



**HIT Standards Committee  
Implementation, Certification and Testing Workgroup  
Final Transcript  
May 14, 2015**

**Presentation**

**Operator**

All lines are bridged with the public.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Implementation Certification and Testing 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. I will now take roll. Cris Ross is not here today, and Liz Johnson will be joining late. Andrey Ostrvosky? Danny Rosenthal?

**Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System**

Here.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Hi, Danny. David Kates will be joining late. John Travis will be joining late. Kevin Brady? Kyle Meadors?

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

Here.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Hi, Kyle. Rick Moore?

**Rick Moore, MS, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance**

Here.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Hi, Rick. Sarah Corley?

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Here.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Hi, Sarah. Steve Waldren? Sorry, I'm having a coughing attack. Udayan Mandavia?

**Udayan Mandavia – President and Chief Executive Officer – iPatientCare**

Here.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Hi, Udayan.

**Udayan Mandavia – President and Chief Executive Officer – iPatientCare**

Hi.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Zabrina Gonzaga?

**Zabrina Gonzaga, MSN, RN, cNP – Senior Nurse Informaticist – Lantana Consulting Group**

Here.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Hi, Zabrina.

**Zabrina Gonzaga, MSN, RN, cNP – Senior Nurse Informaticist – Lantana Consulting Group**

Hello.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Brett Andriesen from ONC?

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Here.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Hi, Brett. With that, I'm gonna turn over to you, Sarah.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

All right. Well, thank you, Michelle, and I'd like to thank my team members on group three as well as the other members of the workgroup who helped provide comments, so we're going to review the assignments that we have for the measures. Next slide, please.

So—there we go, all righty. So, we have several items that we're gonna review, including encounter diagnoses, medication dosing, implantable device less, pharmacogenomics, data portability, and automated numerator recording and calculation. Next slide, please.

So, the encounter diagnosis—this is an unchanged requirement. They are keeping this the same as the 2014 transition of care that required that the Health IT enable the user to create a transition of care or referral summary that included the encounter diagnosis, using either SNOMED CT or ICD-10 codes. So, while it is an unchanged requirement, we did have some comments about this, because there was a lack of clarity that some vendors and users of Health IT had, and we would appreciate clarification by ONC. The first was to clarify that what they wanted was the billing diagnoses rather than the problem list diagnoses, because we have now artificially separated what was one problem list before using ICD-9 codes into a problem list and billing diagnoses. We want clarification that, in fact, they do mean these to be the billing diagnoses, and we additionally wanted clarification as to whether they wanted one or every single billing diagnosis associated with that encounter. If they only wanted one, we wanted clarity as to how that one diagnosis should be determined. If there were multiple, did they anticipate that the end user would have to sort those so that it was the first one or have some other indicator that it was the primary diagnosis, or whether they should all be included.

We have noted that confusion has occurred because of this, and we would encourage them to consider solutions to this problem that's requiring double entry and double coding with the full stakeholder group of health IT vendors and users of software as well as consumers of these codes, including payers and researchers. Some of the potential solutions they might think about would be providing an enhanced GEMS crosswalk where there was a one to one mapping between SNOMED and ICD-10 that currently does not exist, and if that were to happen, you would of course need addition of new codes where necessary and what we're certain will never happen, but we mention it anyway as a potential solution is getting rid of ICD-10 and moving to SNOMED for billing, understanding that that's unlikely because some of the components of the ICD classifications for subsequent and initial are not currently being met with SNOMED.

Does anyone on the workgroup have additional comments or thoughts about the unchanged encounter diagnoses requirement?

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

This is Kyle. No, I think, I think it's a good point about, and I agree about seeing how things almost get separated out unnecessarily, so I think it's right on.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

I'm very sorry, I had a little delivery incident which has generated dog barking—if we could move to the next slide, please.

So, this measure was for medication dosing, and they were asking for a comment as to whether Health IT certified products should limit the ability to document prescriptions for oral liquid medications to only the metric standard rather than allowing the use of teaspoons or other standard rather than metric measurements. The reason that they proposed this is for patient safety, because there are many cited references that it is safer to try and dose in metric rather than using whatever size your teaspoon is at home.

