

**HIT Policy Committee
Certification/Adoption Workgroup
Transcript
April 2, 2014**

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Certification and Adoption Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also as a reminder, if you aren't speaking, if you could please mute your line, it would be appreciated as we go through the discussion. I'll now take roll. Larry Wolf?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Here.

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

Good morning, Larry. Marc Probst?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Here.

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

Hi, Marc.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Good morning.

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

Carl Dvorak?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Here.

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

Hi, Carl. Diane Bedecarre? Donald Rucker?

Diane Bedecarre, RN-BC, MS – Workforce Development Co-Lead, Health Informatics Initiative – Veterans Health Administration

Diane Bedecarre is here.

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

Good morning, Diane. Elizabeth Chapman? Liz Johnson? George Hripcsak?

Elizabeth Chapman, MS – Program Analyst – Veterans Health Administration

Elizabeth Chapman is here, I'm sorry, that was – I wasn't fast enough on my mute.

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

Hi Elizabeth.

Elizabeth Chapman, MS – Program Analyst – Veterans Health Administration

Thanks.

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

Jennie Harvell?

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

Here.

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

Hi, Jennie. Joan Ash?

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

I'm here.

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

Hi, Joan. John Derr?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Here.

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

Hi, John. Joe Heyman? Maureen Boyle? Micky Tripathi? Mike Lardieri?

Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health

Here.

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

Hi, Mike. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Hi, Paul. Paul Tang? Stan Huff? And from ONC do we have Kate Black?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

I'm here.

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

Hi, Kate. And Mike Lipinski?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Good morning.

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

Good morning and Liz Palena-Hall?

Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology

Here.

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

Good morning, Liz. Are there any other ONC staff members on the line? Kim Wilson as well. I'm here.

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Yes, Kim's here.

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

And Paul Tang's here.

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

Hi, Paul. And with that, I'll turn it back to you Marc and Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So good morning and welcome everybody. A few opening comments about the context that we're in right here. Over the next three months, we're going to be reviewing – taking on two things, review of the 2015 edition NPRM and providing updated recommendations on long-term post-acute care and behavioral health certification. The timing of this is that, and let's see if I have this right, at the beginning of May, we'll be reporting back to the Policy Committee on the 2015 edition NPRM, so we basically have the month of April to do that. We'll also be giving them our formal recommendations on the privacy and security certification criteria and transitions of care certification criteria as applies to long-term post-acute care and behavioral health. So, looking to give them sort of incremental updates on our recommendations.

During May, in case you thought April was going to be the end, during May we're going to have a listening session on long-term post-acute care and behavioral health looking specifically for provider input and developer input on the effort to implement some of the capabilities we've been discussing, as well as the efforts to develop software to meet certification criteria. We'll also be getting feedback during May from the Quality Measures Workgroup and the Privacy & Security Tiger Team, both of whom we asked to give us further input on their areas of certification. Beginning of June, we'll be giving a package of recommendations to Policy Committee and then final updates at the July meeting of the Health IT Policy Committee.

So, that's sort of the overview of the big picture for the next three months and we also specifically looking at the 2015 edition NPRM, we're going to be looking at things that are in it that are part of the proposals for specific criteria for 2015. We'll be looking at Request for Comment about things that might be in the 2017 edition plus some areas of comment on the overall rulemaking and the Certification Program. So, a very busy few months in front of us, and that includes two meetings next week, so, thanks everybody who's made the call today, a reminder on April 7 we have a meeting at 2 in the afternoon Eastern and then again on April 9 at 3 in the afternoon Eastern. And those are intended to pull together the nuts and bolts of our thoughts on the NPRM and then we'll have a meeting at the end of April to finalize what we're going to be bringing forward to the Policy Committee at the beginning of May. So that's the broad scope of what we're looking at, any questions or comments. Marc, anything you want to add to that.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

No, I just look forward to today's discussion and that Paul might remember back several years ago when certification was a really hot topic, it's kind of fun to circle back around to it and see the things we've learned and some of the changes that need –

Paul Egerman – Businessman/Software Entrepreneur

Yes, I do remember the good old days.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Yeah, those were the good old days, huh Paul.

Paul Egerman – Businessman/Software Entrepreneur

But you are right, it is a hot topic again and it was a hot topic before because it's a really critically important component of the entire process and we've learned a lot since then.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

So, it'll be good. I appreciate it and thanks, Larry, for leading us.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, well we've got some specific report backs from some of the workgroup members and I think with that we're ready for the next slide. So, we had a subgroup working on this, Jennie, do you want to talk about that?

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

Okay. Thanks, Larry. So this sub-workgroup I guess, was asked to look at – our volunteers, to look at two parts of the 2015 NPRM and actually Larry, I'm not sure – I don't think this sub-workgroup looked at the complete EHR –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Oh, I'm sorry –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

By the way, Don Rucker, I'm on, I had a lot of – I had to dial in three times, for whatever reason, but I'm on and ready to present on this topic, so –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Jennie, my apologies for –

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

No problem.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– misspeaking about who was – what we were looking at. Go ahead, Don.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

Yeah, sorry about the tech delays here. So as I understand this, this is basically, as people can see, taking out the complete EHR category, which was in the 2011, 2014 criteria. There are basically a couple of reasons why I think this was proposed, and they seem pretty reasonable. I think reasons that's in part one is that the complete EHR now is actually sort of a bigger set of requirements than what is required for certification, so it's just more than is "necessary." Then I think there was confusion between the combinations of the various individual Meaningful Use requirements on top of the base versus the complete, which is trying to be eliminated.

The third item was that some stakeholders actually need additional things in order to meet their clinical quality measure documentation. So, calling it complete is not actually because of these additional CQMs, is not technically correct and would lead obviously to some confusion. The next point that was sort of made in the Federal Register was the attempt to, which I don't know how much – how many of these actually exist, but apparently the statement was made in the Federal Register that there are a bunch of vendors or some vendors who are only certifying under complete and not under modular. And so there was a goal to discourage this for the reasons above. There's additional feelings that especially as the 2017 criteria come out that the gap in disparity between the complete EHR and the rest of the certification is going to get larger. And then the final one that's listed here is the "regulatory simplification," I guess that one maybe is a little tongue in cheek, given it's a pretty long proposed rule.

But those were I think the reasons in the Federal Register for doing it and seems pretty reasonable to me. I think if we can take out one area that people have to sort of understand and just have them basically looking at individual measures that they need to comply, as well as some base communication. That seems to me to be a bit more realistic – especially as we’re going now beyond physicians and hospitals out to long-term care and SNF and mental health and other settings. So that in a nutshell, I think, is the report on this slide or this topic.

Paul Egerman – Businessman/Software Entrepreneur

And so you also have some alternatives written here.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

Yeah. So the alternatives are basically to keep a complete definition. I think, what is sort of maybe missing in the alternative is how that would then address whether – how that would address the points above. You see the comment below, change complete to EHR to sort of have more of a blanket label. It was also in the display copy of the rule in the Federal Register, some comment on complete as it relates to numerator counting of quality measures versus the full reporting of quality measures. I was a little confused about that, but doesn’t seem to be central to the discussion, but that was sort of tied in under this label of complete EHR as well.

Paul Egerman – Businessman/Software Entrepreneur

And so Don, one question I don’t understand in looking at this slide, it says discontinue complete EHR for the 2015 edition. Does that also discontinue it for like Stage 3, which I guess is the 2017 edition?

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Yes.

Paul Egerman – Businessman/Software Entrepreneur

So it discontinues it going forward, it’s not unique to –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

It would be permanent – yes, it would be – exactly, and it would be permanently stopping it.

Paul Egerman – Businessman/Software Entrepreneur

And you – you also said there were some vendors who only get complete EHR certification don’t do modules. I’m under the impression that doing the modules individually is more labor consuming, that doing it all at once is easier. I don’t know if Carl’s on the phone and a vendor can comment, but it doesn’t getting rid of the complete makes it harder for some vendors to certify.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

No, I don’t think it made it any – I think it might have actually simplified things a little bit.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Complete did.

Paul Egerman – Businessman/Software Entrepreneur

Okay.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

No, is that what you’re saying, Carl?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

What’s that Marc?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Is that complete is easier than modular or –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

That was my sense; I neglected to ask that question. But one thing I was curious about, by the way, is there anyone from ONC with data on those who attested?

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Right.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

What did they actually attest with? Did a fair number of people have to attest with a complete plus a couple of modules or – do we have the breakout of those who attested, what did they actually attest with regard to being complete versus modular, etcetera? Here's what the data shows.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So this is Mike Lipinski with ONC. I don't actually have the data in front of me, but I mean we do have the data as to which vendors were used for attestation and I do want to say that, for the most part, it was complete. But that – you have to recall that that was two – that was Stage 1 using 2011 edition, which complete lined up with the cert definition, so that's going to be the case in those instances. So, because you needed to have everything for either the ambulatory or inpatient setting, in terms of meeting the cert definition. So, for Stage 1 you're going to see that pretty much in almost all cases it would be complete.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

(Indiscernible)

Paul Egerman – Businessman/Software Entrepreneur

If I understand Carl correctly, is that bullet on the first bullet, where it says complies with Executive Order requiring reduced regulatory burden, getting rid of the complete concept actually increases the certification burden for most of the large vendors or most of the vendors.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Can you expand on how that would be the case? Because you can get an EHR module up to – I mean, these are just regulatory terms, and they don't require you to develop a product in a certain way. So for instance, you can get an EHR module, based on the way the definition of the EHR module is in the regulation; it could meet all the capabilities for the ambulatory setting minus one, or could meet all of them except not meet the other requirements of the complete EHR definition related to CQM. So I'm trying to understand how that impacts your development of your product.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

So, Don Rucker again. I agree with the last comment, I think that having spent a lot of time in the vendor space, typically the problem for the vendors is there are a limited set of features that just sort of really go against some grain of how the product was originally conceptualized and developed that need to be added on. It's typically, I think, the rub in many cases for sort of pre-existing products certainly, which I believe is largely the case in terms of market share. So it's not having – I don't think there's a lot of difference in terms of work effort between modular and complete, because it's the specific features that's the sticking point so having complete, I don't believe really materially simplifies the economics of it for a vendor.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Let me throw –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

So, just having one pathway I suspect probably is better for most vendors.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I think –

Joseph M. Heyman, MD – Whittier IPA

This is Joe; can I just ask a question? It seems to me that when you have a complete versus a modular, when a vendor needs to apply for a complete, there's one set of paperwork and one –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah.

