, proven doctor engagement in that process, whereas quality is being hit from so many sides, I think we need to work with them and support them through certification. What about that idea?

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

Let me make one comment and open it up. Yes, there's a lot of people using quality measures. One of the big concerns is that, and they all use different quality measures and so one of the calls from the field is better alignment in particular for these quality measures. A number of benefits, one, you have much better benchmarking if you use similar, the same denominator and two, you reduce the burden of actually having to do reports on all these different nuances in the definition. But interestingly enough, I think a lot of the existing quality measures, and the ones that are particularly in the existing programs, are built a lot more from the administrative databases and claims, just because of the necessity in the past. And there's been a huge cry for what's been referred to as de novo quality measures, and that's the feedback we got from the Quality Workgroup that the RFC comments on the QM stuff.

And this group, the folks worrying about HIT policy and HIT systems may have better insight into what is possible, likely and makes good use of the clinical data in EHRs. So, while I certainly appreciate – there's lots of people working on quality measures that both may be of benefit, but it's also one of the liabilities and where people I think want to go are so called eMeasures. Not just electronic measures, but measures that are designed from the bottom up, from the ground up, taking advantage of the clinical data in EHRs. And we might have more of a say in that. Other people's thoughts on that question or any of the discussion we've had.

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

Well, this is Amy, and just on the quality measurement and the CQMs, I mean, there is a lot of effort and our ONC colleagues on the phone can speak to this way better than I. There are numerous efforts at the federal level to align a whole host of quality measures and link that with the National Quality Forum. And then actually try to work with states for states to think about how to set up HIT infrastructure on a state basis to start the infrastructure to gather quality measures and use then for payment reform. So I think the alignment, while it's slated to happen over the next around five years or whatever, I mean, I think there's a lot of work being done to try to align the measures and include aligning with meaningful use. So, I'm not sure which came, which measures came first, but I think it is very relevant in a lot of people's minds that are working on the alignment part. So, I just wanted to make sure folks were aware of those multiple different efforts at the federal level.

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

I think that's right. Thanks Amy. Other comments?

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

This is Art. In listening to John Halamka talk the other day, about the comments that the Standards Committee had about meaningful use measures, it seemed like there's this functionality that we need in the charts. It may go back to what George was implying, I think, around exchange that Neil spoke about. How do the records consume external knowledge and how do they then act with that knowledge? How does that make for a different outcome because the knowledge has been shared broadly with records across the country? And this idea about eMeasures, setting up a system for the EHRs to consume that knowledge and then act with it seems to be something that we're close to, but not quite there. The same thing happens with public health in terms of case reporting. There are probably other ways that this external knowledge that we anticipate some federal agency would help distribute, like NLM or AHRQ, – I don't know which, or CDC. But there should be a way that the EHR is made smarter and helps the user to achieve quality measures or other meaningful use outcomes that it would not necessarily have achieved if we just left everything to the EHR vendors to build for each customer.

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

I'm having a little trouble following you Art. What would the suggestion be ...

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

So the suggestion is ...

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

... or what's an example of the knowledge you're referring to?

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

Well John was saying that he didn't think all this is really available yet, that the ability to con-, to go out and find an eMeasure and then apply that knowledge that's embedded in some rule that live at NLM, AHRQ, I don't know where, and then use that in the EHR, that they'll be new eMeasures over time. And for each person or provider to implement this without some structure that the EHR is capable of consuming that knowledge, it seems wasteful.

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

Okay, so I think ...

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

... easy for an EHR to find knowledge, consume it and then act on it.

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

I think you're referring to the ability to consume the knowledge, let's say, about clinical decision support.

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

Yeah, it could be clinical decision support. I think there's – there are places where the EHR has an opportunity to help people down the road. This is about this exchange, does the EHR go out and find information, bring it in, incorporate it in its workflow and then allow something to happen from that. Whether it's generating a reminder to a provider about a clinical decision support or generating a quality measure or sending a report to the local health department because that's a disease that's on a list of reportable diseases, that they consume from this knowledge base.

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

Okay, are you drilling down on one of the obje- ... I mean, I think you are ...

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

It's a function that I think applies to several objectives.

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

Yeah. So I guess we wanted to reserve working on individual objectives for when we meet face-to-face, and we may get some time today, but wanted to start, first start with the high level, should we be looking for other options besides the ... just the continuing functional objective.

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

This is Amy. Art, are you suggesting, I mean, I think it was one of the options that sort of Paul put out there, which is sort of focusing on, focusing Stage 3 on some of the areas where the interoperability or the patient engagement, like really focusing them on areas where we feel that the EHRs aren't, don't have full capacity. I mean that's kind of – what I hear you saying is sort of tying to that strategy.

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

Oh, I see. Is that Art?

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

Is that what you're trying to say Art?

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

Yes.

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

Okay. Okay, so you're saying, pick on – so in addition to interoperability and patient engagement, add this ability to share knowledge about different kinds of things. It could be clinical decision support, it could be the immunizations we talked about.

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

It could even be, I mean, I wasn't thinking about this, but so all this discussion about where all this patient data's going to live when shared with an electronic health record. How does the EHR anticipate taking in that information and storing it?

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

So Art, this is Amy again. I think – what I hear you, again, I think what I hear you saying in that is sort of this bi-directionality functionality and actually consumption of data, which certainly, I mean I don't know how far we'll get with Stage 2 on that, certainly right now it is still a huge problem.

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

Yeah, there's very little progress in this area, it's still mostly what is collected in the office and not much brought in from outside and stored inside a record. And, it's going to be this enormous pile of data sitting in a separate vault that doesn't get integrated.

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

Okay, so when you say – you use the term data, do you mean data or knowledge that you were talking about?

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

So in the first case I was talking about knowledge, when I started describing clinical decision support, eMeasures, public health reporting rules, immunization schedules, and things like that.

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

Um hmm.