So, there were not a lot of comments from our group on this in terms of requirements for health IT vendors to do so. It would not require a lot of work; however, non-metric units are included in the NCPDP and C-CDA standards, and if we are going to limit what the vendors are displaying, we should update the standards to exclude those other options, and we would need clarification that this is only applying to the structured fields for data entry for the Sig, because we must always support free text to allow for the full range of prescriptions written, and that free text could be used by a prescription writer to put in non-metric measurements if they so desired.

Are there any other comments by the workgroup members? Hearing none, we can move to the next slide.

Ah, the implantable device list—well, we have a lot more comments about the implantable device list. So, this requirement was not only proposed to include the ability to record, change, or access a list of unique device identifiers, but there were other requirements for parsing the data from a unique device identifier and retrieving it from a Global Unique Device Identification Database and making it accessible to the user. The workgroup did have a number of comments about this, so we did not feel that the full functionality of this requirement should be applied to all products and all domains of care, because most devices are not inserted in the ambulatory environment, and when you add additional core requirements to products, you increase the cost of those products to everyone. So we thought that it was reasonable to require fields that would store and display the device identifier in the description, but not to expect that all software should support the retrieval of the device description from the Global UDI database or to support parsing of that.

As I mentioned, that increases the complexity of the product, leading to increased costs for end users that might not benefit this. Because these databases will be changing frequently, many vendors would need to contract with third party providers to provide that service which, again, would increase the costs, so it would really be more appropriate to let the market determine who needs this for vendors at service providers that do a lot of implantations. They are definitely going to want to support the enhanced capabilities of parsing the data or searching the live database, but for most other vendors, simply supporting a location to enter, store, or display the device identifier should be sufficient.

And we did point out that this is a phased in implementation of the requirement for unique device identifiers, and that all devices will not have device identifiers for, I think it's five more years. So it would be an evolving requirement, and that would add to its prematurity in terms of being a core \_\_\_\_\_ requirement.

Any other comments from the workgroup on this? Wow, we're buzzing right through today. All right. And, just as a reminder that you're seeing from Lonnie, if you have, if you wish to submit a public comment, please do so. It looks like we'll have lots of time at the end for public comment. Next slide, please.

Pharmacogenomic data—this was a request for comment, so not a proposed rule, but asking for a comment on pharmacogenetic data which identifies genetic variants in individuals that alters their metabolism or other interactions with medications, and we're seeing more and more information about that, so really, the question was, what could Health IT Systems do to capture this information that could potentially increase patient safety and enhance patient outcomes.

So, we had a lot of comments on this question. We actually have two slides' worth of comments, here. So, the first area that we wanted to make sure everyone understood that this really does hold promise for a more personalized precision medicine, that being the current term in vogue, but it's really not ready for incorporation into electronic health records and structured data. We're missing a number of parts before we can do that. The first is consensus in how these genetic variations should be represented, and we're seeing a lot of movement towards the use of these RSID numbers, so their reference SNP ID numbers, but they've still not been standardized, they certainly don't have LOINC codes. I don't know that doing LOINC codes will ever be reasonable, because there are, as we stated here, in a typical genetic profile from one of the commercial vendors out there, 23andMe, there's about 46,000 of these SNPs per person, so that would be a lot of data to store in the electronic health record, but we don't have the standards now as to how to represent it.

We also don't understand that well what other factors are going to affect the individual with a given mutation, because the mutations alone don't tell the whole story. There are different levels of penetrants, environmental changes, and there are other modulating factors for genetic response to how you're going to behave with a given mutation. And the studies to date have really failed to identify, for most of these mutations, a clinical benefit in making dosing changes. I would point out the Coumadin, the mutation that affects your, how you metabolize warfarin, and we do see that it correlates with how you metabolize it, but to date, no one has really come up with algorithms for dosing that provide any benefit in getting people to therapeutic levels at a faster rate, or increased safety.