Joseph M. Heyman, MD – Whittier IPA

– charge. When a vendor needs to apply for modular, they have to do it over and over again for each module –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah.

Joseph M. Heyman, MD – Whittier IPA

– and I wonder about the charges, I'll bet you that they're more –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I was going to say –

Joseph M. Heyman, MD – Whittier IPA

– for the same EMR.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I was going to comment on that, Joe that is the point I think that we should consider. And it's not just the doing of the certification, I think it'll – whether or not it's a greater burden will come down to the overlap of features in each module and from what we were seeing before, you could definitely see overlap of features in modules. So there's the first certification pass, which has historically been charged per certification you want to get. And I don't know all the details on it, but I remember it's fairly expensive and it's fairly time consuming to get ready and sit for certification, plus you pay the fees and the listing fees.

And I guess one question I would have is if in the new world, post-complete, we had modules that had significant overlap, one of the challenges is that as a vendor, you sit in judgment of a certifier who asks for everything you touch in your system. And then they make a judgment on their own whether or not they should make you sit again for certification, which again requires the time and the fees you pay to the certifier. So we've – we have to also remember that we've created certifiers who can, at their discretion, charge a vendor to recertify based on something they read in a correction note or a release note or in some other enhancement that's been made that they deem might be relevant to something that was previously certified. So I do think we'd have to be thoughtful with these modular certifications if that became the new norm, how much crossover and how much extra certification time and expense might be required.

Paul Eggerman – Businessman/Software Entrepreneur

That's a –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Mike again with –

Paul Eggerman – Businessman/Software Entrepreneur

I had thought there was one other problem, too, which is if you do it one module at a time; you might have to get certified for security on each module separately as opposed to getting certified for security on your complete system.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So this is Mike again with ONC. I just want to try to clarify how the certification works. So privacy and security currently is not tested to each module, that's how we did it with the 2011 edition, but we changed that certification requirement for the 2014 edition. It's now part of the base EHR definition, which simply means that a provider, to meet the definition, does have to have those privacy and security capabilities and it's really up to them to implement them across their healthcare environment appropriately. So that's currently how privacy and security works. I do want to point out that there is a Request for Comment on whether we should change our approach to privacy and security again for certification. So that's the one thing I want to say about privacy and security.

The other thing I want to try to get us out of this box of complete versus EHR module in terms of how a product is developed and brought forward for certification. A developer will always retain the discretion in how they bring their product forward. So what we are trying to do as – and I'm just saying what's in the rule is that the complete EHR was a misnomer, it wasn't complete for most purposes or it had more than was necessary for a provider to meet the definition. For instance, if you were doing Stage 1 versus in the future, Stage 3, Stage 1 and Stage 2 providers can all exist at once. A complete EHR would pretty much have to have everything the way our definition works now, to meet Stage 3 requirements. But obviously, somebody doing Stage 1 wouldn't need all those requirements.

Now that's kind of the rationale, and you've gone over the rationale why we're proposing to do away with complete, but I want to emphasize it doesn't change how – what the developer brings forward for certification as an EHR module. You could again, have all the capabilities that you want in an EHR module that could be in some respects similar to whatever you brought forward as a complete EHR for certification to a complete EHR. So it's not really changing how – in any way how you would design your product or bring it forward for certification, what it's doing is making comparisons more easier for a provider in terms of seeing okay, everything's an EHR module. But what does your EHR module have in it versus this person's EHR module, instead of getting caught up in this oh is it a complete EHR because that doesn't really rule the day anymore with the way the CEHRT definition is and the way we define a complete EHR in the regulation. So I hope that's –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I think –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul. I didn't quite understand your last comment.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

Paul Egerman – Businessman/Software Entrepreneur

So how does a purchaser know that they're buying everything they need to get to do Meaningful Use Stage 3?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, so the CHPL lists what a product has been certified to, so you would check the CHPL to see what that product has been certified to and a vendor, as part of certification, is supposed to list in any marketing materials, what criteria it's – the product was certified to. So those would be two ways in which you would be able to compare products, in terms of what capabilities those products include.

Paul Egerman – Businessman/Software Entrepreneur

Wouldn't it be easier in the marketplace for there to be some sort of complete or total EHR certification so the purchaser says, yup, this has everything according to what the rules are and you don't have to go through every single thing? Because there will be a lot of modules, right, there will be like 30, 40, 50 modules you have to go through to make sure it's all right.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, but I mean I think that's – our proposal was based on the feedback in terms of your – if you were to do that, there's no way you could do it for every particular provider's situation because you'd have – you have different specialists that have different requirements, particularly related to the CQMs. You have different stages of Meaningful Use out at the same time, and that's why we changed our CEHRT definition, otherwise we wouldn't even change our CEHRT definition and then the CEHRT definition would have been, you need everything for the ambulatory or inpatient setting and thus here's a product that's been certified to all that. And based on our 2014 edition rule and the feedback we got, people wanted more flexibility so, I mean it does put more onus on a provider to ensure that they have what they need, that's clearly the other side of the coin. But the flexibility was what ruled the day in terms of the feedback we got from stakeholders on the 2014 edition and why we changed the definition.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

I think the challenge here is that there are sort of three levels of things we've been talking about. One is the vast sea of sort of CQMs and individual line item requirements, which don't really change and which unfortunately providers have to get deep into the details of – in order to be certified no matter whether you call it modular or complete. So that's sort of the underlying work product and that's both for providers and also obviously for software developers. Then there's this sort of middle layer of how do we name it and then there's the third layer of how do we do the testing of it and how do we do appeals of let's say irregularities in testing and the cost of testing.

So I think there are almost three separate things. This discussion is really about sort of almost a middle level of a naming convention, but really has to take into account that the complexity underneath that providers and software vendors have to deal with doesn't change whether you call it complete or modular.

Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health

Yeah, and this is Mike Lardieri. Agree with what's being said, but I think it's diff – it's going to be difficult on the provider side, and I know from the providers that we represent, for them to figure it out. They don't have IT people, for the most part, folks who know this stuff, so I think as we go forward, even if we do modular, we need to identify I think what Paul was saying, that you select these modules and you're going to meet the criteria. And they need to know which ones they need to meet if they're going to meet Meaningful – if they're a Meaningful Use provider. And in my mind I think that the quality measures, that may be the piece that sets it apart because I'm – because it seems to me that except for quality measures, everybody if they're going to be a Meaningful Use provider needs to be able to do everything else. So, I don't know how you – what's different except the quality measures. I mean they do get the quality measures, well that's going to be different by specialty and then they need to know which quality measures that particular EHR can do, and see if it meets their specialty. But I think you need to be clear.

Paul Egerman – Businessman/Software Entrepreneur

I think what you just said was very helpful and it also might be a path to the solution, so maybe what to do –

Joseph M. Heyman, MD – Whittier IPA

But, this is Joe –

Paul Egerman – Businessman/Software Entrepreneur

– like a column A and a column B, but you have a concept of something that's called a complete EHR for Stage 3, which has everything you need to be able to qualify under Stage 3, except for the quality measures piece. And then on the quality measures piece, then you have to pick from a menu of things in order to do the quality measures.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Right.

Paul Egerman – Businessman/Software Entrepreneur

But that would still be from a provider's standpoint or a purchaser's standpoint, simplification –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Yeah, I think they'd –

Paul Egerman – Businessman/Software Entrepreneur

– of the process.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

I think they'd be able to say, okay, I need these quality measures and I can use these and that fits my practice, but all the rest of the stuff, I don't think we want to have them trying to figure it out.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, so –

M

I think –

Paul Egerman – Businessman/Software Entrepreneur

– but put all the rest of the stuff in one package then, one naming thing, call it a mandatory Stage 3 certification requirements and it's one package.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

It's worth understanding as a provider you have a lot of requirements you have to meet underneath here like did I do percentage of med lists, have I reached out to patients, have I implemented decision support. So there's a ton of complexity underneath here that the top-level labeling does not provide, I think, clarity for if you're going to actually meet the requirement. So I think the things that I'm hearing really go more to all of the other components in this rule and the prior two rules rather than the top-level labeling of it as complete or not. Because that doesn't ultimately – that doesn't – the simplification of the title does not in any way help simplify the underlying process that people need to get at. And if you only have one way, it probably provides some clarity – the modularity actually probably provides in a perverse kind of way, some clarity to the complexity of the underlying process and the number of components and the number of features in there in the moving parts. I think there's also a lot of concern among specialists that med reconciliation and things, there are a lot of pieces under here that the label complete I think may obscure –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Yeah, I could see that. This is Mike Lardieri again. I can see that, so I could see having all the modules listed, but somehow color code them or something so all the ones in green, you have to have these clustered to be in Meaningful Use for sure. The one that's in blue, you have to look at that to determine whether the quality measures are the ones that are important to your practice. Something like that so you still have the capability for, I don't know, because we're talking about other providers who might not be Meaningful Use eligible, they're going to still need some modules and this way it might be clear to everyone just what they need to get for what they want to use it for.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I wonder – this is Carl. I wonder if our problem isn't complete certification or not complete certification. Because I do think that, there will be significant confusion among providers in that complete certification at least signaled that that it was likely to be a product that was built to work together in concert. Versus if you just color code what one might need for Meaningful Use, there's no guarantee that those actually are designed in relationship to each other in any way, shape or form.

I wonder though if the real problem is that the quality measures got off track early and seem to have stayed off track. And I wonder if what we should be thinking about is a different way to describe and document compliance with quality measure capabilities as different from certified EHR technology. And just think of the clinical quality measures as its own area, given that it seems to be done by different people at different times and not on the same schedule as certification requirements.