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

But, as Amy started talking about it, it made me think, well maybe there's been this concern about how to bring in patient data, how does the patient get engaged and how does the patient contribute to this. So, it's not just this broad knowledge that drives clinical decision support, but it may be these bits of data or knowledge from a patient that the patient is trying to share with us.

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

Okay. So, can I go back to the higher-level approach and people's thoughts about that.

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

Paul, this is Amy again and I'll just put this out to try to get you back on track with what you're discussing and then have others pipe in, but, as I was listening to what you were saying, I think rethinking this strategy is really good. And I think ultimately, when we think about what we're trying to do with EHRs, they are tools to get us to better, safer, you know, cost-effective, whatever care. So I think an approach that focuses, one of the approaches you talked about, if I heard you correctly, was focusing more on the outcome of the clinical quality measures as a way to, as the achievement as opposed to as much of the process. And if the measures are being met, whether it's full functionality of the EHR or partial functionality of the EHR with other components in there, if we're getting the outcome we want, that's the ultimate goal ...

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

And using a certified EHR, that's the only qualifier.

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

So – yeah, yeah, using a certified EHR. So, and I'm not minimizing the role of the EHR, because I think it would be very hard to get there without that, but I think putting more of the focus out there, and to me, that's a couple of strategies combining. It may be the strategy of sort of assuming that once you put in a certain functionality and gotten to 30-40 percent, you're naturally going to get to 80 percent or 90. We currently have one physician in our community who's sort of was giving comments on Stage 3 saying, the bar is too low on all of these for the same reason, once you've hit 30 percent, you're not going to go backwards, you're going to naturally get to the 80 percent kind of mark. But instead of raising everything to that level, whether we can drop them or just refocus them on more of the outcome measures, I think is certainly worth serious discussion and thought.

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

Okay.

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

Paul, it's Christine. I was just listening to the discussion and I think there's nothing I disagree with but I think we've all articulated, probably a number of different ways to slice and dice, and think through what could stay, what could go, what gets advanced by getting simplified, things like that. And I think you were right in the beginning to say none of these are potentially mutually exclusive. But I think it might be worth crafting some kind of, I don't know if they're criteria or principles or whatever, but just sort of things to think about so that as we go through this, we can check against these multiple dimensions that people have articulated. So, for example, I'm thinking that you used the example earlier about, I think it was after visit summary and view, download, transmit, that you could potentially simplify if maybe you did a couple of things, and I agree with that. But, I think there's – what that means is something like view, download would probably need to stay and we need to discuss whether it's just a certification criteria or if there is a use criteria. And what I would suggest is that one way to think about whether or not the criteria stays just in certification, we make sure the capability is there, but whether or not it actually is something that we have as a smaller set of criteria that actually get used. That sort of list of criteria might be where we have

this other sort of punch list of things that we think about things like, well, we really think that capability is going to be widely in use. Because there are lots of new models of care that will require it, or there are standard care processes today where you really just have to do that, and they've been doing it for four years or two years or whatever, so that maybe doesn't need to be there.

But then there would be some other things where, and I think we talked about this at the Policy Committee, the kind of network effect or the social benefit of having everybody do it is so valuable that maybe there is a kind of use requirement in that way. And we can talk about the big picture, overall program structure and incentives versus penalties and how that could be an improvement, that kind of thing. But I think to have this list of the processes need to – we can assume that there are people that are going to use the stuff that they've been using, that they found useful, if I can use that word more than four times in a sentence. And we know a gap in functionality remains, so we'll preserve that, but when we think about all of the other things that we talked about, are they in new models of care or are they things that patient family engagement, I'm using the term broadly. But there's probably some, but not all of the patient family engagement criteria, that you can do a new model of care successfully, without doing those and the societal benefit, we would really want to promote, so maybe those go on the list. So that way we have sort of a multiple criteria way of looking at this based on the feedback that everybody has come up with. And the last thing I would say is, so if we – if, another option would be to have a small set of criteria plus the improvement dimension that you described earlier, that you're somehow – I don't know if you're doing a baseline and an improvement and all of that stuff, but there's some also demonstration that you're actually improving something.

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

Right. Okay, so you listed a couple of things. One is, let's assume that if they're already using it in Stages 1 and 2, they're not going to stop using it, so let's ... we don't ... it doesn't have to actually persist in Stage 3.

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

Well I think there are some things, but I don't think that's universally applicable. But the other piece that complicates it a little bit are some nuances, there are new things in Stage 2 that people will have been using for at least two years, maybe more, but not four years, and so you kind of have to think through those things. And that's why you need multiple criteria, but particularly if it's a, if it's a process, you are recording a piece of data, then that would – I think the second criteria I would say is, can you advance that process through use. So, you don't need to require it being recorded if you're actually ... if that data is contained in a more advanced use, like a care plan.

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

Right.

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

So that would be another one.

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

Okay. And CMS ONC did that with, for example, problem list, we sort of brought it back out ...

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

Right.

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

... said okay, if it's already in the summary of care document, then why do we have to have a separate objective.

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

Exactly, particularly if it's in more than one objective, because it could be in care plan and da, da, da, when we look at Stage 2, yes.

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

Right. And the other point you brought up is, if they're improving, and we go baseline to sometime in the reporting period, if they're already improving, then for this particular quality measure, some kind of outcome measure, what does it imply, what other functional objectives are subsumed by the fact that they are improving this. So I think if they're improving in a lot of their use measures on prevention, well they don't have to go back and say, well here's the prevention CDS' that I'm using, it's almost like ...

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

Exactly.

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

... effective ways of doing that. So, creating a map of...this is sort of the Kleisinger consolidation.

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

Well that I think is also an example of, it's simplification through advancement.

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

Yeah.