So, right now, we're recommending that Standards body start to develop requirements for how to represent them that it's unlikely that the way that we want to handle this data in the future is going to be storing it in the EHR. It's more likely that we're gonna see expansion of what we, of the companies that already exist that are providing external decision support where they do the genetic testing. They store the genetic profiles of the individuals and a call is made from the electronic health record when the physician or other health care provider is seeing a patient that can check against medications or for guidelines there. So—can we move to the next slide?

So, we think that the focus should be on enabling the distillation of all of this data into recommendations by third parties and that the Health IT vendors of EHRs are going to be simply using functionality that is already required, whether we're using info buttons, or the API, or other external decision support such as the Healthy Decision, that we would look to that as being the most likely way that we're gonna be handling this information.

So, in summary, the standards for representation are not mature. The evidence for improved outcomes with widespread use of genomic data is not available. The costs are high for this. There are some privacy concerns as well. We do have GINA, which does protect someone from discrimination based on their genome, but there are still, I'm sure, areas of privacy that people would like to look at with that. So it's an emerging field, but we feel like it's not—it's certainly not ready to be mandated, and there are a lot of parties that need to be working on this now.

Anyone else with additional comments? All right, we'll move to the next slide.

Data portability—so this is a revision of the existing data portability requirement in the 2014 version which allowed for a bulk export of C-CDAs for the patient population. So we were asking for, there are a number of requirements in this proposed criterion that we requested clarification from or had some issue with. So, we wanted clarification on the requirement that the user should be able to do this data

export at will. We wanted to make sure that, by using the term user, they didn't mean any end user, but meant a specific, authorized user of the product, because doing a mass export during production, in your production environment while seeing patients could have grave implications for performance. We wanted clarification that the phrase “without subsequent developer assistance” meant that after the user—it meant that the user had to have had adequate training on the functionality per the vendor recommendations.

There were requirements there for supporting multiple document types, and we requested clarification as to whether they anticipated that vendors would support all of the document types mentioned, or just a single one of those, or more. Again, we had a similar question about the encounter diagnosis as to whether this should be a single billing diagnosis or every diagnosis associated to the visit, and the same questions we had on the first measure as to if they only want the primary one, how we expect that to be decided, whether the user has to specifically identify it or select it first.

We requested clarification on the patient sex. They currently have three options that are allowed—male, female, and unknown. Currently, many providers of Health IT have a category for undifferentiated, where the patient’s phenotype may not make it clear what their sex is. I've listed a couple examples there for those who are medical on the call. So, the question was, if we continue to allow our end user to select undifferentiated, should we roll that up into the unknown category, or do they want to add a category for undifferentiated, or are they asking us to remove that capability of adding the more granular undifferentiated rather than unknown?

We requested clarification as to whether it was acceptable to roll up the granular data on race and ethnicity. So, as you recall from earlier calls, the race and ethnicity can be represented at a child level where it can—so, for ethnicity, if you select Hispanic, it could be basically any country where Spanish is spoken, it could be that child level, and we're requesting clarification as to if the user enters a more granular item for either race or ethnicity, whether we should roll those up to the parent categories of black, white, Asian, Native American, those categories—Hispanic, non-Hispanic, or if we should leave them granular in the C-CDAs. Next slide, please.

We did make some recommendations in terms of the documents that they listed, if it was their intention that every vendor should support every one of those listed. We felt—or we recommended that, for base certification, an ambulatory vendor should only need to support the transfer summary, referral note, and care plan documents, and the hospital product should only need to support the transfer summary, discharge summary, referral note, and care plan. The remaining document types of consultation note, history and physical, the common clinical data set, and the postop note, should be optional. We recommended that cognitive status and functional status not be required data elements for data portability in that they are not commonly collected across all specialties, and therefore should not be required for certification. We ask that terminology should match the terminology used in the C-CDA to avoid confusion, because some of the terminology was different.

We note that vital signs are not part of the base EHR definition, and they are not part of the meaningful use requirements, but they are listed as part of the core clinical data set, so we feel that this is discordant and that they should either be made part of the base EHR requirement or else removed from the core clinical data set.

