

**HIT Policy Committee
Information Exchange Workgroup
Transcript
May 23, 2013**

Presentation

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

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 Information Exchange Workgroup. This is a public call and there is time for public comment built into the agenda. The call is also being recorded so please make sure you identify yourself when speaking. I'll now go through the roll call. Micky Tripathi?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Micky. Peter DeVault?

Peter DeVault, MS – EPIC Systems Corporation – Director of Interoperability

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Peter. Jeff Donnell? Jonah Frolich? Larry Garber?

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Larry. Dave Goetz?

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Dave. James Golden? David Kendrick? Charles Kennedy? Ted Kramer? Arien Malec?

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Arien. Deven McGraw? Stephanie Reel? Cris Ross?

Christopher Ross, MBA – Mayo Clinic – Chief Information Officer

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks Cris. Steven Stack?

Steven J. Stack, MD – American Medical Association

Here.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks Steven. Chris Tashjian? Jon Teichrow? Amy Zimmerman? Tim Cromwell? Jessica Kahn? And, any ONC staff members on the line?

Kory Mertz – Office of the National Coordinator

Kory Mertz.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks Kory.

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks Michelle. And with that, I'll turn the agenda back to you Micky.

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

Okay. Great. Thanks. Thanks everyone for joining. We're now shifting gears. We had – we sort of had a small diversion in the IE Workgroup work plan to respond to the CMS, ONC RFI on Health Information Exchange, which I thank the workgroup tremendously for all of the input there. It was very well received by the Policy Committee, as well as by the Standards Committee. So, I thank you again for all the thoughtfulness and attention to the pretty quick turnaround response that we put together as a workgroup.

So, now we're going to turn back to our bread and butter, which is Meaningful Use and start to think again about Stage 3. I think what we're going to cover today is, Michelle Consolazio Nelson is going to be giving us a presentation on where the Meaningful Use Workgroup is, because I think as they are sort of the lead on putting a lot of this stuff together, kind of understanding what their thoughts are in terms of the overall frame, I think will then be helpful to us to understand how generally they're thinking about it and then the specific areas where we're going to provide input.

And I think Michelle and Kory, if you can help us try to understand exactly, in terms of the working level, not only the areas specifically where they're expecting IE Workgroup input, but also at a working level from a process perspective, how we accomplish that. I think that would be tremendously helpful for us, as we think about the work plan over the next set of meetings. I know that there is a Meaningful Use sub-workgroup meeting tomorrow that they have invited the IE Workgroup to participate in, and I think that's just one part of the process. So if you wouldn't mind sort of describing that and framing that for all of us, I think that would be helpful as well.

Michelle Consolazio Nelson – Office of the National Coordinator

Micky, do you want to start with that or get to that after we go through the Meaningful Use stuff?

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

Whatever you think is appropriate Michelle, I defer to you.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. All right. So I think it makes sense to kind of walk through where the Meaningful Use Workgroup is at, and then get to some of the finer details of how the IE Workgroup can work with them.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

So I guess I'll just start and go through the deck. This is a deck that Paul Tang had presented at the Policy Committee, so some of you might have seen this before. I'm not going to walk through all the details, I'm not Paul Tang and I don't think you need me to read you some of these slides. But essentially what happened is after we got the feedback from the Stage 3 RFC, there was a lot of concern about timing, and so I think some of that, as we all know, there won't be a Stage 3 rule until 2014. But there were a lot of concerns making sure that we had experience from Stage 2 and just concerns about the amount of work that is being put on providers with all these competing priorities between ICD-10, some of these new models of care that are happening, just all these other things that are going on in the industry.

So, that being said, the Meaningful Use Workgroup decided to take a step back, look at where they currently were and make a few adjustments. So, they went down two pathways, if you will. One of them being that let's see if there's something new or innovative that we can think of that really gets us to focus more on outcome, because that was one of the resounding things that we heard from the RFC, was that Stage 3 was supposed to focus on outcome. So if you're looking at the second slide in the deck, and I'm sorry I'm not online, Stage 3 has always been about, at least proposed to be about improving outcomes. And people just didn't feel like in the RFC that we really did enough to push on that. So the Meaningful Use Workgroup wanted to say, okay, what can we do to really try and focus more on outcome.