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

And the improvement piece we should probably figure – I mean, we should probab ... that's going to take some time because we have to think about specialists and how that all would be structured, in terms of you know, is it one thing, two thing, three ... you know, all that. The other thing I mentioned was, so if there's a societal benefit to having everybody do it or if it's something that we don't think is necessarily going to reliably or routinely be part of new care processes under new payment models. So I'm thinking of things like reducing health disparities maybe or patient reminders or like recording family health history, let's take that...that might be something where gee, it would be better if you were, if it wasn't a process objective, recording of it. But we think that if people are engaging patients and families in that process, and everybody's getting family health history and maybe there's a larger kind of network effect and societal benefit kind of thing.

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

Okay. So that – as far as that term where we, so we talked yest ... a couple of days ago about there are things that you sort of rely on individuals, whether their people or organizations ...

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

Yeah.

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

... doing the right thing; it may be in their business interest, it may – whatever reasons they do the right thing, that's the best way. The second way is to rely on, well even if you may not have your own special interest, as part of society there's a corporate citizenship that says, this is, we count on everybody as being part of the society to do the following things. And when all else fails, you have the regulation, either to address public good or things where you need everybody to do this because of network effects or nobody will make the first move because it involves some ... and everybody agrees that it's a good thing, so it's to level the playing field kind of a move.

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

Yeah, yeah.

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

So that's another principle.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

This is Neil – just to throw in a comment. You know, as we sort of do the simplification process and move forward, we really, I think we need to map all of the things that we require to make sure that they're somehow included in some new initiative that we're putting forward, so that we don't lose important things along the way.

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

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I think it's possible to just sort of lose something. And the family history thing is, you know, that's a good point, but I would say the question to ask is okay, so what is it that we're expecting to be produced that will require people do a family history so we don't have to require it. But I think we're going to have to map all these things ...

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

Yeah.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

... in a way to make sure that we're not losing valuable pieces and we don't come back and say, wow, you know what, people are doing the right things but they've, we're still not getting this very important piece that we think is needed to be part of the clinical record. The family history is so critical.

MacKenzie Robertson – Office of the National Coordinator

Hi, sorry, this is MacKenzie – can I just ask everyone not speaking to mute their phones because we're getting a lot of background noise. Thanks.

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

Okay.

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

Hi, this is Charlene. I actually wanted to do something, suggest something a little bit different, and I think it would be great to send this thing ... the Meaningful Use Workgroup. I think you mentioned this one Paul, relative to identifying area to improve, and then demonstrate improvement on it.

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

Yeah.

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

And I think moving from like, if you will, technology driven regulation to policy driven regulation is really what we're trying to do here. So in that, if we send the signal, okay, you guys, we're going to be looking in Stage 3 for reducing disparities or, you know, you can do those kind of things with your data. To reduce disparities you've got to know who's disparate, right, or whatever signal we want to send, but if we send that signal, there's a couple of things that could happen. Number one, I don't think we should prescribe all the tools that you need to be able to do that. Because what will happen is, you've got really smart people who are out there trying to do these kind of things and in doing it, they'll come back to their vendors and say, okay, I need you to do "X," "Y," and "Z," and I can't read this. So now you start to lift the burden, if you will, on the vendors in terms of just responding to certification to actually getting them to start to support their customers.

The other thing that I think, and this is what I've seen so much in Stage 1, is check the list. We now really start to get people to more broadly critical things such as care practice, all those kinds of things. So I would love to send the signal that that's what we're looking for somehow in Stage 2. I'm not sure how we're going to get there, and be much less prescriptive in the how. I think we've put a lot of tools out with Stage 1 and Stage 2 that will help them that are not even used yet. And then if we could drive toward that in Stage 2. The other piece, I do think we need to continue to focus on the interoperability piece and make sure that we continue to advance that, because I think that's a piece that – well, I don't know. Even if you say, we want to show improvement in reducing readmissions, you're going to have to have interoperability and maybe the standards will start to fall out of the private sector more, you know, because we've got to do it now.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Um hmm. But I don't see how that helps the vendors. Let's just use the issue of disparity. So, if we're not saying, you're required to look at occupation, race, gender, sexual preference, all ... whatever those things are that were all of the things that we're capturing. Let's say that that disappears. So then you have one of your clients comes back and says, you know, we really want to do this thing on disparities, but there's no place for us to capture people's information on sexual preference. And there's another person that comes back and says, you know, we really want to do this thing on disparity based upon the occupations of people that are in our community and there's no place for us to capture it. So, I mean, unless people are going to have to come back and pay for every advancement, I think we, the certification criteria have to require that the tools that people are going to need to meet the objectives we have still stay solidly in the certification criteria.

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

I think, again ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Even if they don't stay in meaningful use.

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

I think it's going to be a balance in that particular case, we need some standards for those, and then they can be adopted. I know it's a slippery slope here, but on the other side of it, if we can be saying, if we're driving it from the outcomes perspective, we're capturing the data, there's going to ha ... and the customers are going to want their meaningful use money, the vendors, if they're going to stay vendors, they're going to have to respond. You know, you want the market to drive this at some point.

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

In fact, that's the only sustainable way. So once the money dries up, really it's if we put in place the market drivers to sustain continued improvement, that's the endgame.

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

Right. And I mean, it links them to the broader quality initiatives and all those types of things, too. I mean, there's a lot of work to get from here to there, but I think sending that signal would create a lot of positive momentum.

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

And actually, as we've talked about before, the...we started off with the incentive money and we tried to put in place good functionality in the product and effective use by the provider. As the incentive money goes away, what we wanted to do was have people responding more towards the pull from either the market/payer program, such as ACO and bundled payments, etcetera. So there's certain behavior and certain tools they need in order to perform well in these new programs. It speaks back to what Amy was saying about there's a lot of federal initiatives going on, it also talks to what George was saying about there's a lot of quality measures. Ideally we'd like these lot of – these many federal programs to use a consistent and uniform set of quality measures, that are available from EHRs. So we're trying to, this is sort of the big alignment in the sky, but this is the time to sort of make that happen, to try to start pointing

people towards the new programs, the new payment programs and the tools they need to perform well in those. So this speaks to what Charlene is saying, that the new programs essentially is what the market is asking for, and if we align our functions to serve those new programs, then we're sort of handing it off to the market to create the sustainability we need.