If they are going to be included in the core clinical data set, we recommend that they remove the oxygen saturation, because that is not commonly done by all specialties, and again, requiring that these be present when people are not using them is, I will use the analogy of selling a car where you require

that every manufacturer put in heated seats and a heated steering wheel, even if you live in Florida and never have a need for those. So, that we should have, as our core requirements data and requirements that all are going to need to use.

Similarly, we recommended removing the mean blood pressure. Mean blood pressure is not ever calculated when you take a manual blood pressure, which is still done in probably the majority of smaller ambulatory practices, even when it is taken with an electronic blood pressure monitor, it is rarely tracked or documented outside of the critical care setting. We also recommended not including the unique device identifier for the reasons that we specified before, and there was a proposed requirement that the measuring or authoring type source for the vital sign measurements would be required, and this could have the unintended consequence of adding a lot of work to the end user. Because, if you're manually taking it, we could insert the name of the person signed in and entering it as a vendor, but if you are using a vital sign machine with an interface, as many people are, not all of these interfaces or devices support sending information about the device type and you would then have to manually be adding something to say, "I took this with the well child and vital sign monitor," and then you were adding extra steps that defeat the whole purpose of automating vital sign measurements. Next slide, please.

So, moving beyond what's in the core clinical data set, there were some requirements for time and ability to generate these C-CDAs, so they had time frame requirements and event requirements, and we thought that these were overly prescriptive. Event generation doesn't really fall under the description of data portability where you're talking about data moving with the patient for one reason or another, because you would assume that the functionality for exporting the summaries based on transition of care would already be handled by the transition of care requirements, and so we would caution ONC to be careful about having prescriptive, detailed, and numerous requirements that could result in a negative cost/benefit ratio.

We felt that a more appropriate name for this would be bulk export of C-CDAs rather than data portability because, by using the term data portability, you are creating assumptions that the entire record is moving when, in fact, it's just a subset of that record that moves and, if the goal on this requirement was to allow someone to more easily change vendors or change practices, that expectation is not going to be met by the data that's in here. When people change from one health IT vendor to another, much of the challenge of that data conversion relates to the practice management software, converting the financial data and the accounts receivable. There are other items such as images of EKGs that are not included in this, and so the term data portability might lead people to believe that they're getting more than they are with this requirement.

We would ask that ONC provide realistic use cases for these new timeline or event requirements, because they don't really make sense to our technical interoperability folks. Some of the examples they gave are bulk exporting of C-CDA on all patients on the first of the month. We could not really think of any sort of business case where that would make sense. If you are exporting to an HIE, you would be sending updates. Rather than the entire C-CDA, you would just be sending updates on what had changed, and you would certainly be doing it more often than once a month, and so we would ask that they take a more careful look at this, and if the goal is really supporting HIEs, the requirements should be retooled to support that and, more appropriately, word that for the HIE as opposed to the capability of doing a bulk export of the core clinical data set.

Other comments from the workgroup members?

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

Hey, Sarah, it's Kyle, and actually, by and large, I agree with these comments. I thought it was all well done. I think, I just want to especially point out about the naming of it, because I always kinda thought that data portability was a little misleading, too, about—because in this case, especially now that they are wanting to reflect really a large export of files, not just porting because you're leaving one system and moving to the next, but for a lot of reasons. And I think, along those lines, the point about the HIE is well made. If you're gonna do this bulk export—and it's really for certain scenarios, it's not just something anyone does just casually—there are some key scenarios of when you would do that, typically. I think it would behoove them to better define that, just so we spend our time working on those things, and not this very just general requirement that could be, that we spend all our time implementing but it's not particularly usable or cost intensive.

So, anyway, I just wanted to say I really, I actually agreed to everything here, and especially the part about the—I don't know if they're rename it or not, but I always thought a better name could be chosen than data portability.

**John Travis, FHFMA, CPA - Vice President & Regulatory Solution Strategist – Cerner Corporation**

This is John Travis, I—

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Yeah, I think it sets unrealistic expectations of what you're getting with that.