So one of the pathways that they decided to look into is what they're calling deeming. And I'm going to flip through the deck to slide 7. So essentially the thought was, in order to deem, you would have to be performing well. And by Stage 3, the assumption is that people will be doing all of these things that we are hoping they would be doing. Stage 1 really getting structured data and starting to use this data in a way to manage their patient population. Stage 2 more about patient engagement and interoperability and then hopefully by Stage 3, people will be able to work on their performance and start to focus on outcomes. So the proposal by the Meaningful Use Workgroup is, perhaps there's a way that we can almost double-down on quality measures and identify areas that people could show that they're improving upon and instead of doing kind of checking the boxes for some of the other functional objectives.

So the proposal on slide 8 is that for eligible professionals, and this is only for those that are really showing either high performance or improved performance, that they would be able to select two quality measures related to prevention. So for high priority diseases like breast cancer and colon cancer, and then also pick two quality measures related to controlling those high priority chronic health conditions, like diabetes and heart attacks. And then for eligible hospitals, the options would be for two quality measures related to patient safety and two quality measures related to care coordination. They also suggested that there should be something related to disparities, and this was a discussion amongst the group, and it's still being refined a bit. But so the outcomes would be that if you are able to prove, for an eligible provider, that if you're performing in the top 30 percent or you've improved outcomes by 20 percent and the same percentages for eligible hospitals, then you would be able to deem for some specific functional objectives that are currently proposed for Stage 3.

So if you look at slide 11, the proposed objectives that you would be able to deem for are clinical decision support, reminders, electronic notes, test tracking, clinical summary, patient education and then reconciling problems, meds and allergies. There's still a lot of discussion about the deeming and as you can see, there are still quite a few that would still remain that providers would have to prove that they are still doing work on and achieving performance on.

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

So can I just stop you for a factual question?

Michelle Consolazio Nelson – Office of the National Coordinator

Sure.

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

You said top 30 percent of whom? Like people are attesting at different times and so you're going to have sort of a different denominator.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, that's a good question, 30th percentile, maybe we – I'm not quite sure if we've identified specific benchmarks or what that would really mean. So this is really, as you can see, high level and still needs to be refined.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry. I don't have a good answer. And so two other considerations though, that would have to be made for deeming is that we're not sure for Stage 3 if it would be a 90 day reporting period or a 1-year performance period. But assuming that it would be a 1-year performance period, that the reporting period for the deeming would only be 6 months, assuming that providers would need to have time to make sure that they are improving and are able to achieve these goals, because if not, then they're truly doubling – they could have almost a double jeopardy where they aren't improving to the percentage that they thought they were, which means then they'd have to revert back to doing all of the functional objectives and making sure that they're meeting the right thresholds for those.

The other concern is that as of right now, there aren't quite enough quality measures related to specialists. So unfortunately, unless we are able to identify additional quality measures, some of the specialists would probably have to go to the alternative, typical pathway that we are used to. They may not be able to deem. So, I know I went through that fairly quickly, and I'm not sure how well I explained it. Let me just pause before going into the next part of their work and see if there are any questions.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

So this is Larry. If I've got this right, what you're saying is that if we achieve certain outcomes that we're the best in the country or we've dramatically improved over what we've been in prior years, let's – we're going to stick with the best in the country, then we're automatically sort of assumed that we've satisfied some of the other meaningful use that normally we would have to be measuring, is that right?

Michelle Consolazio Nelson – Office of the National Coordinator

Exactly. Yes, yes.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

And so in theory, does this mean that someone wouldn't actually need to use electronic medical record, that as long as they achieve awesome outcomes and they did it with paper, that they would be okay?