Joseph M. Heyman, MD – Whittier IPA

This is Joe, I'm still not –

Paul Egerman – Businessman/Software Entrepreneur

This is Paul; I think that's an excellent suggestion. I'm sorry, go ahead Joe.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

Well, that was in the SGR Bill that the "complete Bill" was I think a regulatory requirement that the quality measure landscape that Carl's described, be cleaned up. But that's a very slow moving work in progress.

Joseph M. Heyman, MD – Whittier IPA

So this is Joe, I'm still concerned about the cost because representing the little guy doctor out there, who's still in solo practice or in a small practice, that cost is going to be borne by them. And if this is going to increase the cost of an EMR, without giving anything better to them, I just don't see it as a good solution. So unless the processes that an EMR vendor can just apply for all of the modules in the same way they used to apply for the complete EMR or EHR; it doesn't – it just seems to me like it's going to become much more expensive and so maybe somebody could reassure me.

Paul Egerman – Businessman/Software Entrepreneur

Well, let me ask you a question, Joe. This is Paul. My guess is, but tell me if this is right, is that a solo physician would be more likely to do what I would call one-stop shopping, just go to one vendor and say give me everything, as opposed to going to three or four vendors and putting the thing together like Lego blocks. Is that correct?

Joseph M. Heyman, MD – Whittier IPA

Absolutely.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Unless –

Paul Egerman – Businessman/Software Entrepreneur

Would you –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

– I think unless as certification progresses – this is Carl – they might be approached by people trying to sell them a piece that is certified for a new need or a new quality measure or new feature. But they'll have to be really careful to make sure that that piece is actually designed to work with pieces they might already have that might be certified modular under an upgrade plan. There may be confusion in the market about the notion that these modules are somehow designed to work together when they may, in fact, be just designed with two completely different paradigms.

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, this is Mike with ONC. I just wanted to follow up on where I think you guys are headed in one respect and also mention – I don't – not really correct a statement, but provide a clarification of something I think Carl said. So if you bring something forward for certification I want to be clear that the certification bodies and testing bodies do not test or certify for integration of components, they test for each capability. So presumably, a one-vendor product will work well together, but they don't test for that or certify for that. So I just want to make that point clear.

Two, so if you were – I think you guys were coalescing around possibly a recommendation for complete by stages. I think the one potential drawback to that is CMS has changed requirements for Stage 1 just in this last rule, so you would then have some potential confusion as to what is complete now for that stage. So that's just one other thing I wanted to mention in terms of policy interacting with your potential recommendation.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul. I didn't understand that last comment. I thought that –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

On Stage 1...CMS changed Stage 1 with like for instance, CPOE in terms of – so, that would probably have an impact on what necessarily constitutes a complete EHR for Stage 1.

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And that could happen and if they were to change stages in the future, that could have multiple impacts. You could have changes of Stage 2 and Stage 1 again; so just something to keep in mind with this potential concept of complete by stages.

Paul Egerman – Businessman/Software Entrepreneur

I'm still confused. When CMS makes a change, aren't they just changing what you have to do for Meaningful Use, they're not really changing the certification criteria, are they?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I think the – if I remember correctly, it did require a change for the being able to calculate the numerator and denominator for CPOE. I'd have to go back and look at that again, but – because I think they changed the measure there, they gave you another option as how to calculate it. So I think that changed the – there were two different denominators then.

Paul Egerman – Businessman/Software Entrepreneur

Well –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So it did change what you would need in terms of being able to capture the correct numerator –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

We'll have to be careful – by the way, this is Carl. One thing we observed is that it is often the case the denominators are calculated in one module, but the numerator is derived from a different module. So I think we'll have – we'll just have to be careful as this hits the ground with certifiers. I think it's going to be more complex than people realize.

Paul Egerman – Businessman/Software Entrepreneur

But it seems to me –

M

So –

Paul Egerman – Businessman/Software Entrepreneur

– I understand that comment, it seems to me though that there's some view, I don't know if there's consensus, that we ought to have some definition of like a complete EHR technology that – so like what you need to do Stage 3 and that we look at the quality measures as a separate issue that has to be addressed. So carve that issue out and have either a separate discussion or something separate will go on with that, but it – except for the CQMs, the idea is that would simplify the purchasing and arguably simplify the certification. There is some argument about that, but some people think that it could make it easier to certify.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

The quality measures are really what all the payment schemes are now increasingly based on, right –

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

– I mean the upticks and down ticks on CQMs are basically the way that all the sort of policy on payment is going. For folks who have the document open, just to get a sense of the underlying complexity, Table 3 on page 10 – 15 of the Federal Register or page 129 of the display document. This can sort of – some of the pieces underneath here that we're sort of dealing with. I don't know if it drives us one way or the other in this discussion, but as clinicians, it's sort of what you're looking at.

Paul Egerman – Businessman/Software Entrepreneur

Well yeah, and what I was hoping that the direction we might go to based on Carl's comments is at some point, either this workgroup or some other workgroup, re-examine that because you should be able to do the quality measure reports based on the data that you already have. It seems odd that producing the reports creates such a cascading series of issues for the rest of the system.

Joseph M. Heyman, MD – Whittier IPA

Without extra clicks.

Paul Egerman – Businessman/Software Entrepreneur

Yeah –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Well, I mean there's almost equal complexity in the CQM world as there is in the Meaningful Use world. When you think about vocabularies and workflows and cost of obtaining the data, obviously the hope is that EMRs would make that simpler or –

Paul Egerman – Businessman/Software Entrepreneur

But –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Mike again from ONC. So if I understand correctly, this complete by stages, you are willing then, absent the CQM issue, you'd be willing to have a product again where it would meet all the menu I guess – support all the menu criteria for a stage and so even if a provider wouldn't be doing some of those menu measures, you feel that them having a product for – that has capabilities they may not use, that's okay in terms of balancing that against the clarity that it would provide to the market? Is that correct?

Joseph M. Heyman, MD – Whittier IPA

It's like Microsoft Word, not everybody uses everything in it, but they like to know they purchased something that can do whatever they need it to do.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, I mean yeah, I just wanted to make sure that's where you as a group are coming down, that that's an okay policy position.

Paul Egerman – Businessman/Software Entrepreneur

Yeah –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

And this –

Larry Wolf – Health IT Strategist – Kindred Healthcare

This is Larry, I want to jump in with a counter thing that no one's mentioned that we've heard a lot of around the importance of modular and some of the problems that providers were having because they had components in place that they were very happy with. But that their vendors had not certified as modular, so they had to buy more from that vendor in order to be able to meet the criteria.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

And this is Mike Lardieri, I would just like to jump in and say, I think the concept of identifying that this is complete and meets everything you need is okay. But I think we have to sort of merge that with listing all the modules, because then you can actually allow both those Meaningful Use providers and the non-Meaningful Use providers, who do need to select modules. But somehow group them together so it's clear that all these modules are included in the complete and from this vendor, these modules you could also select on your own as a module and it meets the criteria and you could cover both sides of the coin, so to speak.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and that makes sense, Mike, I mean like doing this complete definition, that doesn't prevent vendors from also selling modules. In other words –

Larry Wolf – Health IT Strategist – Kindred Healthcare

No, but we've seen examples of vendors only certifying as complete.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and I can understand why –

Larry Wolf – Health IT Strategist – Kindred Healthcare

And that requires – I understand why as well, but that then requires that if a customer wants 80% of their functionality from vendor "A," they've got to pay for 100%.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Right.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, but that's sort of like something that happens in the modular place, it's sort of like – it's like the comment that Joe Heyman made where, if I go to buy a laptop, it might come with Word and Access and PowerPoint and I might not want PowerPoint, but I want Word and Access. I might not get that choice buying it and it just comes as a package. And if I work hard at it, I suppose I could find somebody who will get – exactly what I want, but I probably will end up spending the same amount of money. And so it's –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well now, you're –

Paul Egerman – Businessman/Software Entrepreneur

(Indiscernible)

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think your example is right on, Paul. A lot of people who use Access but not the other elements of Microsoft Office could buy – pay a lot more for that one piece.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and so it's – like there because it's like almost a convenient – it's easier for the vendor to figure out, well this meets a higher percentage from the market requirement and I only have to ship one thing out. And also the argument that I think the gentleman from ONC made about well gee sometimes providers will end buying things that they don't need, an individual provider will. But you also have to consider in there, related to Joe Heyman's concept of a solo practice, you look at the concept of somebody like Intermountain Healthcare where you have potentially thousands of providers. Well basically they pretty much end up purchasing everything anyway since there's going to be almost – at least one provider somewhere who's going to need something – those features because they end up with almost every specialty.

So, I just think keeping the complete thing works, it doesn't stop you from doing the modules. You might need to tweak the description or the definition of it and also tweak the wording instead of – if complete has some confusion associated with it, you can call it Stage 3 mandatory or something. But I think that's the direction we are heading on this one.

Joseph M. Heyman, MD – Whittier IPA

But – this is Joe. Could I just ask one more time, with a vendor that has a complete EMR, will that vendor, because they now have to ask for modular certification, will it become more expensive for that vendor? And therefore will essentially become more expensive for the user.

Paul Egerman – Businessman/Software Entrepreneur

What we're saying in this proposal is it's sort of like the status quo, they can keep doing complete if they want, you don't have to do the modular.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

The vendor cost is sort of a function of the pricing that ONC puts on testing, which is not even at the level of a proposed rule, but can be implemented by ONC in whatever way they would like. The true cost for the vendor is building the software underneath, which I think in most cases is vastly larger than the sort of cost of sort of certification, per se.

Joseph M. Heyman, MD – Whittier IPA

Yeah, but they're building that anyway, they're building that anyway. So my concern is that the regular –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Well maybe or maybe not.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

There's an extra cost, there's an extra cost to continuously submit every change you make to the application – this is Carl – and we do this. To a certifier at whose discretion can call upon the vendor to recertify at an expense. I think we should be very careful that if this modular approach ends up with a lot of duplication of features by module, a vendor who makes a subtle change to something that a certifier believes they should recertify at a fee, they may have to recertify four modules that touch that functionality versus a prior world where they might have just recertified once under a complete notion. So I do think that's worthy of a little bit of investigation and discovery.