**John Travis, FHFMA, CPA - Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah, so this is John. I agree on most of those things as well. One thing maybe, and this is the only thing we talked about last week when we were going through the base EHR and thinking about this criteria and thinking about the one on the API access, especially from a consumer perspective, but really also from a provider is, are those two criteria that really, in some sense, can be merged for the stated purpose? And maybe the flip side of that is, if they really aren't the same thing, at least with respect to the whole of the common clinical data set, which they hold in common as a requirement, can you at least delineate the use cases why they would be distinct, and maybe that dose point to what you were saying last, as it might have been contemplated to mean porting information for purposes of converting one vendor system to another, this really doesn't do that.

For some other purpose that might be to service ad hoc reasons why you'd want the CCBS in a CCBA form, then okay, but what are those? And they do probably exist, but then why have two criteria that more or less both enable the same thing to occur, just maybe in different forms, or anticipate in different models of sharing of that information. But it just seems like we're being asked to multiple things of the same kind.

**Udayan Mandavia – President and Chief Executive Officer – iPatientCare**

Well, yeah—this is Udayan, and I would also agree to this. I'd just like to add one more thing, that when we're talking about data portability, it's not only bulk export, but there should be a bulk import into the system. But they're not, the systems are not geared to do data import, like this data are imported for all the elements such as \_\_\_\_\_, lab reports, vitals, so that's where I also agree that data portability, it's a misnomer.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Thank you. Does anyone have any other additional comments? All right.

**David Kates – Director of Interoperability – The Advisory Board Company**

Hey, Sarah, it's Dave Kates—partly just to say hi, and partly to add my two cents. I agree that the portability thing actually doesn't reflect what I'm about to say, but to the extent that there are external decisions port applications, analytics, benchmarking tools, things like my company invests in, I think the ability—as John said, whether it be in API, or whether it be in document export or something like that, I think that's the use case that is also contemplated here. So, portability doesn't represent that, but the industry need for being able to do that, whether commercial products, or whether research or state reporting agencies, I think it's that broader set of use cases, and portability actually confuses the issue rather than clarifies it.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Thanks, Dave. Anyone else? All right, we'll move to the next slide—automated numerator recording.

So, this measure was unchanged in that the requirement was unchanged; however, the task procedures would change because there were new items that you would be calculating the automated numerator on, and so we will go ahead and get started with our comments on this.

The first item that we wanted to recommend to ONC is that there be no requirement for automated numerator recording for any measure where doing so requires additional clinical documentation that is not necessary for patient care. We have found this requirement to be the single biggest factor in creating inefficiencies in the use of the EHR as vendors have had to add buttons or checkboxes or other methods so that items could correctly add them to the numerator without benefit to the end user. Members of the workgroup said that poorly constructed measures equated to bad data requirements, which led to awkward workflows, and therefore, the primary requirement should be measure retooling and testing prior to deployment to make sure that we are not making requirements that are not having a positive impact on the care and outcome of the patient. So there should be a proven business need to document numerator performance, and it should be done without requiring development work or data entry that's not necessary for care provision. If to do so would be required, then it should be eliminated.

We'll give you some examples where there is a complicated setup and recommend eliminating these. That would be e-prescribing, because right now, there are several reports that have to be created, depending upon whether you're using controlled substances or not, and the measures are not going to be comparable across providers, because you're using different metrics. Transitions of care—there is an undue burden to the provider and unnecessary data necessary to capture that to meet the numerator requirement. Because you don't know if it's a new patient, because someone could've just implemented an electronic health record rather than having a new patient, you don't necessarily—you don't know, electronically, if that patient has seen someone else. So it does require additional work on the automated numerator recording, here. And patient education would be another issue that has been a big problem for end users, because they can only count patient education that was suggested by the software. Next slide, please.

So, I provided some examples here, but many practices routinely give out patient education based on conditions such as which trimester of pregnancy you might be in, or situations such as a pediatric well visit for a given age, and they have set up their order sets to have these. A lot of times they have them pre-printed, because it is more efficient to have it pre-printed, rather than try and put a printer in every

exam room or try and centralize handing the patients these information—particularly vaccine information statements. That is an area where it is much more efficient to have them pre-printed when you're doing high volume clinics such as happened with flu clinics, rather than waiting for one to print out with each patient as they're seen, so that they are suggested. So I think this is an example of where the good thought that you want to be taking advantage of decision support in the product is getting in the way of good patient care and efficiency.