Michelle Consolazio Nelson – Office of the National Coordinator

No, because what they decided is, you won't be deemed for all of the functional objectives, so there, on slide 11, there are still quite a few that remain. So through the discussions of the Meaningful Use Workgroup, they kind of decided that all of the public health measures that public health agencies aren't quite where they need to be, so they pretty much decided that most of the public health measures couldn't be deemed. And then, patient engagement and interoperability aren't quite where we want them to be as well, so most of those objectives still remain.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

So, you'd still have to use an electronic health record to be able to do all of those things.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

Just making sure.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry Larry, you're breaking up a little bit.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

No, that's good. I'm just making sure because there are also – there are patient safety issues and things like that that we – you can't measure, that paper would not achieve. So I'm –

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. And just one more note on that, if you were a high performer, you would have to be reporting – you'd have to report on clinical quality measures and the thought would be that you would need your electronic health record to report on those quality measures, to get the data out, if you're reporting on a 2014 certified system, for example.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

Okay.

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

Larry, after all these years, you're trying to go back.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

(Indiscernible). Absolutely not, I'm just trying to make sure – it's a big country and a lot of creative people out there, I'm just trying to think what we might see.

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

Absolutely.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. So that is the deeming approach that the Meaningful Use Workgroup has undertaken. And then the other work that they have done is to really try and consolidate a lot of the objectives. So what they heard from the RFC was that there were just way too many kind of check the box type things, and by the time that providers are at Stage 3, the hope is that you won't need for them to continue to prove that they're doing these check the box things, that they would have to – if you're pushing more towards outcomes, for example, that you'd have to be using things – using the system in a more meaningful way, so why do we need to still have you, for example, for demographics, why do you still need to say, yes I'm collecting them, especially because you need all that demographic information for your quality measures and what the trends have shown is that if you start to capture the data, most practices aren't going to stop. So why are we going to continue to have you check and say, yes, I'm doing this 80 percent of the time, for example.

So the consolidation work what happened is, there were 43 objectives proposed in the RFC, the Meaningful Use Workgroup has now consolidated that to 25. It doesn't mean that things completely disappeared, they were either pushed to something a little bit higher level or integrated somewhere else, or just included as certification criteria.

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

But Michelle –

Michelle Consolazio Nelson – Office of the National Coordinator

So – yup.

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

Sorry, I know some of these details are not yet figured out, so – but I'm just trying to figure out how would a deeming process work where whether I have to submit a whole bunch of the regular underlying process measures depends on the outcome of my quality improvement – so I actually have to submit that and then I only find out afterward that oh, you were supposed to be the top 30 percent, you're top 50 percent, so you need to go back.

Michelle Consolazio Nelson – Office of the National Coordinator

So that – the resolution that they currently came up with was to do this 6 month reporting period, the thought being that for the first 6 months of the year, that you probably have to do everything, but you could then check and see where you are at with your quality measures and see if you are going to be able to meet that, whatever the deeming threshold is, and then if you see that yes, I'm going to do that, then great. And then for the second part of the year you won't necessarily have to do all the check the box.

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

– said that already. But that places a very large burden on CMS to generate that benchmark data.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

And it would seem to me from a – this is Arien. It would seem to be from a hospital or a physician – well, from a physician practice you're expecting your EHR to be tracking a lot of this already, but it seems like you've already got the operational burden tracking the attestation measures. And you kind of incur that regardless – it doesn't seem like you're saving much, particularly when you have to switch it up every couple of years or every, I guess, six months of every year.

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

Right.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Unless you'd be continued to be deemed if you – I guess you'd be continued to be deemed if you're in the top 30 percent, but –

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

But it does give us another opportunity to pass. In other words, if for some reason we didn't pass on the aftercare summary –

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Yeah.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

– so – but we're tops in the country in quality measures, then you can still pass. And I think that does make sense, but I think what – I think to Micky's point, I think it's really important that before the measurement period starts, you need to have already determined what that 30 percent threshold was.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

And so the other thing about a 30 percent threshold that – my belief is the health systems that have the hardest trouble meeting meaningful use, or at least tracking these operational considerations, the health systems that are already in the top 30 percent are likely – more likely to have a much more mature electronic records capability, much more likely to have a much more mature quality measurement and monitoring policy. So I'm wondering whether we're putting together a policy that really rewards the folks that have already crossed the threshold, as opposed to putting together a policy that encourages the rest of the folks to catch up already.