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

Paul, it's Christine ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Can I ask just for clarification? Are – would we back off on any of the certification standards ...

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

No ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

... currently in place ...

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

I'm almost ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

... huge.

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

See, I'm almost saying no. So the reason for – so right now, certification serves meaningful use sort of on its own, which was sort of this bootstrapping for adoption of EHRs. Like to try to – it would be nice if certification could serve the future market-driven payment reform program, like ACO as an example under prototype. And so if our meaningful use objectives can be oriented towards the needs, and we always did orient this way, to health reform and again, I'll just use ACO as a prototype, not an only, then that would redirect the certification towards the longer lasting payment reform program. Does that make sense – that connecting the dots? So instead ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

It does, you're building on it.

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

Yeah.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I think my concern is while we've had discussions about backing off on the use on some of the specific requirements in meaningful use, I guess what my point is is, I don't want to back off on requiring any of the tools that we've built into the system. Those have to continue to evolve, but those tools are critical and people should need to pay for them over again or make sure that they're in every system that they buy. We have to supply the tools, so I don't want to back off on the certification requirements, even though we're backing off on how they're being used.

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

No, I think ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Does that make sense?

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

Yeah. Certification is cumulative, so no ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Right, okay.

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

... they can't sell version next minus this functional objective just because it's no longer – it's subsumed. Yeah, no, I think the certification criteria ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Okay. Great.

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

... are cumulative.

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

But can the certification criteria, this may be a question for Charlene or people with more technical knowledge. I mean, I would imagine that they could be simplified in some ways because if you're calling for more advanced functions, they're going to rely on the foundation of some of the more basic functions continuing to be there, but do you have to put that in the rule, right.

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

Yeah, right. But I do think, I think, and again like ... and again, once you're certified for that, do you have to be certified to that every time or all those kinds of things. So what's the – we've got a base, okay, check off you've got the base, right.

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

Yeah, I think the thing though that I – and I'm sorry because my phone died right as you were about probably two-thirds of the way talking Charlene ...

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

That's okay.

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

... but the thing that I do want to be cognizant of in terms of our look at certification requirements is, we do hear from people a lot of concern that the incentive dollars don't cover the full cost and that part of the reason is because they do need some customization or they need a function or feature built in. So I think what Neil was saying is right, which is where we're looking at more advanced functions that we want the entire market to be able to perform, that's the stuff you don't leave up to a solo doc office to try to get the vendor to cut some ... something.

The other thing Paul, while I am talking, can I come back to the quality measure piece. I think you're right about the conceptual need for alignment and pointing people in the right direction and etcetera, and probably advancing the functionality around that, is in some ways even more important in this program. Because I'm worried that we still don't have a great capacity to generate a quality measure that's either from relying on data from multiple settings or is longitudinal or has a component of patient-generated data, those kinds of things. And also the whole challenge of you don't want to kind of hardwire today's quality measures in ...

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

Right

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

... because they'll have to be rewired, we hope.

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

Right.

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

Things like that. And I'm sure there's work going on at ONC, but I think in terms of quality measurement, I think we have to be thoughtful about how the certification criteria relate to the policy related improvement criteria, because I think we want to really advance the field and people's ability to do more sophisticated and meaningful measurements ...

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

Yeah.

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

... but at the same time, we want to see improvement but not all the specialists have the right set of measures and not all the primary care docs are going to love the measures as they currently exist – and so I think that's going to take some pretty good brainpower.

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

Yeah. I think it's useful for us to continue to be involved in ...

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

Oh yeah.

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

... the definition of these de novo quality measures.

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

Um hmm.

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

Um hmm. Definitely and I was encouraged by the event that ONC described at the Policy Committee ...

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

Kaizen, yeah.

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

Yeah.

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

This is Amy, and one thing maybe as a sidebar presentation or something to ourselves, unless others had a better handle on this, but, and again our ONC colleagues on the phone could speak up if they want. But there is work going on around the QRDA quality reporting data architecture standards 1 and 3 and I'm still trying in my head to fully understand them and how they relate to meaningful use measures and other measures. So as we go down this, I just want to make sure that if I'm the only one that's still trying to

piece all this together in my head that's one thing, but if you haven't even heard of QRDA 1 and QRDA 3, we might need some better education of connecting on these issues, because they are related. So is anyone familiar with what I just said?

Michelle Nelson – Office of the National Coordinator

This is Michelle. So maybe it would make sense next week when we have our in person meeting to have somebody from my team talk about the Kaizen event and what they're doing and even take a step back and explain QRDA 1 and QRDA 3. We could make it part of the agenda and it probably will be helpful.

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

I think that's a good idea Michelle. Thank you.

Michelle Nelson – Office of the National Coordinator

Yup.

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

Yeah. Do ...

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

Yeah, that would be good.

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

Michelle, something – I think what I ... having listened to the Policy Committee discussion, something that is a little bit more detailed around how folks are thinking about it, at least at this point, and its relationship...like it also needs to probably connect somehow to maybe the measure authoring tool or the quality data model at NQF might be helpful tools, if we build them into certification. So I think we just need a little bit more depth than what we heard at the Policy Committee.

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

And so, because you talked about the whole supply chain having those representatives at the Kaizen, maybe the output that shows what would a streamlined, less than one year approach look like and what you're thin ... and particularly since everybody is unanimously headed towards de novo measures, what is going on in trying to develop those things, so that we can try to piggyback on that, encourage it or support it or facilitate it.

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

And how – right the meaningful use relationship specifically, because we did ask the question in the RFC about, can meaningful use have like a third innovation pathway that people could voluntarily do to try to accelerate that and what do we need to do in terms of policy or certification criteria to facilitate that. That would be very helpful.

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

Yeah.