And there are concerns, still, about the appropriate time periods for accurately calculating numerator compliance. There's been varying guidance about that, so it makes it hard for developers to construct accurate reports, and we're talking about that before, during, and after advice where, if a measure does not have a specific time frame it must be completed in, we have been told in times past that it could be entered before, during, or after at any given whenever, and then that was changed to before, during, or after in the reporting period, and so it has created a lot of confusion and lack of uniformity across vendor products, and even across providers within the same vendor. Next slide, please.

So, I'm gonna wait for asking for additional comments from the workgroup on the numerator until I do the measure calculation, because they really go hand in glove. And again, the automated measure calculation is unchanged, the requirement; however, the test scripts would change, because the requirements have changed or the thresholds have changed. So we see similar issues as we have with the automated numerator calculation that we've had to add extra work for the end user to be sure that they are accurate.

So, just adding one other example to the automated measure calculation here is lab results. The requirement for the lab results was that you only included results that had a numeric result or a positive or negative value. But the fact is that the same tests run at different labs might be numeric at one, and might be text based at another, which requires extremely complicated setup by the practice to try and say what should count towards this, and what should not count towards this. And that's really not providing any benefit to the end user. The fact is that if you have a lab interface, you know things are going in structured fields, whether they're numeric or not, and it would probably be more beneficial if the whole goal is to drive people to having lab interfaces to specifically say so, rather than this overly complicated requirement that has a lot of setup issues.

Another area of concern among the developers is that the term "seen by EP" can have variable interpretations, so this has led to unnecessary development and setup so that each practice can define what it means, what type of visit counts as being seen by an EP, and we recognize that ONC wants to have flexibility in this to allow for different styles of practice and how you may practice. But the fact is that, when you have that, it requires more complex setup, more development work, more decisions by the practice, and really doesn't benefit the care of the patient.

So, a more appropriate way to handle some of these would be either to—you know, for example, the lab measure, just lower the threshold and use all labs as a denominator, understanding that if the non-numeric results are not populating structured text, you're gonna have a lower threshold, but you would not then have the complicated setup. And similarly, for the seen by EP to simply provide the CPT codes that would be acceptable and lower the threshold, adding that some of those might not truly be seen by a physician in that given practice.

So, other comments on the automated numerators and the automated measure calculation by the workgroup members?

**Male**

Sarah, I'm trying to remember—and the potential, I think, is probably there, we haven't seen the test procedure yet, but especially in the transition year for 2017, did you see anything where there might be a potential of certifying any current measure definitions, or any measure definitions that would carry over into the 2013 criteria edition in terms of what the software actually has to do? And why I bring that up is, if there's any potential for Gap certification at a measurement level where there really hasn't been a change, I'm thinking, like, I don't know that the CPOE measures will have changed—not in terms of what the software actually has to do to calculate. I'm sure the thresholds have changed, but it may well be that the measures themselves haven't changed in terms of this—

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

That would be a good question for Kyle.

**Male**

Yeah, I bring it up, I realize Gap certification has been at a whole criteria level, but here, there might be some opportunity to consider it at a measure level.

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

Yeah. That's a good point, because you're right, they're silent on that aspect of it, and—but that is a good point. So the idea that CPOE medication, for example, which is, like I said, Gap, it's gonna be unchanged from 2014 to 2015. Could not the measure itself be gapped? I think it's worth mentioning here in terms of—I mean, I'm just now thinking of it, so I don't know if I have a great answer for it in terms of the concern of doing or not doing that. But there should be something there for things that are—you know, if something is unchanged and its functionality for the criteria, then, could not Gap kind of coverage go to the measure report as well? I think it—I think it's worth noting.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

You certainly wouldn't expect that if you can already calculate these. Just because the threshold changes, you shouldn't need to retest them, because you're already calculating what percentage it is, so.