Michelle Consolazio Nelson – Office of the National Coordinator

So I think I've been –

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Yeah, this is Dave Goetz. So to the extent that I guess what you're saying Arien is by making it the 30 percent, it's kind of a rolling target as opposed to a threshold that people could get to and then reduce it and flex –

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Exactly right. So the alternative approach would be, there's a threshold, either a threshold for improvement or an absolute threshold, that I could reach and then stay in deeming mode as long as I reach that and – as opposed to the top 30 percent, which you can probably already go across all the hospital systems in the country and predict which the top 30 percent would be.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Right.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

And they're again, very likely the ones that are the longest and furthest on this journey already.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Right. But if you set it as a static threshold, as opposed to a changeable one, you could then encourage the other people –

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Correct.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

– to achieve that threshold.

Steven J. Stack, MD – American Medical Association

And this is Steve. So if it's rolling, it seems to me what it does is it gives you a second way to pass, but it doesn't obviate any extra work –

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

That's right.

Steven J. Stack, MD – American Medical Association

– because you have to constantly maintain all the other measures so that you can ensure you have a chance of passing one way or the other, so it doesn't save any work for anybody.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

So I'll bring that back to the Meaningful Use Workgroup because I think that's a very good point and something that when they present it to the Policy Committee, that wasn't really thought through. I will say to your point, I mean, part of the intention was to reward good behavior, but it would be great to encourage others to do this as well. So just before moving on to the consolidation work, are there any other questions?

Steven J. Stack, MD – American Medical Association

Just one other – Steve again. So many pieces are moving in so many big ways that it gets hard to imagine where we'll be a few years down the road, but what 10 percent of Medicare patients are now in some kind of ACO or bundled payment or pilot project and it really gets kind of interesting to look down to the future, those new approaches make some of this stuff not necessarily germane or relevant. Because the systems who will go those bundled routes will hopefully have more flexibility internally to determine how they're accountable for the care and the costs, without the same level of scrutiny for the means they employ within their own delivery of the care. So I say that because this – the program and all of this great specificity and detail probably does more to encourage people to find a way to get out from underneath it and join those bundled payment approaches than it does to foster further excitement or success within the program. But I say that constructively, not pejoratively.

Lawrence Garber, MD – Reliant Medical Group – Internist/Medical Director for Informatics

And this is Larry. I still wanted to bring up one more thing just to think about with this deeming, is that also I do like the concept, but at least for the eligible professional, it does focus on just a limited number of specialties and just remember there are dermatologists and ophthalmologists out there who are going to look at this and say, I'm not given an opportunity to head on a separate path, so I don't know if you can be creative and come up with an expanded list.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, so on that note, we have been trying to work with the Quality Measures Workgroup and those at CMS to see what else could possibly be coming down the pipe related to quality measures, because as of now, there just aren't enough measures to be able to deem them for, to that point.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

I mean, that's one of the things that I've been unclear on is what timeline there is on this consolidation and rationalization of quality measures and whether it's in our lifetime or not.

Steven J. Stack, MD – American Medical Association

Well you know Dave, to that point, I think that there is – I mean, there's so much that's stuck in statute and reg, that getting to that new end state is difficult to see because it'll take a lot of work. But, I think there is some discussion and a tension, there's tension both on getting more quality measures so we can use it in programs like this, but there's a big push in some of the quality circles about a real consolidation, too. About, do we get down to a much smaller, much more distilled set of true outcomes measures –

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Right.

Steven J. Stack, MD – American Medical Association

– instead of having 300 different measures or 4 or 5 and continuing to grow that, maybe there's only 50 or 70 or 80, and that's it, because those are the things that are important, and there isn't one for every specialty and some specialties may have none. But at the end of the day we don't really care because we're trying to incentivize the highest impact things and maybe not every physician or clinician has a role in all those highest impact things. And that's fine.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Yeah. No, I kind of agree with that philosophy, I think that makes sense. So, but is this going to – help me again, do we have any sense of when any of this is going to be delivered?