George Hripcsak, MD, MS – Columbia University

Paul, this is George. I actually find this conversation is hard to do on the phone as opposed to in person ...

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

Yeah.

George Hripcsak, MD, MS – Columbia University

... because there's a lot of subtlety and maybe some of this conversation should occur on that Thursday. However, but I'm trying to picture what this looks like and what I'm actually hearing is, that we pretty much continue on the same path. And what we'll do is we'll look at the objectives, some will be redundant or provably covered elsewhere so we can get rid of them. I've also heard some things that people want to add, so they'll be some off and some on, and so Stage 3 will look more or less the way we envisioned Stage 3 before, as opposed to a new direction.

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

So, I would agree with you George that a lot of discussion has been in that direction. This is a good opportunity to open up the discussion to whether people do want ... think it's a good idea to have this alternative pathway. And let me just sort of lump and say, this deeming pathway. I for one am interested in that as something that emerges in Stage 3, but is not available in Stage 1 and Stage 2. And so let me just also restate, nothing we're talking about now is intended or – we don't have either the intent or the anticipation of changing Stage 1 and Stage 2. This is to look at the ... point between 1 and 2 going to Stage 3 and beyond, so we're not at all discussing a complete revamp of meaningful use, in case there's any misinterpretation. So, let me open it up for people's receptivity to having this alternate pathway, this deeming pathway. All the details remain to be defined, but is that something people are interested in discussing next week.

George Hripcsak, MD, MS – Columbia University

Well one approach would be to have the deeming, but pick, as I said earlier, there's two things, the action you want to get accomplished that you can't just deem ...

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

Yeah.

George Hripcsak, MD, MS – Columbia University

... and I was thinking that would be health information exchange and patient engagement. But other than that, do deeming for the other part.

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

Well, allow deeming. That would be two tracks ...

George Hripcsak, MD, MS – Columbia University

Yes.

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

... one is ... so I think there still can be improvements that we've been discussing in terms of consolidation and the implicit compliance, that's still a good thing, because it just reduces the overall burden and points people more in the right direction. But as an option for people who are well on their way, and as people become well on their way after going through the first two stages, then have a path where they can show what good they've been getting out of these systems and not worry so much about the individual process details.

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

Paul, it's Christine. I agree. I think we should consider – I think part of what's a challenge is the ... so we're talking about this sort of advance and simplify concept, but then we're also talking more about the structure of the program itself. And I think we have to talk about both and we have to understand the relationship between the incentives and the penalties in very real terms ...

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

Uh huh.

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

... and when they play. And I think we have to also, at the same time, be at a level of detail with understanding exactly if we did a deeming pathway also, what would that mean in terms of what you're giving up in terms of other uses, like George was saying, kind of the patient engagement stuff or the information exchange elements. And that's where the criteria that I was trying to kind of get to earlier might come into play. But I think we have to – the more the merrier in terms of the structure of the program. I think the more ideas we can consider to facilitate our thinking would be better ... there was a large discussion at the Policy Committee around how do you, what is the right point and then once you get there, what is the right way to facilitate some real innovations. And I think Neil talked about that very eloquently. So, with all if those pieces in mind, I think it better to have lots of pathways to think through and understand the pros and cons and the architecture and what's feasible from CMS and ONC's perspective, as well. And then, of course, we'll have to consider all the issues like, well, would this work for all provider types who are eligible ...

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

Right.

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

... specialists, but also hospitals, etcetera, and some of the nuts and bolts. I do think it starts with the detailed kind of mapping of what can you simplify. So we – I think I mentioned to you, are trying to do some work to help with that and happy to bring that forward, as soon as it's ready, which I would hope would be by then. But I think understanding that level of detail around, well what happens to things like advanced directives if you do a deeming pathway. What are the really important pieces that we think, umm, just saying I improved is really important, but it doesn't mean that you necessarily also did some things where there was a real important societal benefit that's not otherwise incentivized by new models or current care processes, etcetera. So I think it's probably that hybrid George was describing, is a valid pathway.

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

So let me just clarify. So when I spoke of deeming it was always partial, it's not like you are deemed ...

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

I got that.

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

... now deemed a meaningful user just because you did this, this and this. It's much more along the lines that George was talking about, deeming for certain things where it really is implicit compliance with meaningful use objectives in order to achieve this.

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

Yeah.

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

So let me, yeah, let me just put to bed, it's not an opt out of the program. So let me...actually, this may be a good point to describe a draft timeline, since Christine mentioned sort of the ... and George mentioned the brainstorming and where do we go and what needs to be done. So here's a thought, so we're talking about what things are we open to, and I think we seem to be open to a mixture of let's simplify, make less prescriptive and more meaningful the meaningful use objectives as we've always known them. And let's consider ways where people who are achieving good performance or improved performance can be deemed as passing out on some of the meaningful use objectives, not all. And clearly they would not...well, there might be ways you get deemed if you're an ACO or – well anyways, there are ways you could imagine deeming as accomplishing health information exchange, for example.

Okay, so, on the 14th, we don't have a whole lot of time, but what's nice is it's face-to-face time and we'll flesh out some of these emerging ideas. And my goal would be to have two or three ideas that we really would like to see fleshed out and have small groups of us go work on those two or three ideas to bring back to our subsequent face-to-face. And I'm proposing March 15th, because it's after the 14th Policy Committee meeting and essentially present much more fleshed out, well here are the things ... and oh, by the way, on the 14th I also have what are the ideas we want fleshed out? What are the questions we want answered? And so this small group assigned to that particular concept would bring back on the 15th, here's an outline of how we think it would work, how it might work and here are some of the potential answers to the questions, the key questions that we were posed back on April 14th. And then we basically would emerge from that having possibly even one or two, but some very small number that we really flesh out, incorporating all of the meaningful use objectives we currently have.