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

This is Paul. I wonder if I can take sort of a step back and – it's been a long conversation and a very informative, but I'm a little nervous of where we're going. If I step back and say, and this is sort of the Joe Heyman approach, which is valid is, from the point of view of a purchaser – from a provider, trying to look for one of these things. What you're really looking for is, I'm going to use a phrase, but you'll see, is complete functionality that is integrated for a specialty, by stage and reports quality measures. In a sense that's what the purchaser wants to get out of it and the struggle has been to be able to give them that information.

And so the question to us is, is it possible to, with less burden to the vendor, provide an administrative way to assemble the options to a potential purchaser that meets that test; complete functionality that is integrated for specialty, by stage and reports quality measures. I think the hardest part of that is the integration, this is something that Carl mentioned, because you could get a whole bunch of modules and they cover – fill the – but they don't actually work together; that's the “complete functionality” part that's integrated. I'm not sure we're – I'm struggling to see whether we're achieving any kind of roadmap to getting to that place for the purchaser.

Paul Eggerman – Businessman/Software Entrepreneur

Well Paul, you're raising a good question, but it's not quite the question we're addressing. The question we're addressing is very narrow is, should we eliminate this concept of complete EHR.

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

Well, I –

Paul Eggerman – Businessman/Software Entrepreneur

And we're sort of saying, eliminating that is like a step backwards and we're saying –

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

Well I'm just –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Paul's formulation I think is just perfectly right on to my mind. I think it – that is what we're really trying to provide people and maybe there are other ways of doing it or –

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

Right.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

– some version of this way. But that's really as a provider, that's sort of what you want. And I guess one thing that bothered me a little bit that maybe Mike from ONC can answer is, there is a comment in the Federal Register that the complete is actually not fully complete and can't do some things that are required, which would sort of go to our conversation. Do we know how big that gap is on what's sort of “labeled complete but is incomplete?”

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well right now I mean the two that stand out are obviously the CQM and then the other one is cancer registries. So if you are a provider needed to report to cancer registries, to meet the complete EHR definition, you don't have to do – have that capability, because it's an optional capability in our regulation. So those are the two that – two big ones that jump out to me right now. But that could – I mean the more optional criteria that we adopt, the more that would expand, in terms of being a potential disconnect for a provider.

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

So this is Paul Tang again. Let me try to answer Paul Egerman's question about well, that's not the question we're addressing. I think it is in the sense of according to the slide and what ONC is saying is the term – the phrase complete EHR has neither been complete nor served its function for anybody, the vendor, the user, the provider. And if we go back to the problem we're trying to solve, can we find ways to solve it other than having a certification of this thing that's hard to define. Okay, so what I meant by the true value to the user is having all the sets of functions that serve them, that's the "by specialty" part.

But importantly, and what we are trying to, I think a surrogate for this concept was "integrated" and that's – so can we figure out how to provide information about the integrated way these modules work together. The one was this definition of complete EHR, but it had all these limitations that we discussed. Is there another way, perhaps could voluntarily attest that this – the module I'm submitting in conjunction with these options modules work together as an integrated package. Because I think it's going to be really hard to design a test or certification process to "guarantee integration," but a vendor could attest to that as one – and then I guess there would be the market that has to enforce that. But I – so I guess first the question of is complete EHR useful to retain, I think not because it's not meeting the test of "complete functionality that's integrated for a specialty."

Paul Egerman – Businessman/Software Entrepreneur

Well, again Paul, we just had a discussion where we all came to the agreement that it's important to retain and you cannot, the way I understand the NPRM process is, we cannot add anything new to it, we can't come up with a new idea. And so attesting to integration is a new idea and also the concept of attesting within a certification approach is not a good concept, in my opinion. But I do think having a complete EHR and buying it from a single vendor gives you a much greater opportunity to have a system that's integrated, because after all, it's sort of like implicit if you're buying from one vendor, all their stuff is supposed to work together and you can write that into the contract. So, I think that the conclusion we came to is still the right one, that we need to have this concept of complete. And if we just have lots and lots of modules, then you're going to be in worse shape as it relates to integration.

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

Well, let me just – so the Microsoft analogy was, I think, a useful one. So there are let's say five modules in that suite and all of them are – there's a spreadsheet and it works like a spreadsheet, and the purchaser decides, do I want to invest in this suite from this one vendor, but they really are modules. They're offered as a suite and the purchaser decides to take them.

Paul Egerman – Businessman/Software Entrepreneur

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And they may or may not work together, either. There's this misnomer that because it's from a single vendor things work together. There is a long –

Paul Egerman – Businessman/Software Entrepreneur

That is correct.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– we have a long history of vendors who've acquired product that takes decades until they work together.

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

And that's the – that's why this term integration really is a powerful one, but it's hard to test for.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

This is Mike – oops –

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

Go ahead.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

No, no, go ahead. I'm sorry.

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

I mean, so we didn't certify the Microsoft Suite, but the market decided whether it was useful and tested whether it was "integrated." Sorry, thanks.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Yeah, this is Mike Lardieri. So maybe there needs to be an extra piece on the CHPL that says, from this specific vendor, this complete thing only sold as complete. And then you don't – because I'm a provider, I'm going in to look, I'm looking at the CHPL, I didn't get a consultant or anything. I'm going in to figure out, what am I going to buy? I see all the modules and I don't know what is, but if I know that this on – this company, this EHR only sells this as complete, then I know, okay, I don't need the complete, I'm not even going to look at that vendor, I'm going to go to the next one. So maybe that's an extra clarification that could just happen in the CHPL and then we might be able to cover both sides.

Joseph M. Heyman, MD – Whittier IPA

And this is Joe –

Larry Wolf – Health IT Strategist – Kindred Healthcare

I guess I'm still hung up on complete.

Joseph M. Heyman, MD – Whittier IPA

I just want to point out one other thing about the Microsoft model and that is, that each of those modules, the Word, the Excel and the PowerPoint, each one of them is very powerful and each one of them has way more than most users need, and yet they buy it. So you can either look at it as the whole suite or you could take any one of those particular modules and understand that it alone might be something that could be a model for whether you buy a complete one or you buy a modular one that only does some part of Microsoft Word.

Paul Eggerman – Businessman/Software Entrepreneur

Right and the analogy, Joe, is still – my comment is, the purchaser has a choice, they can buy the complete suite or they can try to buy things bare bones and add the things that they want now and then add other things later, and it's really up to the purchaser. I think most purchasers choose to buy the suite because it's simple and also because they don't want to take the time to figure out what they really need, and they also don't really know what their future needs might be. And so it's – it generally turns out to be to cheaper to do it that way and I think that's sort of what you have with people buying the complete EHR it's sort of like cheaper to do that, it's one-stop shopping. The organizations that are more likely to modules are the larger organizations.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And having sat for certification – this is Carl, the certifiers actually made us run through scripts on what was theoretically the body of software being certified. You could argue that it might have been some acquired pieces, some home-built pieces or not, but you had to actually run through a fairly comprehensive set of scripts on a piece of software that you were going to mark as a certified piece of software on the CHPL. And it's a body of software for which you had to disclose your testing, I mean your usability testing on and it's a body of software that's the unit of measure that the certifier wanted update streams to, from which they would decide whether you had to recertify for that body of software.

So although I agree that ONC didn't assert a measure of how well integrated or how not well integrated it might have been. I think there – I think if we went back and looked at what got certified as complete, there was probably some utility in the provider in knowing that whatever they certified and they're trying to sell me survived the test scripts that NIST and ONC and the certifiers put them through. So I wouldn't dismiss the entire value of that, because I do believe there's value there.

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

Carl, this is Paul Tang. So you're saying the test script for a complete EHR did, somehow, exercise the integration aspect, and is that what you're saying?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

It was simply that you had to assert what you were certifying and that that became a bundle that you had to offer and you had to document there were two or three other things that were done through attestations that you had to submit. I forget exactly what they all were, but you had to attest to certain things and then that became your unit of measure and your unit of failure reporting and all that sort of thing. So I think that those criteria, although maybe ONC would assert they weren't designed to validate integration, I think to some extent they forced vendors to either push pieces together and bind them so that they could survive certification. I think there was utility there, I guess, and the scripts did actually walk through these swaths of doing things, all the way from just basic data entry functions through some of the quality measurement in the early days. I was on the Microsoft Office website, you can buy Word or Excel or PowerPoint, you can buy lots of different combinations, and that's okay, but you can still tell that they're built to work together.

Paul Egerman – Businessman/Software Entrepreneur

Right, and you can also buy Word from another vendor, there's somebody who sells like Open Word and there's other spreadsheet software you can buy and you can – I mean, all that stuff exists, you don't have to buy Access, there's other database software.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Mike from ONC, so in the interest of time, since we're an hour in and this has been a very robust discussion and I think worthwhile, do we have any – can we maybe recap for if there's consensus in terms of what you want to put forward as your comments? And in that regard, I did want to make clear that ON – any comments can be submitted on a rule, we get comments that aren't even relevant, but that's – we make a determination of if they're relevant or not. So just want to be clear, you should feel free to make any comments that you think are, in your opinion, worth making. Whether or not we could act on them in this rulemaking or potentially in another rulemaking, I don't think you need to worry about that. I think anything that you think's a good recommendation in terms of improving our regulatory scheme, you should make that recommendation.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I would recommend again here that we bring the data forward as to what those who attested actually attested on.

M

That's right.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Again, I mean that's going to be – I mean what we have right now, Carl, is just 2011 edition. So, like I said, and as we say in the rule, the complete EHR lined up with the CEHRT definition, because the CEHRT definition said, you had to have everything. So that's – I mean, it's probably going to line up with all complete EHRs, is going to be my guess. And what we've said in the rule is that we continue to see certain vendors only getting complete EHR certification, yet we've adopted a new, more flexible definition, which says, you don't need all this, you need just what you, specific provider, need.