Steven J. Stack, MD – American Medical Association

No. It's a one word answer.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Just thought I'd ask.

Steven J. Stack, MD – American Medical Association

There's a lot of moving pieces.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Yeah. Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay, so I'm going to move on to the consolidation work. So as I said, in the RFC there are 43 objectives they consolidated down to 25. And they used a few different approaches, and I'm sorry again, I'm not online so I'm not sure what slide they're showing. So some of the different approaches they took on slide 15 were to think about how do we advance this concept within another objective. So if there's a way to – rather than just a simple demographics objective, but if there's a way to kind of build upon that and consolidate it somewhere else, they did that. If a measure seemed somewhat duplicative, they either made it certification criteria only or consolidated it in another place. And then there were some where it seemed like by Stage 3, where Stage 1 and Stage 2 demonstrated use had really already happened, people were showing that we had good percentages for Stage 1, then people have shown that they are actually doing these things, then it was just completely removed.

So some examples of these things, on slide 16. So advancing concepts, so for example there was a proposed objective for identifying patient preference for communication. So what they did is they added it as an element that should be captured within demographics, and then they also consolidated it with patient education, so the patient education should be part of the patient's preference, patient reminders and clinical summary. So that's one example. Another example is where a concept was a bit duplicative. So there was a new objective for the public health domain about essentially clinical decision support and intervention for immunization. And so that was consolidated with the CDS objective itself, which already had something related to preventative care and immunizations in it. Another example is for structured lab results, so it will be included in the care summary as a required element, at least they're talking about that, and in view, download, transmit. And additionally there is the hospital lab objective which was proposed by the IE Workgroup which helps get the structured lab results where they need to be.

And finally, another example is the patient list and dashboards, which it was pushed to dashboards in Stage 3. This objective was completely removed, the thought being that if people are really starting to focus on outcomes in Stage 3, they'll be using population management tools and other tools to enable them to better manage their patient populations, and they won't need to be required to conduct a patient list, check the box type item. Another example of demonstrated use was CPOE. So the thought was that by Stage 3 people have already shown good performance in Stage 1 and by Stage 3, that it should be pushed a little bit further beyond just order entry.

And on slide 20 is a quick glance, and I know it's a bit hard to see, but the blue items that became certification only and got consolidated to other places, and it's indicated where they went on that slide. And then on slide 21 we tried to show again what happened to things and what remains. So it's kind of hard to show, but we wanted to at least have some visual for people to look at. So all of the green items remain and all of the blue are certification only. So again, I know went through that fairly quickly, but are there any questions? Okay, so hearing none, the current work of the Meaningful Use Workgroup.

So they first went through and came up with this deeming pathway and took the work to really consolidate some of these other objectives. They are now meeting at the subgroup level, so there are four different subgroups. The first is Quality, Safety and Reducing Health Disparities. Subgroup 2 is Patient and Family Engagement, subgroup 3 is care coordination and subgroup 4 is Population and Public Health. So they are all meeting to reconcile the comments that they received from the RFC, adjusting objectives where appropriate and making sure that the decisions that were made related to consolidation still make sense, based upon public comment.

So, for example, they had originally consolidated patient family history, but based upon public comment, they decided to pull that back out. So that's just one example. So as Micky had mentioned earlier, the subgroup 2, which is Care Coordination, has asked the IE Workgroup to join those calls. Arienne Malec and Larry Garber were on the last call and they helped – I think they helped the group a great deal. Larry especially brought forth a lot of information and so they will continue their work tomorrow, specifically related to the care summary and care plan, which were two objectives which were fairly controversial from the RFC.