The target then is by April 3rd HIT Policy Committee to essentially let the rest of the Committee know what we're thinking, get their reaction. So they heard the feedback two days ago from the public, we're saying, hey, there are some valid points there, can we at the same time, move in the direction we wanted to, go towards outcome and reduce the burden and allow the flexibility in innovation. Because I think it's actually possible to do all those things. And here's what we're thinking, April 3rd. Then they give us their feedback and then for the next two or three months, we really hunker down and say, okay, here's the new, here's the, I'm just making this up, the consolidated meaningful use objectives with the hierarchy and the implied compliance. Here's the alternative pathway to be deemed in compliance with this section of meaningful use requirements, and basically flesh that all out and have answered many of the questions we've raised along the way. Then come back to the Policy Committee at the July 9th meeting and say, here's what this new program that we talked to you about and we got your feedback on. Here's what it might look like. And it may take us another one or two months, depending on the feedback, to finalize what this new approach would look like. And just again, for the record, it does not in any way disturb Stage 1 and Stage 2, and it does not tear out all the work we've done with...even what we've done so far with Stage 3, it's a way of consolidating, simplifying the many objectives and recognizing high performance or improved performance along the way. So that's sort of a work planish kind of thing, let me get your reaction to that.

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

This is Amy. Paul, is there a – do we have a hard date by which we have to finalize or that ONC has to be able to put out another final rule or an interim rule? Like are we – is that in line with if you were to work backwards?

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

Right. It's a good question and it's implicit in the work plan I described. So our existing hard date was to deliver final recommendations in the May meeting. Given the kinds of feedback and the 600 people, 600 organizations that wrote in, it seemed like it's worthwhile to take a step back and look at more options. So what I have to work out with Farzad, unless ONC knows differently, is, is there room for us to take additional time to do that. So that's why this is just a draft sort of proposal, throwing it out, here's how we would do our work if we wanted to look at these other kinds of options, and then I'd have to go back and ask Farzad if we have that additional time, can they compress something on the rule writing process, the NPRM process. So, that's contingent on permission to do that, but that's where we stand.

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

Okay, that's great. And one other thought, and I don't want to take us off track of the work plan, but as you were speaking, and again, I think the devils in the details and we can't get there yet. But one of the things I just want to put out to the group is, as we rethink these strategies with deeming or combinations, the one thing, you know I'm going to put on sort of my state hat now and thinking about overseeing the EHR Medicaid program from a state perspective and even from a Medicare perspective to the extent that there are audits, I think we just have to make sure that whatever we rethink is ... while it may give more options and choices, which I'm all for, and ease some burden on the providers, we do need to consider what it means from a management and administration process and an audit process at the state and for

whatever Medicare is doing that. Because I wouldn't want to end up with something that then becomes so unwieldy that there's no ability to manage or monitor it at the state level where you're accountable for the dollars, as are the feds. I just want to put that out there.

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

That's a really good – and I hope ONC and CMS will have some representation at our, particularly at our face-to-face meetings, but really all to give us this reality check. So, we can't redesign the system, it's just way too much administrative cost. So, this is a good point. What do other people think about sort of this staging of our work and giving us time to flesh out some of the details that we don't come out with, oh my, we didn't, we completely didn't appreciate that and it sort of tears down our whole approach.

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

Yeah Paul, it's Christine. I'm really excited about it because I think we ... this is important stuff and I think it's very responsive to public comment and we should really be thoughtful and I think it's going, it is complicated, take some time, so I think it's a great approach.

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

Thank you. Other people's reactions?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah, this is Neil. I think it's great and I think...

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

Thank you.

M

This is ... I really like the approach also.

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

Thanks. So I – it's going to be a bit of work as you can recognize, but I think it is very useful and appropriate work for us to do. I think there were a lot of ... I mean, the amount of time people spent putting in very detailed responses to each objective you'll see. And by the way, of course ONC went through all of that in the past two weeks to summarize it, but that was just a summary we got. They have, they're working out individual, they've summarized individual comments on individual objectives, so that will be extraordinarily helpful as we go through and both revise as well as consolidate some of these.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Paul.

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

Yeah.

George Hripcsak, MD, MS – Columbia University

Can you before our meeting on the 13th or 14th really compose an email, less than a page, that summarizes both the ... what you just said, both the timeline thing, which is a good way to look at it, but more important, the options and kind of where we ended up, both for the people who aren't on the call ...

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

Yeah.

George Hripcsak, MD, MS – Columbia University

... and even for the people who were on the call ...

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

It's – yeah, yeah, we agree.

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

Thank you George. Okay, yes, I'll do that. So just sort of as a bit of a level-setting, but it's by no means anything definitive. And it's just – so just start thinking about what are the questions. Christine introduced the concept principles; I may sort of summarize what I've heard so far, just to get our thinking together. But start thinking of how would we approach this, what would be the principles, what would be the test of something having good effect and what are the gotchas we need to be looking out for. Those would all be helpful, that kind of an orientation would be helpful as we go into the meeting on the 14th. And so remember, the output of the meeting on the 14th are two, at most three concepts to explore with accompanying small groups tasked to go do that work between then and the next face-to-face, which I'm proposing to be March 15th, the day after the Policy Committee meeting. And then the output of the 15th ... the March 15th meeting is really our decision on what to drill down on and how would we ... then we'd go through all of the meaningful use objectives we have so far and map that to both the consolidated sort of path and the deeming path. A lot of work, but, I think it's the right thing to do and it's very responsive and of cou- ... it's very responsive to the public, who's living with this and really is offering how do we make this program work in real life.

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

So this is Art. Do we think that the deeming path would have new meaningful use objectives that we might not have yet developed or even proposed in Stage 3?

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

No, I think it's more – no, I don't think it would be new things. Maybe I'm saying that prematurely, but I think it's how would you prove, it could be a new CQM or new concept, and of course that has to get through the pathway to get developed. But, how would you prove that you're meaningfully tracking your problems, you have structured lab and you're, you've got good results in preventive health screening, for example. Well, that means you probably have to have structured lab, it means you have to understand risks, which might include family history, and you almost surely have to have clinical decision support in the prevention area and you probably have to have report.