So I mean I've heard the discussion by you, you think that that may be too complicated for providers and if that's the case, you should – if that's the consensus; you should put that forward as your comments. But I just want to be clear as to what has changed and while the data would probably support complete EHR, because it's supporting a different definition, there's a new definition for 2014 and that's the more flexibility.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Well the – and I'm okay with that, I think the assertion that a complete certification was problematic in the past was made. So maybe we're foregoing that and not asserting that a complete certification was problematic for providers in the past any longer, in which case it's irrelevant, you're right.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

This is Jennie and just to be clear, at least there were a handful of long-term post-acute care vendors that sought certification for their products, and at least in my review of – I'm not an expert at looking at the CHPL, but it seemed as if they were somewhat selective on the components that their products were certified on.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, I mean that's a helpful comment Jennie, but we're talking about the complete definition, we're talking about in the context of Stage 3, is really the way I'm thinking about it and sort of the concept that I have is that we can continue to do modules – with modules. But there needs to also be some definition of complete, maybe we need to tweak the wording so it says "almost" complete or "nearly" complete or "minimum mandatory except CQM," but it – we somehow describe it so a purchaser – to simplify it for the purchaser. So the purchaser can understand that they're getting everything they need from on source and that that is – becomes a reasonable option.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And I –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

– this is Mike Lardieri, how many variations are there because I know CQM stands out, but are there like two or three other modules that certain types of providers don't use and will still allow them to be Meaningful Use eligible? And maybe it's just a matter of how you display it, along with the definition, Paul, but then just how you display it. Like you say, those that are identified in this way, you may not need, if you're a certain specialty.

Paul Egerman – Businessman/Software Entrepreneur

And that's a good comment and I'm comfortable with that comment, the best way I could describe comfortable with the comment is it sort of like simplifies the purchasing. In other words, if it's sort of like instead of just you get one choice, complete. If it's like complete and that's like in one column of what you've got to choose and then you've got to choose like two or three other or four other things, based on your specialty or something. But then, it should be like that as opposed to trying to figure out color-coded modules and there are like 30 or 40 that you have to get, that just strikes me as an odd way to do things.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

And I do – this is Carl again. I would still suggest we look at clinical quality measures. This puzzle I think in part was initiated when clinical quality measures were allowed to run at an independent schedule. So we were left with the puzzle of if you got complete, you really weren't certain because quality measures were coming late and you'd have to independently certify them. I still think an independent track for certification of quality measures from the EHR core functionality might still be valid, but we'd have to be sure that quality measures didn't add new requirements in the core, or if it did, that certifying it as the quality measure alone would suffice, and not uncertify you as a complete.

But I do worry that we're – and I have to apologize, I'm hopelessly logical as a programmer, but when we put the reasons forward for why we're doing this, if we later say, well those reasons aren't really the reasons why or the data doesn't support those reasons, I kind of fixate on that. And one of the reasons on the slide is it complies with an Executive Order requiring reduced regulatory burdens. And I will go back to Joe's point, this has the potential to increase regulatory burden, at least on the vendor, and I worry that it would also likely increase it on the provider, who might be confused and presume that because ONC says they're modular, that they're somehow built to work together when they might not be. So I can – I'll stop with that.

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

This is Paul Tang again. Is there a way, when I look at the CHPL, it has these check offs and presumably these checks mean what they got certified against. So, still going back to Joe's – it's hard for a doc to look at a list by product and look at check lists versus is there a matrix, and I understand that this would be difficult to arrange, but is there a matrix by specialty that could give a better view, rather than a per product view of the certification. And then to this whole integration, Carl alluded to the fact that there are some side benefits of the test scripts that actually do, implicitly indicate integration. Could we be more explicit on some of the integration scripts?

So one, can we get a by specialty view of the CHPL, instead of a byproduct view? And two, can we add some kind of integration surrogates, integration test scripts in a sense, and then you do get to claim level 1 through level 7, whatever it is, I just made that up, obviously. But I'm trying to look at it, how is it most useful to the provider and in a sense, that also helps orient the vendors to look out for the provider – for the provider's needs, and they do need integrated views of a "complete assembly of modules." And yes, today the best way to get an integrated set of modules is really to buy from one vendor, but maybe in the future that won't be true. Did I make sense at all? I'm trying to find a different way of assembling the data we have so that it can be more useful.

Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

When you say by specialty, do you mean two categories, eligible professional, eligible hospital? Or are you drilling down even – categories.

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

Yeah, unfortunately I mean drilling down a bit further like primary care, and then we do have some specialty care, maybe we can cluster them, but I think that's one of the issues that's being raised. And as far as –

Paul Egerman – Businessman/Software Entrepreneur

Well that might be helpful for people who want to buy modules, then, is that what you're suggesting?

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

Well, it's helpful for – if they do want to buy it by module, yes. It will be clear, just like it was with the Microsoft example, that although there are different spreadsheets, the market could decide, well, I like one that's integrated with other things that I also use. But it can be clear, by this matrix check sheet as an office productivity consumer, I would like to have the following things, and I find out what my options are. And then, like I say, there's this additional integration test script that helps me understand better what does it mean to be part of a suite, oh, you mean you can import this into the presentation module that you'd like to use. And then let the consumer decide. I'm trying to give better insight to the consumer.

Paul Egerman – Businessman/Software Entrepreneur

So, the way I'm hearing you, Paul, is we would take some variation of the proposal that I and other people are suggesting, that you retain complete, you do separate certification path for the quality modules. And then you would also retain the ability to do – the flexibility to do modules and for purchasers. They would either be able to buy a complete system or there would be some additional aid given by ONC that would say, oh, if you want to do modules, here is the list of the ones that you need to do if say you're an obstetrician.

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

So, I'd say Paul it's similar, but the – that I'm tak – the objection to complete that's on this list is, complete to whom? And is it one, really complete and two, is it complete to whom? So I'm trying to overcome that by instead of having different certification for each specialty, trying to assemble all of these certification check boxes in a way that's more meaningful to the purchaser, represented by a specialty or cluster of specialties.

Paul Eggerman – Businessman/Software Entrepreneur

Well, yeah –

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

And the other, instead –

Paul Eggerman – Businessman/Software Entrepreneur

– that was the answer, the answer to your question –

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

...of using – as defined now, is to put this crosscutting – called integration, and yes, that has to be defined, but we may have some key things that have to work together like CPOE with other things. And just test against that and just gives the consumer a little bit more of a hint of what integration – what is – how integrated is this set of modules.

Paul Eggerman – Businessman/Software Entrepreneur

So the answer to your question is complete to whom, my answer to your question to whom it's complete, to everybody except for the CQM stuff. And that means that some people might be buying stuff that they don't need, that's my answer to that. And my answer to the integration side is, well that's not one of the issues that we're actually even addressing in this discussion, we're only discussing eliminating complete. But that – and it's a good topic, but it's a separate discussion. It is the case that if you get everything from a single vendor, the probability of having an integrated system is a lot higher.

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

Well, I – but as I think as Mike from ONC was saying – so my attempt, my goal is to try to understand the problem to solve and address that; yes, I understand how complete – the concept of complete EHR arose. I think they're saying it's not working as intended and I'm trying to get to the problem to solve and then a way to do it. And I don't think it's outside of bounds either for the NPRM or, as Mike suggested is, we're giving comments that they can use in ways that they see fit, either to change the 2015 edition or to make further changes in other programs, but it's certainly – by the question.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I mean I get your point, and this is Mike from ONC. Carl, related to the integration issue, but you can still have that same integration issue with an EHR module if it's one vendor who puts together an EHR module that has all the capabilities that his customer or her customer needs, then it's still going to have that same "implicit integration." So I just – I think we're getting too much caught up in these terms and that's what we were concerned about, that complete doesn't really mean complete and – or it's too much for a Stage 1 versus Stage 3 provider. And so we just want it to be a vendor gets whatever vendor wants to get certified, it's called "an EHR module," the provider – it should have what the customer needs in it and that's what we've always advocated that a vendor should get certified to what his or her customer needed.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Are you –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And wanting to get away from like having these terms be what rule the day, especially when they didn't really mean what people were interpreting them to mean.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Can I ask a clarifying question? It's Carl. Are you saying that a module will be tagged as 2015 certification criteria but for Stage 1 use only? I thought your assertion there was that a complete or a module might have more than what's necessary for Stage 3 and it might – or the user might just need what's necessary for Stage 1. Are we also talking about tagging each module with not only the year, but also – how would that work? Did I misunderstand – ?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Who was that question to? Was that to me?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

You, yeah, you had said something about a certified product might have more functionality than is needed for a Stage 1 user.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I was trying to understand how that was going to be factored in.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

That wouldn't be – so, we're saying that with the complete, with the way the complete EHR definit – because complete EHR definition requires certification to all criteria – all mandatory criteria adopted for either the ambulatory or the inpatient setting.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Um hmm.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And our criteria for either of those settings has to include all the criteria to support whatever Meaningful Use stage we are up to.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So that's what we're saying about complete. EHR module it could be certified to anything, one criterion all the way up to every criterion in a setting, it's up to the vendor. And we say the vendor should get certified to what his or her customer needs. So if you have a hospital that you're servicing that's only in Stage 1, you could just get certified to the base EHR definition and whatever else they'll need to do Stage 1. And you would take into account even whether or not your vendor could meet exclusions and not need to do a capability, or what menu objectives they're taking.