They are working to present their recommendations to the Health IT Policy Committee by an August timeframe, and that is because Paul will be on vacation in July. The IE Workgroup has been asked to present their recommendations by July. And just keeping the different topics in mind that the Meaningful Use Workgroup has come up with, if the initial objective that the IE Workgroup had come up with for the RFC, if it seems like they could be consolidated somewhere else, or if there's a way to pushing them further towards outcomes, those are things that should be kept in mind when we shift toward looking at those. One more comment I will make is that when these two concepts were presented at the Policy Committee, Farzad just suggested that we be bolder. So, if you have ideas or ways to be bolder, we certainly would welcome those. The thought behind the Meaningful Use Workgroup is they're going to finish reconciling all the comments, have an updated list of objectives and then go back to the deeming approach and see what they could possibly do to be a bit bolder.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

So my – this is Arien. My concept for being bolder would be to be a little more radical in deeming and require only the attestation of purchase and use of an electronic EHR if the organization participates in, for example, a Medicare Quality Improvement program, like an ACO, so an MSSP, a Pioneer, bundled payment project, etcetera. Essentially put most of the quality improvement eggs in the value-based payment basket and most of the EHR eggs in the certification basket. Same thing would apply for a PCMH Pilot, and potentially allow for a quality of program deeming between a commercial program, so for example a pediatric practice that isn't likely to participate in a Medicare Quality Improvement Program may well participate in a commercial or a Medicaid Quality Improvement Program. If you wanted to be super-radical, you'd basically say, the path for quality improvement is value-based, the path for EHR adoption is certification or an attestation-based and you're going to sort of double-down on the value-based payment arm of the program.

Steven J. Stack, MD – American Medical Association

So this is Steve. I like that because I think ultimately that's what we're trying to achieve.

Michelle Consolazio Nelson – Office of the National Coordinator

Thanks Arien. Do others have other ideas or suggestions or comments? Okay, hearing none, I am going to turn it over to Kory, who can talk through next steps for the IE Workgroup.

Kory Mertz – Office of the National Coordinator

Great, thanks Michelle. So the IE Workgroup has two more calls, so we have today and then two more calls before the July HIT Policy Committee meeting, can we actually go forward to the timeline slide. I'm not sure what slide number that is, but if we can go to the timeline one, that would be great. So, and we've got – so, for the IE Workgroup in particular, our focus is going to be on those three objectives that the IE Workgroup put forward for the RFC, so IE101, IE102 and 103. So that's – 101 was the Query Response, 102 was the Provider Directory and then 103 was on the Portability. So those are tasked up to the IE Workgroup to work through the process and develop – respond to the comments and develop any revisions. Or, as Michelle mentioned, I think we should be thinking about – the group should be thinking about if there are ways to consolidate some of these into the existing IE Workgroup ones, or if there are spaces they would fit in the broader framework, I think that's part of the conversation that would probably be good to have. So, that's kind of where we are and we've had some of these initial conversations around each of the objectives back before the RFI. So I think we've had some groundwork, but I know we're kind of jumping back into this, so, one of the things that, I don't know if it'll be helpful to run through the comments again, just as a refresher for everybody, before we jump into the individual areas. But, I think at least the proposal on the table is to circle back and start with the Query Response item as the first item up for discussion, because I know that was the one that had the most meat and I think the one that was going to require the most time.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle. Just on that note, Deven did send an email just before this call that indicated that the Privacy & Security Tiger Team has done some work related to query, so it might be helpful to have Deven or somebody on that group talk through what they've done, to see if there's a way to align efforts there – sorry.

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

Yeah, this is – sorry. I guess the other, the one general question I have is that when we created these RFC points, so 101, 102, 103, it was kind of done – it was done a long time ago and pretty much in isolation. Now we're – now we've got a mode where the Meaningful Use Workgroup, as we just discussed, sort of has an overall framework and approach for how we move forward and I'm just wondering if it still makes sense to consider these three in isolation, in the way that sort of the timeline has it laid out. Or is there a different way of thinking about how these things get incorporated in some of the stuff the Meaningful Use Workgroup is doing and have it be a little bit more relevant to the specific sort of framework they have and some of the deliverables that they have.