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

Maybe a registry – yeah, maybe a registry.

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

... so, it's so easy to put together saying, golly, that's right, you would have to have all those things. So why should we beat people over the head and say, oh, you got to make sure you document, you do all those things; they have to in order to get good results.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

In that track?

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

Yeah, in that track.

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

Yeah ...

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

But it does not necessarily mean, for example, that you had to talk to anybody else, i.e. interoperability, or that you had to engage the patient meaningfully. So yeah, we have to figure out what are the measures or

the quality measures that would almost, would implicitly mean that you are using specific functions of an EHR meaningfully.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

And one of the things might be that there needs to be multiple of these things that are in different domains ...

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

Yeah.

W

Um hmm.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

... of meaningful use. So you don't want somebody just doing a new quality measure and saying, okay, we did that...

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

No.

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

... we don't have to worry about these other things.

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

No.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

But yeah, I think this is the right track. I think this can – the thing that I don't know if you talked about, because I was on and off the call once, but, I mentioned at the other meeting is, we should incorporate a way of capturing this information and somehow creating a compendium of these things so that they become available to the larger audience of people who use electronic health records. I mean it would be a shame if people reported this stuff and it just sort of sat there in some ... as having met some criteria, but never got, never saw the light of day.

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

Yeah.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I don't know how to do that, but we should think about that.

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

Okay. The other place I thought you were going to go Neil is, and if we come up with these measures that implicitly – that have implications about what it took to get there, that would be good news to like a CMS. That's the kind of thing where I think it would be really nice if they adopted, if we had that, these measures that were so indicative of not only good care but good processes, that would be a lovely thing to build into let's say an ACO or something like that. And then that alignment would create, would reduce the burden on the providers, etcetera.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah, I got a couple of calls just over the example that I had given about the early sort of making sure that people were getting good quality care for end-stage renal disease and just a couple of comments just about how – just the cost of that savings alone if you could forestall somebody going on dialysis or having a transplant for one year even ...

W

Right.

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

Yeah.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

... across the entire country, what that would mean. So how would you take some innovation that's going on in one place and I guess first voluntarily allow it to be spread by giving people the tools if they wanted to do it, but then, what you're saying is actually building it into some ...

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

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

... some hardwired process that people with EHRs just do, because that data becomes immediately available to them.

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

Right. And then this – so this is the hand-off to the payment reform folks or you can think of it as the market, and then we aren't pushing people to use the tools, they're, we're just pushing them to get good results, which is where we want to go.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yup.

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

Good. Any other comments? The pathway is pretty clear and I will take George's advice to try to summarize where we're at going into our February 14 meeting. So put on your thinking caps for the 14th and then get ready to sort of drill down, as we prepare for the March 15 meeting. And let me check, is that ... people look pretty good on the 15th? I know it would be ...

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

Yes.

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

... a change, but at least we're all ...

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

That's a Friday, right?

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

Um ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

It is.

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

Yeah, it's a Friday this year, about a month.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

What were you recommending for the 15th, Paul? I'm sorry.

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

March 15th be a face-to-face – so March 14th is our Policy Committee meeting ...

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Oh, okay.

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

... and if we could tack an extra day on that while we're there, to really ... this is going to be the ... sort of the bake-off of the various concepts we're looking at.

M

I can't do that.

M

Yup.

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

All right. Any other comments about either this process or the new exploration?

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

So this is Art. I wasn't quite sure. You said that you thought it would likely not be any new items, new meaningful use measures for this deeming process, but earlier we had this focus on, and I think you were the one who was suggesting the ACO flow of information, which implies greater health information exchange. And I think Christine suggested a greater use of patient-generated data as opportunities to show that you really had done more than the checklist. So, do we have those currently in meaningful use objectives or sufficiently represented in our current proposed list?

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

I, I think we do. If there's anything new, it would appear on the consolidated track instead of being new for deem ... I mean, I'm just giving an off the cuff remark, I don't know that it means there will be nothing new. I was thinking the newer ...

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

Well, it's Christine ...

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

Go ahead.

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

Sorry Paul. I was just going to say that I think there – as we go through the kind of consolidation simplification piece, I think there – we started to do it and there does emerge some newer stuff, and we heard actually about it at the Policy Committee. Like the need for, at least functionally, a population health dashboard kind of feature, that if you have this, you could actually simplify a couple of things underneath it. So, I just, I don't, I think as we go through the detail, some things may emerge like that, I don't think they're going to be large in number, but I do think we should be open to them. I mean, in terms of Art, you may be asking about sort of patient quality measures that are fed by patient generated data, there's just a larger problem with their availability in the world period, let alone the ability to build them into meaningful use. But, I'm thinking more around the kind of functionality that would support higher performance or could potentially support the creation of some kind of measure like that, if you had the semi-structured survey piece or something else in there. Or device standards and so those things would, could stay in certification, essentially.

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

So I guess I would look at it Art as, I think we could have better measures, it's not necessarily de novo new things. Because for example, the clinical dashboard we already had in there, the semi-structured questionnaire we have in there; so, I think we could be more precise, they asked for clarifications and I think that it was misinterpreted. So, we could do a better job creating the objective and the ... but I don't think ... I think we should have a high threshold for introducing anything new. I don't think that's what people were asking for; but I think we have a lot of the gamut covered, but we could do a better job tightening up on it.

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

Okay. Thank you Paul.

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

So Paul, I have – this is Charlene. I have kind of a clarifying question. I know, and you may not know this, but I know that ONC launched a request for a new Accountable Care Workgroup ...

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

Yes.

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

I don't know if it's ... reporting. How would that compliment and/or overlap what we're doing because it all seems to start to talk about the same thing.

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

Yeah. Okay, so, I'm glad you brought that up. I was going to talk about it and forgot.

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

Okay.