So, I mean, I think most people don't – we understand that most people don't go to the CHPL to decide what product they're going to buy, a lot of people have relationships with vendors. And we're saying that whoever your vendor is should be getting certi – we're trying to make it easier for both provider and vendor and that's saying, vendor get certified to what your customer needs, don't get certified to something just to meet a definition that will have capabilities that your customer doesn't need.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Yeah, but – this is Mike Lardieri. So, okay, maybe I'm under – maybe I don't understand but, I thought that starting in 2014, even if I'm coming in as a Meaningful Use Stage 1 –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

– eligible provider, I still need to have 2014 certified software.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

You do, you do.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

So why would I want to even go backwards and have 2011, that doesn't – I'm not understanding why we'd want to have that flexibility so it looks like as of today, you need to be able to start at 2014 and 2011 is out of the picture.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I don't – so I'm not understanding why you're referencing 2011. I'm saying that MU Stage 1, any stage that you're on –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Well we're saying Stage 1 –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– any stage that you're on currently – any stage that you're on, you still have to use 2014 edition EHR technology. What I'm saying is, for the menu and objective – the objectives, the menu objectives and/or whether or not you as a provider can meet an exclusion based on which stage you are in –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Um hmm.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– that can impact what capabilities you need. So for instance, you're not – if you're in Stage 1, you're not doing family health history, so you probably don't need technology yet certified to that.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Okay, okay, that clarifies.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

Paul Egerman – Businessman/Software Entrepreneur

Let me ask – let me first ask Carl a question, we've talked about this a while. Getting back to the original question, eliminating complete EHR, if we do that, if we eliminate a complete EHR and say everything has to be submitted as modules, does that reduce – does that make life easier for you, Carl? As a vendor, does that reduce the regulatory burden on you for – ?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Yeah, and how many modules, Carl, would you be getting certified?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Well, I guess I don't know exactly, so I'd want to preface it with that and I think the magic will come down to do the modules have overlapping features and capabilities that would be mentioned in certification scripts. So that if I had to change the software in any way related to a capability that shared across six modules, would I have to sit for six independent re-certifications, pay six independent fees, I would worry that that would become time consuming and more expensive. And then coordinating releases out to customers, there's a lot of complexity, a lot of nuance and a lot of unspoken things in that body of regulations for whether a user is in or out of compliance based on pieces.

So I'd want to dig in to that more deeply, we have our user forum here, so we have all our Meaningful Use people over in a Meaningful Use forum with customers, so my person to ask is not handy. But I'd want to dig into that some more and I can send a note out to the group afterwards. I'm unsure but my sense is it tips towards more regulatory burden and more recertification expense, although the cost of development probably doesn't change, so our comment on that is accurate, I don't think we'd spend a lot more time developing, but we may spend more time certifying and recertifying for any specific change that happens after initial certification for sure.

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

So Carl –

Paul Egerman – Businessman/Software Entrepreneur

Let me make a suggestion. I would suggest that we've been talking about this a while and I would suggest that I propose like resolution has four parts to it. So the first part I propose is that we complete – we continue to have a concept of a complete EHR or a total EHR, I don't know what it's called, that does for Stage 3. The second part is we have some separate certification process for the CQM stuff. The third part is we continue to also have the modules, as described, that that has value by itself. And the fourth part is to be responsive to Paul Tang's comment, is we say go and see that additional effort needs to be done to make sure whether it's complete or modular, that these things integrate together.

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

And Carle, this is Paul Tang, so just to put a plug in. We're going to be doing a certification hearing next month, so if you do get that information –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay.

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

– send it along so that we can incorporate that, because I think this is part of a bigger –

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay.

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

– topic.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah. Will do.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So in terms of – this is Mike from ONC, in terms of this recommendation, if you're going to recommend to retain complete, what does complete mean?

Paul Eggerman – Businessman/Software Entrepreneur

Well, what I'm saying is, it's – we're carving out the CQM process, so it should be everything you need to meet Stage 3, which means that its – for any individual provider, it might have more than they need. It's...you'd think of it in terms of an organization like Intermountain Healthcare, somebody that has a thousand physicians, or Sutter, they would have everything they need. It would also have everything you need if you're Joe Heyman, if you're a solo practitioner; it may not be the only choice he has, but it would also be everything he needs to qualify for Stage 3.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

The only –

Paul Eggerman – Businessman/Software Entrepreneur

With the exception of the CQM –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Right.

Paul Eggerman – Businessman/Software Entrepreneur

– which would be a separate certification?

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Because they may be different – I'm not – this is Mike Lardieri. I'm not sure that if the CQM is separate certification or it just depends on which clinical quality measures that software actually can do that they have to identify.

Paul Eggerman – Businessman/Software Entrepreneur

Right. So in other words, it's everything except the CQM stuff.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Right and then you said to look at that separately and see what CQM they – that vendor actually can do.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Now CQM is part of the reg at 315 subsections (c) (1-3), I mean it's one of the many things there so, and that's probably for the providers increasingly the most important specific economic reason for an EMR beyond this sort of the broader value of electronic data. So I think – whatever our recommendation on the terminology "complete EHR" is, I think to – our advice to ONC should be to absolutely try to maximize the harmony of CQM and our definitions going forward. Because this is a huge political issue and if this isn't addressed, it'll sort of end up the same way ICD-10 has ended up, which at the end of the day, there are so many people squealing that the thing just grinds to a dead halt.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And so on that point, which I think is a salient point in terms of what CQMs are going to mean going forward. How do we incorporate that into the definition as if you've been following our regulations over the years, that is such a difficulty because CQMs are so specific to providers, and do you want a product that can do every CQM, which is quite a burden on a vendor, and then not even be used by a provider? And how do you assert, for those costs, where a provider who would not have more than half of those CQMs, have to have a product that has those CQMs in a "complete." So, I mean that's why we're –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

I think we're saying...

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I thought the suggestion was to –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– we've given our reasons why we don't think it works, but I'm trying to understand how you think it would work.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I thought Paul's suggestion was you do a complete EHR and then separately be able to certify for individual quality measures, that way a specialist could –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

Right.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

– look for a complete EHR and the five measures they planned on using. So just think of measures –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, but then it wouldn't be – like he just said; I mean that's what an EHR module would be, too. I'm not following how like that would be "complete."

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

This is Mike Lardieri. I would see it as – because I'm somebody who's purchasing this –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Um hmm.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

– and helping providers purchasing this, so I can go and see that, okay, this is complete. Now I get directions and I know that I still have to do quality measures, so I click on the quality measures and I get to the list of those quality measures that that vendor does. If they're behavioral health quality measures, fine, I can consider that vendor, if they don't have behavioral health quality measures, then that vendor's out; I go to another vendor that does have behavioral health quality measures. That's how I would use it and that's I think what we're proposing.

Paul Egerman – Businessman/Software Entrepreneur

– hung up on the word complete, maybe it's some other word, core or foundation or –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

We already have base, right, I mean the challenge is –

Paul Egerman – Businessman/Software Entrepreneur

They have base but – somebody can find a better word, because you're correct, what I'm proposing is it's not 100% complete, so you need another word. It's sort of like –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

– you call it the mandatory EHR or something, but the idea is to somehow put together all the functionality and transport and everything else you need in one spot and to apparently carve out the CQMs because they're problematic and that becomes like a separate certification.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So in capturing your comments, I'm hearing we should retain complete, complete should be – includes all capabilities to support a provider's attempt to achieve Meaningful Use all the way up through Stage 3. Is that accurate? And CQMs are separate.

Paul Egerman – Businessman/Software Entrepreneur

That's correct, I mean, there are two other things I said. You still would have all the modular capability, so –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, no I mean, you could always get modular certification –

Paul Egerman – Businessman/Software Entrepreneur

– that would continue to exist.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– but I just want to make sure that I understand that we thin – and the value to this, the reason why you are making this recommendation related to complete is that you find it would be valuable to providers, in terms of knowing what they have or need, is that what I'm hearing?

Paul Egerman – Businessman/Software Entrepreneur

Yeah, there are two reasons; one is, it seems like it's valuable to the purchaser and the second reason is, based on Carl's comment and also my suspicion, I believe that the complete is less of a regulatory burden on the developer.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Agree.

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

This is Michelle.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

And this is Mike –

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

So I think that we've tried to – we've spent an hour and a half on this so I think ONC should take it back and make sure that we got the comments right and we'll share those comments back with the group for validation before we have our final summary for the Policy Committee. But I'm concerned that we're not going to get through everything, so can – would it be possible for us to do that and move on to the next topic?

M

Sure.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

I just wanted to say one thing. I think instead of keeping quality measures separate, maybe to say quality measures need to be specific or specified, because it's not really separate, they still have to do quality measures, and we're saying you be specific about which ones.

Paul Eggerman – Businessman/Software Entrepreneur

Yeah, that works and actually that comment is a good comment because maybe what we can do is, picking up on what Michelle said, is if we can somehow start to write it up and circulate among us, maybe we can tweak the language and get something that people are comfortable with.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

And this is Joan. I'd just like to say that I'm not sure that everyone on the workgroup would agree with keeping the term complete and so we should continue the discussion offline.

Joseph M. Heyman, MD – Whittier IPA

I think FACA groups you can't do the – is this a FACA group?

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

Yeah, so you can't do this offline. But maybe do you want to at least do a vote or something so you have a better sense of who's in agreement? I think Paul had a motion; maybe you want to just reconsider –

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I think Joan was actually not suggesting we actually have discussions offline, but that we – as we circulate the wording, that would be a place to focus on –

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

Oh.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– where we're all in agreement and where we've got issues.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Was there anyone on this call that would argue to remove complete?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, this is Larry, I struggle with complete because it implies complete.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

And I feel the same way.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'm happy to have the workgroup try to sort out can we sufficiently tailor it so it communicates what actually complete means.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Which wouldn't be a bad recommendation here.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I guess – its Don, I'd probably have to vote against it, too, though very, very reluctantly, and it's very complex. But, I think ultimately it's sort of a little bit, in some ways, a fake help if I as a provider still have to dig into all of these details, both for Meaningful Use and for CQM, if I've got to do the work, I've got to do the work. I totally agree with Carl that there's another implicit discussion that we've sort of touched on that to a vendor, the costs and the recert and the vend – the regulatory variability sound like these need to be addressed in concert with this. Because obviously having dozens of little modules each of which can sink the battleship is sort of poor policy and very expensive and has to be paid by somebody.

Joseph M. Heyman, MD – Whittier IPA

And this is Joe; I'm also concerned about the marketing costs of having to figure out how to tell people that your EMR actually does include everything.

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

And this is Paul Tang and I wouldn't probably be comfortable with keeping it either because I think we're basically asking a question about a symptom and rather address the underlying cause. So, for example, the cost of the modules, I think we need to address that rather than voting to – I think we're treating a symptom and need to be addressing the cause.