Kory Mertz – Office of the National Coordinator

Yeah, I mean, if you want to take an approach like that, and that makes more sense, I think you can totally do that. I think it's – probably what you'll have to think about with that is how you hit the various pieces. So do you have that conversation first and then focus on the comments, so I think it's just that workflow piece of how you want to do that. But I think that makes sense.

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

It just seems like we've got a lot of interdependency. I mean it's hard for me, just off the top of my head, and would love other workgroup members here just thinking in isolation about query response outside of the care coordination work that's already going on. I mean, so this workgroup, it just seems like there could just be a lot of disconnects there. But I would hate for those to be exposed at the Policy Committee itself.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

So Micky, are you proposing something specific or –

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

I don't have anything specific; I was just raising a general concern.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Sure.

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

Now I will apologize, I haven't had time to sort of look in detail at where the Meaningful Use Workgroup is and how we might think about doing that, so perhaps –

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

I haven't either.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Is there material about that that we could be – we could receive so we could kind of contemplate that, because I frankly, yeah, would have no way – don't know where to look exactly.

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

Yeah, I don't – is it – Michelle, is it just in digging or spending time on our own looking through the material you sent, or there is the workgroup meeting tomorrow. I don't know how many people from this workgroup are going to be able to attend that. That was a very specific ask from the Meaningful Use Workgroup that the IE Workgroup members participate as much as possible in their Care Coordination Subgroup, that call is tomorrow from 9 to 11.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, thank you Micky. I mean I would say that the closest alignment in Meaningful Use to the work that this group is doing is in that Care Coordination domain. So, definitely joining that conversation would be helpful to the Meaningful Use Workgroup members.

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

Just a logistics detail, are we on the distribution list for that, so I – for whatever materials they have as background. I mean, I hate to just jump into that cold and I wasn't able to join the last one.

Michelle Consolazio Nelson – Office of the National Coordinator

I believe that you are, but I will follow up with Caitlin to make sure.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

They haven't been distributed yet.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

I haven't seen it, but it could have passed by me. Would it come under the same rubric as ONC FACA meetings like our other stuff does?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, but the materials haven't been distributed yet, Charlene's still working on them.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Okay. All right.

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

Well actually I'm looking, I see that I did get the subgroup materials for the last call, which was on May 7, so, for everyone on this call, if you just looked under the ONC's FACA meetings under May7, you should have gotten an email from – that is MU Subgroup #3, it says meeting materials.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Yeah, there it is.

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

It's essentially that there are some interdependencies here that may be we just need to think a little bit more about before we set the specific agenda for the next two meetings. And the interdependencies that come to mind are with the Meaningful Use Workgroup, and in particular with this subgroup, as well as with the Privacy & Security Tiger Team.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Seems reasonable.

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

So –

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

So you've given us homework to do –

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

Yeah, I was just going to say – we can – if we try to do that offline, we won't have to impose another call on everyone.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions

Right.

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

When is our next call Kory?

Kory Mertz – Office of the National Coordinator

Um.

Michelle Consolazio Nelson – Office of the National Coordinator

The 6th I think, June 6.

Kory Mertz – Office of the National Coordinator

Yeah.

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

Okay. So that is – that's two weeks from today. Okay. So, if that's reasonable, maybe if as many of us as possible, I will certainly join the call tomorrow, the Meaningful Use Subgroup call, and I can get with Deven and see about the coordination with the Tiger Team. And then perhaps via email, we can next week perhaps targeting a week from today, get workgroup members thoughts on how we should think about the work plan for the next two meetings – for the next two formal calls that we have. And how we want to tackle the issues that we see in front of us, given those interdependencies, and that'll set us up for the July recommendations, if that makes sense.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Yeah.

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

Okay. In terms of – Kory, in terms of what we're expected to report on at that July meeting, what is that? Is that just sort of the first pass, high level thoughts?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah. The goal is to have your high-level recommendations for what you think should be in Stage 3. We're hoping to have final recommendations by September.

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

Okay. So we'll have a July, and is there an August meeting scheduled right now?