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

Yes, there is, there are a couple of new workgroups, you already know there's a Consumer Workgroup, both on the policy side, Christine's chairing, and on the standards side. And the other new workgroup is the ACO Workgroup, for which there's a call for nominations; that closes next Friday. And that is to respond to the business needs of ACO-like models and that is to be a driver for the kinds of functionality and quality measures that we've been trying to pursue with that in mind. Now, if that were in existence already, a year ago, we would ask that group right now, what are the things, where are the biggest gaps and let's concentrate on those.

The problem is they aren't in existence yet and so they have about a year's work plan to get to the point where they're making recommendations. Hopefully there will be some interim recommendations that come out earlier, and that's – we could use that as soon as we possibly can. But as you know, we have a very tight timeline for Stage 3. So the good news is that the need is there and so we're creating a workgroup to try to explicitly address those needs and they would come up with recommendations to the Policy Committee about, from this model, what would be needed from EHRs in the quality measures. So they would provide the answers we're looking for, it's just a bit too late for our process right now. Does that help?

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

Yes.

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

To the extent we can get them up and running like really quickly, then we'll take any advice we can get from them during this few months we have for Stage 3.

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

So Paul, this is Amy. Given that the timelines are not really aligned or whatever, we'll do what we need to do and then – are they going to then feed back into that? I mean, it seems like if that workgroup is getting formed around these issues, I just would hate to see that work and then the Meaningful Use Stage 3 stuff completely not aligned.

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

Yeah. You, of course, know from within the government, there's what would be optimal and then there's just timelines, and it's not like a government timeline, it's sort of market our own version of fiscal crisis timeline. So, we are going, we're trying to get them up running as quickly as possible and we'll try to have them feed into our process as quickly as possible ...

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

I mean, I understand the realities and practicalities. It just seems like there needs to be some way to make them merge.

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

So if ...

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

I mean not merge, but ...

W

Align. Harmonize.

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

Yeah.

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

So, if we get a bit of a reprieve in terms of extra time to work on Stage 3, our recommendations, then we'll take advantage of that by trying to get this ACO group to feed into it as quickly as possible. So, let me try to summarize, at least along the principles line that Christine mentioned. Let us remind ourselves of where we were with meaningful use all along, which is that it would be designed to provide EHR and HIT functionality that would support new models of care, like team-based, outcomes oriented, population management, along the lines of ACO. That it would address national health priorities, such as the National Quality Strategy, A Million Hearts. That it would have broad applicability since MU is the floor, so broad applicability, to the extent possible, to cover various provider specialties, various patients health needs and various areas of the country. That we try not to concentrate on things that are topped out. I know we had public questions about what does that mean, and that really means that people are already doing it to a great extent, let's not, let's consider that more standard of practice and work on things that are not being done, that are yet critical. And that to the extent possible, and we do have a challenge here, that we use the call for implementation of functions where the necessary standards are already widely adopted by the time they're going to be put into use. So, we may have to do some pushing on that, since we got a lot of feedback from HIT Standards Committee, but we want – some areas we may just want defined mechanisms, ONC or Standards Committee can help accelerate the creation of adoption of standards.

From today's call, there are some other kinds of principles, and I'll try to reformulate these going into the email. One is to address the big remaining gaps, these are gaps where there may be a public good, there are network effects that require people to participate, those kinds of things and amongst those is interoperability, patient engagement, measuring and dealing with disparities. So those are still areas where we want to have an emphasis. That we want to consolidate the objectives where we can create higher-level objectives that imply they're in compliance with ... so a more granular process objective, to the extent possible, and we've come up with a number of examples in this conversation. That we want to find some way where either performance or improvement deems compliance with the implicit functionality it would take to get to that level of performance. That we want to assume that if it's already in use in Stage 1 and 2, people are going to continue; it's really counterproductive for them to stop doing something. And we need to, we may be in a position, and it may be a good place for us to help drive the electronic QMs and the eMeasures that fully leverage the EHR and could be used in other programs, like ACO.

So those are some examples of things to consider as we come up with our options on February 14th, things we want to really flesh out. Did I miss anything, or is that clear?

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

Paul, I think also we have to think, we talked about where gaps in EHR functionality persist.

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

Okay.

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

And I think that is an important one, and that may just be a certification criteria, but we have to really focus there. And then I think you mentioned sort of societal benefit network effect.

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

Right.

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

Yeah.

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

Okay. So I'll try to distill this down into an email just to sort of come in knowing what we talked about today and also for people who weren't on the call. All right, I think we're ready for public comment, MacKenzie.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Great. Operator, can you please open the lines for public comment?

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We do have a comment.

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

Okay, go ahead.

Julie Cantor-Weinberg – College of American Pathologists

Hi, this is Julie Cantor-Weinberg with the College of American Pathologists. First, I wanted to commend you on the seriousness with which you are taking the 600 plus comments, we were one of those commenters. However, we continue to be concerned that Stage 3 really doesn't recognize, as proposed, doesn't recognize the differences among specialties. While CMS has granted short-term release from pathologists, for pathologists for meaningful use penalties, they state that they still expect pathologists to meet meaningful use. And considering the pathologist practice and laboratory information systems and don't always have patient contact, but their reports are absolutely vital to the functioning of the rest of the healthcare system. There's just a complete disconnect between the meaningful use requirements, which are written from the perspective of the provider placing an order, not from the provider receiving an order like a pathologist. So we hope as you continue, that you look at some unique specialists and consider making requirements that make sense for those kinds of specialists. Thank you very much. We look forward to working with you on this.

MacKenzie Robertson – Office of the National Coordinator

Thanks. And are there any other more public comments?

Rebecca Armendariz – Altarum Institute

No further comment at this time.

MacKenzie Robertson – Office of the National Coordinator

Okay.

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

Well thanks everybody for participating in today's call. We have very important work coming up and really appreciate everybody's contribution and participation. So see you next week in Washington.

MacKenzie Robertson – Office of the National Coordinator

Thanks everybody.