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

This is Michelle, so I heard five votes against, so perhaps there might not be consensus on the comments that are brought back, but we can share both perspectives. So we'll work on that and circulate them with the group and bring them back at the next meeting to make sure that everything is correct and everybody agrees on how we've decided to comment on this topic.

M

So –

Joseph M. Heyman, MD – Whittier IPA

But Michelle, I think the disagreement is about the word complete, not –

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Joseph M. Heyman, MD – Whittier IPA

– the concept. The concept, I think, most of those five votes would vote in favor of the concept of somehow being able to tell a customer that the product can do all the things it needs to do to accomplish Meaningful Use.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Right.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well can't a vendor do that now in their discussions with their customer?

Joseph M. Heyman, MD – Whittier IPA

Yeah but then, what's the point of certification if the customer has to depend on the vendors saying so.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health
Right.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well the point being is that that's why we're proposing to do away with it because it doesn't mean that, so unless you can find out what is – reach something that it means that means something to people and then that's the problem.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

But I'm not –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

You've hit on the problem right there.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

I'm not going to rely on the vendor, you can't rely on – I mean, all due respects, but you can't rely on the vendor to tell me what they do or don't do for certification. I need to see it, go someplace, it's certified, and then I can talk to the vendor.

Paul Egerman – Businessman/Software Entrepreneur

Well again, the idea of possibly writing it up makes sense to me, I mean perhaps instead of the word complete, you – say this complies with Stage 3 certification requirements. And so maybe there's another way of saying it, but, I do think that at least at one point there was a consensus that we needed to keep that kind of a designation.

Joseph M. Heyman, MD – Whittier IPA

Right.

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

So –

Paul Egerman – Businessman/Software Entrepreneur

Maybe the word "complete" is not right, but you say, complies with Stage 3 certification requirements except for CQM, that's a mouthful, but that would do it also.

Joseph M. Heyman, MD – Whittier IPA

It may not be important to all of the people who don't certify for the purposes of Meaningful Use, but I can tell you that for the customers, especially the smaller customers, it's extremely important –

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

Can we hear from Joan Ash?

Joseph M. Heyman, MD – Whittier IPA

– to ones that do –

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

She hasn't had a chance to speak.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I still think it was Paul's original suggestion of complete except for quality measures and then to enumerate which quality measures are available on that complete base is something that would be of use to providers, would reduce regulatory burden to vendors who went that path, would not eliminate the modular path for anyone who chose to go that path. I think that's – and I think agreeing that probably "complete" is not the right word in that scenario, but it does paint a new kind of picture that might be more helpful to providers and more easily supported by vendors, without preclusion of modular capabilities. I thought that's what we were voting on, per se, not the term "complete."

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

This is Mike, I would agree with that and I would vote in favor of that.

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

Joan, what were you going to say, we just haven't heard your –

Joseph M. Heyman, MD – Whittier IPA

Did you just direct that at me, at Joe?

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

No, Joan – Joan Ash.

Joseph M. Heyman, MD – Whittier IPA

Oh, Joan. Yes, okay.

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

Yeah, she had –

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

Oh, I was just suggesting earlier that we take a step back and think about this and I agree, I think we're talking about terminology versus something much more deep and underlying. And from the terminology point of view, that's what I was suggesting we could work on, on the terminology offline.

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

Got it.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

For example, agree to do away with "complete" but replace it with something, like base.

Paul Egerman – Businessman/Software Entrepreneur

Or compliant or something.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

Right, right.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

I like that a lot.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I think – I'm agreeable to that.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

So the concept of complete people are rallying around then?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I think so.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

Yeah.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

That's what I'm hearing –

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Um hmm.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

– I mean, they just don't like the term "complete" and defining that's difficult, but coming up with a concept –

Paul Egerman – Businessman/Software Entrepreneur

Yes.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

– that allows someone to buy a complete, well, whatever the term, EHR that meets the requirements sounds like something we agree on.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Um hmm.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Well I think, its Don, I think what everybody agrees on is there needs to be some type of a wrap-up of this for folks, what the implications of that wrap-up are and the naming of that wrap-up. In the computer science world this is called metadata, is probably what we want to sort of strive for here and that would allow some of the other issues to arguably be solved, as in the Federal Register.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Mike with ONC. I know we need to move on, I just want to ask real quickly is it seems like the issue is people needing to know that they have essentially what they need. So if the CHPL could tell you that whatever product you picked or if that EHR mod – if just that one EHR module had everything for Stage 1 or had everything for Stage 2 or had everything for Stage 3. And/or if we made it that a vendor could market and say, like if you've looked ahead or know anything about our certification packages, where we say that this product meets the transitions of care package – care coordination package we call it. If we did something similar like that in terms of the product meets MU Stage 1 – supports MU Stage 1 capabilities or supports all MU stages or something like that, is that something that would meet your concerns and expectations?

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I mean, you could do it as a table, right, I mean if you had rows and columns so the basic things, the features, functions, this is what you need, people use that and lots of other things.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

I guess, even if we do the separate certification for the quality measures, I mean are you going to have like one per quality measure or do you have one that this is this subset of quality measures and this one is certified for a different set of quality measures? I mean, I can't even get my arms around how many different certifications there would be, of the modules, how many modules are we talking about, 10 or infinite?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Well I think it would be one certi – potentially one certification for this core requirement and then individually certified clinical quality indicators, so there could be dozens and dozens of them.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

So you're going with a base then, Carl, right?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Yeah, yeah.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, but we – I mean, this is Mike again, we already have the base EHR definition. So that is also one of the co – one of the rationale why we're doing away with complete because it's confusing people in that regard, too, because you have to have EHR technology that meets the base EHR definition, foremost, to meet the cert definition. So you have an interplay of a lot of different definitions here and that was another reason why complete didn't seem to need to exist in that regard.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Is base appropriately defined?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Base is defined based on what's required by the statute, and so it's a core set of measures requi – a core set of capabilities required by the statute and then we've included like data portability and privacy and security in the base EHR definition.

Paul Egerman – Businessman/Software Entrepreneur

But again, what we have to be careful of is that we're starting to talk again about the words, base versus core versus complete as opposed to what the concept is and the concept is to try to simplify this from both the purchasing standpoint and also from the standpoint of developers submitting material to be certified. And so that you have as few – you have an avenue where you have as a few things to choose from as possible. So, there's one thing that says, this does almost everything, this is everything except CQI – CQM and then you get to the quality measures. And we also look to see if there's a way you can simplify that so there are as few choices as possible also, in the context of you still keep all the granular modules for people who want that choice, that option; it's like two paths.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

I like that concept, Paul. I don't know if everybody else does, but I like the concept.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

I do as well.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Yup, this is Mike, I do also.

Joseph M. Heyman, MD – Whittier IPA

Me too. Joe.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So it sounds like in the write up we need to address the wording issues versus the complexity piece here.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I mean, I think we agree on the concept, it's just the words, complete, total, base, mandatory, compliance, somebody can figure out better words to express it, but the concept – make it simple.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I think if we're going to – whatever the wording choices, its Don, I think we also have to, and maybe even independent of the wording choice, be as explicit as we can be about the relationship of whatever it is here to clinical quality measures and the expected trajectory. Because for most of the providers, so physicians and hospitals and everybody who builds Medicare, they're increasingly paying to clinical quality measures that have to be, as a practical matter, obtained electronically. So I think we wanted whatever clarity we have needs to be in the context of how this product over the next couple of years fits into that clinical quality measure payment landscape, because it's – I mean that's, I think, sort of probably the biggest user question on some level.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well and that's also a piece of the complexity that we're trying to tease out, that the biggest reason for not being functionally everything I need is because it doesn't do the CQMs I'm choosing to use or it's requiring me to completely overkill on the CQMs.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I think the other challenge is that probably a lot of the CQM things, all these things you get one product from the vendor, but you have to do local customizations and local work. And I think the amount that you sort of have to do yourself, I think sometimes is an eye opener or maybe always is an eye opener to providers.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, are we ready to move on to the next topic? I'll take that as a yes. We have three topics in the mill so let me think this through out loud, we've got non-MU, MU as a – in the certification process. We've got the concept of packages and we've got certification mark. So Marc Probst has asked us to do certification mark on our next call, because he has to get off. So we've got really two to choose from about looking at MU/non-MU distinctions or looking at the concept of packages. Both of them seem to relate to the discussion we've been having. Do we want to dive in to one or the other, is someone chomping at the bit to get into one of these?

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

The package one might be easy and I think it almost mirrors exactly what we've just been discussing.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, yeah, this is Mike from ONC, I think that you have 15 minutes and that probably might be the better one in that regard as well. So –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, let's do it. Let's talk about packages.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Okay, I –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Let's pop ahead a couple of slides, and that's yours as well Don, is that right?

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Yeah. So on packages, the pack – so, and correct me if I'm wrong, but basically the packages is a 2015 only concept. There are two packages proposed that wrap up underlying features. They don't require any separate testing as proposed in the reg, so they just merely are – to our prior hour-and-half discussion, they're merely labels that these components are there. And then there's the question in each of the two packages about are what components could be in it. So the first package is called care coordination and as proposed in the reg components transitions of care and something called clinical information reconciliation and incorporation and then has, as question mark components, the incorporation of the Direct and SOAP standards, I guess as two separate things. So that's the one package, if you will.

The second package is called patient engagement, has as its proposed core components the new download and transmit to a third party measure set as well as secure messaging. The questions there are should this package also include the standard patient list creation and patient specific educational resources. So that netted out, two packages that basically bundle some set to be determined of components requiring no additional certification. This is really a, do we label things or the convenience of providers and so it directly mirrors what we've been talking about. That's my – that's it.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So maybe to focus this discussion if we flip to the next slide, which has the two specific breakouts. So we can talk about both the concept of having packages identified and the potential value or not, or confusion that might further add and then the two specific packages ONC is talking about in the NPRM.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul. First, I have a question. Are these packages certified together like as a bundle? Or are they just still submitted as individual – individual modules and it's just terminology? In other words, in some sense I'm speaking to Paul Tang's integration question.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

My read is that it's the latter, but maybe Mike or folks from ONC can –

Paul Egerman – Businessman/Software Entrepreneur

Yeah.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

...say if it's different. I think it does not get to Paul's comments about the depth and quality of integration.