Michelle Consolazio Nelson – Office of the National Coordinator

There is an August meeting scheduled, I believe that because we've changed things around, I believe that agenda is extremely full, which is why a lot of things have gotten moved to July.

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

Okay. So, also, does that mean that they are not going to be doing all the work in August on Stage 3 recommendations?

Michelle Consolazio Nelson – Office of the National Coordinator

I – MacKenzie, you can help me out here, but I believe the August meeting – I know the Meaningful Use Workgroup is presenting their recommendations in August.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Sorry, this is MacKenzie. Yeah, the MU is presenting in August, I think the Privacy & Security Tiger Team is planning their RFC comments in June, during the virtual meeting.

Michelle Consolazio Nelson – Office of the National Coordinator

And then I believe its Quality Measures and IE Workgroup in July, correct?

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

I believe so. I have Quality Measures down for July, yeah. I don't have IE on my sheet yet.

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

Okay. Is there, is there – do we sort of have an obligation to respond to the RFC comments, I'm just thinking about what you just said about the Privacy & Security Tiger Team.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

There isn't a formal obligation to create recommendations. I mean, I don't think the Quality Measures Workgroup is specifically replying to each of the RFC comments.

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

Okay.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

They presented back to the workgroup and I know they're making recommendations, but I don't think it's necessarily specifically based on the RFC, like all the comments they received. So there's no obligation to actually have a specific recommendation related to them.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

I will say, the Quality Measures Workgroup took a different approach. They just asked questions, they didn't put forth any recommendations though. But I think Micky, based upon what you're – what I'm hearing is, it might make sense to look at in the next meeting related topics that the Meaningful Use Workgroup is doing in Care Coordination. What the Privacy and Security Workgroup is doing and then take a look at the original recommendations from the IE Workgroup. And say, are these really needed now, have they kind of been consolidated in the work the other groups are doing and see where they stand and see if there's anything new that will be need to be put somewhere else.

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

Yeah. And I guess what I'm proposing is if we can try to do what you just said actually offline in the next week, so that we can focus the calls on the content questions that we want to address. I mean, I don't want to have another call on process, I'd like to have the next couple of calls on actual content and providing real content to the Meaningful Use Workgroup, to make sure that our views are incorporated in what they're doing. Does that make sense?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

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

Okay. Great, so I think then it sounds like our task ahead is for us to do some behind the scenes work and get some homework out to the workgroup members, for all of you to be able to provide some input on what areas do we think that within the Meaningful Use framework. Do we – how do we think that it makes sense for us to fit in specifically with the things that we're concerned about, into that framework, as well as taking into account the Privacy & Security Tiger Team recommendations that have already gone forth and been approved by the Policy Committee related to targeted and untargeted query. And I guess we'll have to take as a – and the things that sort of the 3-lenses that we have into that right now, that doesn't – we're not limited to those are the query response, provider directory and data portability, because those were things that we specifically said something about for the RFC. There is a swamp, I know.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Is somebody going to write this up, because –

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

Yeah, yeah. We'll do that.

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Good, thank you. I was at a panic moment where I was, do I understand this well enough to go respond to it, and the internal answer was no.

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

Exactly. No, I was going to say, and Arien's going to present all this back on our call –

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Awesome. Good. Oh, I can make stuff up with the best of them, so –

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

Right. Okay, so yeah, we will write this up, I'll work with Kory and Michelle offline and try to put this together into something coherent and get it out to all of you, so that you know what your task ahead is. Sound good?

Arien Malec – RelayHealth Corporation – Vice President, Strategy & Product Marketing

Check.

M

Sounds good.

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

Okay, great. Are there any other general questions, thoughts, before we turn it over to public comment? Doesn't sound like it. Okay, I think – MacKenzie, I think we're ready for the public comment.

Public Comment

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

All right, 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 have no comment at this time.

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

Darn, I was hoping someone from the public was going to clarify all this for us. Okay, great. Well, thanks again everyone and we'll be in touch via email.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks everybody.