Paul Egerman – Businessman/Software Entrepreneur

Right. Well, in that case, as I read this I had two concerns. One was of what's written as number two on the screen, where it says there might be more than one transmission criteria for care coordination. It seems to me that like undermines the whole concept of what we're trying to do is like to standardize and so these systems can talk to each other. So if you have one system that transmits under one protocol, the receiving system may not be able to do anything with that because maybe it agrees – it doesn't accept that. So that struck me as odd.

And the other concern I have is that this is it's like a variation of our discussion about the complete versus base, it's really a terminology issue, and that we're giving these things somewhat marketing kinds of names, like patient engagement package. Well, that's a nice sounding name that everybody's real excited about engagement, but we really have to see what it's going to be doing, is it doing things like printing educational material, that's not really patient engagement, it's printing educational material. So, those are my two concerns, but the most fundamental concern is the why we would allow – why we'd separate out the transmission and allow more than one transmission process; it seems it undermines what we're trying to accomplish.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Paul, this is Carl, I'd like to add to that a little bit. I'm confused by on the next slide ONC proposes two, one and two there. First off, 2015, I thought 2015 was going to be optional, so I would assume then these packages are optional, but I wonder if, in fact, to make these packages more valuable, one might do them either on the 2014 or on the 2017 requirements for simplicity. And then second, it seems like the second bullet point on the next slide is specifically what we asserted a little while ago that ONC was either unable to do or unwilling to do with regard to managing the marketing message, managing the – are these really integrated bundles or not kind of things. So I'm a little bit surprised that ONC proposes to number 2 on the next slide. Is there – it seems to run counter to what we just discussed.

Paul Egerman – Businessman/Software Entrepreneur

I'm confused, when you say number 2 on the next slide, what are you referring to?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Oh it says, ONC proposes to require certifiers to ensure EHR module developers make accurate representations concerning certified packages and what marketing materials, communication and other assertions related to an EHR module certifications.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So let's hold the discussion on certification mark for the next workgroup meeting. Let's back up a slide.

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

Does – this is Paul Tang. I'm going to say the same thing in terms of I think we're adding more treatments of symptoms and not addressing underlying cause by packages. It's the same argument and what – it's not addressing what users really need. The other comment to make is, Meaningful Use had to choose from hundreds of possible functions and choose a few things to be in Meaningful Use objectives so the things that are there are necessary, in our opinion, but not sufficient. So to add another label of certification endorsement essentially that says, oh, this is what you need to have patient engagement I think is a false use of the Meaningful Use objectives.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, I agree with what you just said, Paul. That was a better way of what I said when I started to say that's a marketing expression for patient engagement, it's package, it's not.

Joseph M. Heyman, MD – Whittier IPA

And this is Joe. This is Joe, if we're going to have packages, then we should have a Meaningful Use package.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

Its Don, I guess my concern with these two things is besides the fact it almost runs counter to the proposal on eliminating complete, because that was confusing, then to sort of go around and do essentially the same thing with a different labeling construct seemed a little counterintuitive to me. I think most clinicians would say, well sure this is exactly what we do and these are, to me, very narrow definitions of care coordination and patient engagement. I mean, what care is there that doesn't at least aspire to care coordination and engaging patients in their care, right, I mean unless you're a pathologist doing autopsies.

So I think it just adds confusion, I think people have to still sort out their functions and things. To me, this just adds a layer of confusion that I don't see the value. I understand that there's probably some political request implicit in that ONC would like to be able to do something about that, but I would suggest that the better way of doing that would be to show how the ONC proposal in its totality helps care coordination and patient engagement, rather than labeling of them as packages.

Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health

Yeah, this is Mike Lardieri. I think where I could see this care coordination package being useful for non-Meaningful Use providers if they're going to – they will be required to have some Meaningful Use functionality in order to play with accountable care organizations or patient-centered medical homes or even show that they can share information with their partners. And as grants come down the road, we've heard from CMS that they're going to require that kind of functionality so for them to say, in order for you to participate and get any money from us you need to have this care coordination package, I think that could be useful. But with what we were saying before, I think it would be better if we just say, these are still modules, so these are still module functions, leave them as modules and then be specific in any of those grant opportunities that you need to have module 1, 2, 3, 4 and say what it is. Because I agree with the other comments that putting together a care coordination package is going to get confusing. I'd rather see it as modules and say, you need to have these 4 or you need to have these 5 or 6, whatever it comes out to be.

Paul Eggerman – Businessman/Software Entrepreneur

It seems like we do have a consensus that – I mean no one seems to be excited about the package concept here. I still also want to make sure we look at what's written there in bullet 2 which says, general – much more general requirements about transmission certification criteria, it says, could risk – to module being unable to exchange with each other. And so to me, on the transmission capabilities, we should not be providing flexibility, we should be saying here is the standard that ONC wants everybody to transmit with.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

But that duality's already present elsewhere.

Paul Eggerman – Businessman/Software Entrepreneur

Pardon me?

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I mean, that's not a ne – I don't believe that's a new duality, I think that duality is already present elsewhere in the body of Meaningful Use.

Paul Eggerman – Businessman/Software Entrepreneur

Actually, not quite, not quite, in Stage 2 the transition of care module, the requirements are married to the Direct protocol; the two are attached to each other. And so, this is – and elsewhere in the 2015 edition, they get decoupled and then this suggests that there might be more than one transmission method. To me that just leaves open an idea that vendors can transmit with a unique method within their customer base that then you have the burden that they aren't going to be able to transmit across vendors. This is a serious issue that needs to be discussed.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So let's see if I can get premature closure on this. It sounds like there's a lot of concern that the concept of packages is just going to add confusion. Is there any counter-discussion? Does anyone in the group feel like there's a strong argument in favor of having packages?

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

May I ask a question? In the absence of – would certifying packages be required or would a package be defined to be the presence of three other pieces, and if you were certified under three other pieces, you're deemed certified on the package?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

That's exactly what –

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine

I think it's the latter.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes, well, yeah, the – you would be – you would get certified and then if you are certified to that, you would just be able to use that package terminology if you wanted. You wouldn't go in to get certified to a package, per se.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor and Vice Chair, Department of Medical Informatics and Clinical Epidemiology – Oregon Health & Science University School of Medicine

This is Joan and what I'm hearing is that the idea of packages we could probably agree to, but these specific packages that are outlined here, I'm sure they're just samples, but there are many, many more and getting into that kind of detail is what's, I think, confusing.

Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy

This is Jennie. I completely agree with that. I think the notion of constructing packages is both a marketing opportunity for vendors, I think it's an opportunity for CMS or other payers to provide some direction on particular packages that they might be interested in. I think the items that are listed here are at – are only partial care coordination constructs that I can imagine providers being interested in wanting their technology to support. And I also agree with the conversation a little while ago about the duality of transmission requirements and until that's resolved, I think big cautionary letters, notes, whatever need to be posted to purchasers about that concern.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

How many packages would you envision? This is Carl again.

Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy

Well I think it depends upon the user. But for example, this care coordination package right here talks about transitions of care and clinical information reconciliation and incorporation. Medication information reconciliation might be yet another example. I just think it depends upon the particular instance of what type of care coordination is – both the user, the provider, their payment situation and a payer, for example, what they would require.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Just to make sure I understand, do you envision these packages as not actually somebody certifying to the package per se, but somebody certifying against standardized module definitions and then when you hit the right combination, the ONC CHPL set would light up the package indicator certified subset – one of the package definitions –

Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy

Well I don't even know that the ONC CHPL site would necessarily light up. But I think, for example, if there were – if a vendor had several modules that had been certified and then, for example a payer says, for this particular program that we're going to make payment available for, we're interested in the following X, Y, Z modules to support our care coordination efforts in this payment program.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

So let me ask a question again, the statement here on the slide says identify subsets of certification criteria as "certification packages." Would a vendor have to, with their certifier, certify to the package, or is the vendor certifying modules or a new definition of complete, whatever that may be from which CMS will just use the metadata to define you as being then currently in compliance with one of many packages?

Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/Office of Disability Aging & Long-Term Care Policy

I think it's the latter, if I'm understanding what you just said.

Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation

Okay.

Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine

It's pretty explicitly the latter in the documents.

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

Umm, can I just raise the concern that I had, which I think we're misusing the Meaningful Use criteria in a way it wasn't designed for. If this were like the comprehensive certification, then I can certainly see like in a car you have the convenience package, you have certain clusters of functions. Meaningful Use is taken as a whole in order to let's say in Stage 3, to focus on four objectives, four goals taken together. So I don't know that we can break some of these necessary, but not sufficient things and then reconstitute it as something else, like it totally manages care coordination or patient engagement. I think that's very misleading.

Paul Eggerman – Businessman/Software Entrepreneur

I agree, but I'm also just curious in terms of like an agenda check, are we a bit over time?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you, yes we are over time.

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

We are.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, I guess I'm also hearing what, that the value in the packages may be in the eyes of the packager, as it were, so that there might be other programs that want to selectively group certification criteria together. That may or may not then be represented in the CHPL, I guess has been the rollover question. But it sounds like the proposal is not to add additional certification criteria or additional certification process, other than that these – that the modules in a package in and of themselves become complete. And that the vendors would be, get constrained by the certification bodies in how they then reference packages, that they could only reference the ones to which they fully met the modules. So, maybe this is something we can again circulate some updated slides and get some written comments back from the workgroup and bring it forward for a final wrap-up on our next call.

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

So, are you ready to open for public comment?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Let's get public comment, thank you.

Public Comment

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

Operator, can you please open the lines?

Rebecca Armendariz – Project Coordinator - 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.

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

Thank you. So we have our next meeting on April 7 and another one on April 9, so we might have to reshuffle some of the topics and where they'll be discussed, so we'll share that with the group. Thank you everyone.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you for the robust session today.