**Male**

Right. Yeah, that's just a difference in evaluating the outcome; that doesn't make any difference to the numerator or denominator statements or anything of that nature. Yeah, I \_\_\_\_\_, I think it's worth mentioning here, Sarah, and then, you know, raise it as a point of consideration. I—Kyle, it seemed you were headed in one direction with it, which was, if the criteria that's related to the measure is Gap certified, can the measure also be?

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

Mm-hmm.

**Male**

I think I'm also on the point that, whether or not that's true, if the measure remains unchanged as to the technical requirements of the numerator and denominator statement, could it be Gap certified? And I don't know off the top of my head if there's anything that would be quite like that. CPOE, though, is a good example of one that sits where you were headed with it that would actually fit both of those.

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

Well, but even then, let's say—well, to take your point of like, say, patient education, which is now, in 2015, they're really just getting rid of the—right, I think there's a change in the info button spec—

**Male**

Yeah.

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

- but now they're just making it info button only. Therefore, could not the measure be in the—how you count analytics behind it should probably be about the same. Therefore, even though it's not technically Gap, could you apply Gap here? I think that—

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Well, that one, you know, that one, I, I think is a real case in point of getting rid of the patient education completely. You could have a certification requirement for updating the standards of the info button without having to, to do that. But, you know, this is one of those meaningful use questions is—what do you mean, it only counts if you have, if you're looking for patient education externally? I mean, that is very problematic in terms of efficiency for a number of the reasons that I mentioned, and most of the patient education that you want to give out, it might be internal to your system, or is commonly already done. Why would you have to go to an info button, which can slow you down when you're using the same thing over and over again?

**Male**

Well, now you're seeing now, currently, like with an attestations inheritance where someone has—or attestations where they have gone from version 3.2 to 3.3 and they say, “You know, we made a change in terms of how we, we have in our interface of how we collect something, whatever, and so we need to re-test this measure.” While a lot of times we do, then, think, let's, we'll consider the measure report of G2 \_\_\_\_\_ and re-evaluate that at the same time? We don't always do it, because we know that there is a distinction there. You could make a change to some forward-facing kind of component that we need to re-test, but the underlining, how your system is basically running the data from the database, yeah, that part is already the same and therefore there's not a need to re-test that, so—

**Male**

Yeah, I agree with that. You know, it's kinda like the difference between, if the evidence the system relies on that knows something can be counted for numerator credit doesn't change, then I think you're on the right track.

Uh, maybe the way we make a comment here, in a little more neutral fashion, because I agree with Sarah—there are gonna be things to be played out between proposed and final rule that will be influenced by the way to public comment, and the education one is a real good point. So let's—you know, CMS comes back and goes, “Good point. We really need to not limit it to external access of the educational materials,” and it winds up that the measure is consistent with the stage two patient education measure, if it remains a percentage-based measure—however that lands, I think the comment here is, if the measure definition doesn't change from the prior stage, this should be eligible for Gap certification. So that way we aren't getting too caught up in where things might head, based on public comment, but as a principle of Gap certification, if it doesn't change, why compel it to be retested in the next certification rounds, as long as the same products are involved?

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

So I think maybe the comment, if I can try to word it here, would be for ONC to consider individual measures within this criteria have DCB to apply Gap eligibility to that. You know, so it is—it is one of those things that kind of fits in between. It's a funny, it's a meta measure or criteria, almost, that kind of sits above things, right? I think it's worth—I think it's worth proposing. I mean, I'm trying to think through in my head a little bit just what we would do. But I—this is, this is obviously, I mean, for those who are not aware, this is probably the most intensive criteria, I think, for people to prepare—

**Male**

Oh, yeah. [Laughter]

**Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

- at least, from what I see on my side as a testing body. So I know that's a lot of work, so it's important, and I don't want to diminish it, but I also want to reduce the burden on the vendors, because they spent a lot of time for this.

**Male**

Yeah. Anybody who tested CPOE for G1 or G2, or the measure that was the original stage one measure, can reflect on the tedium of having done that, on top of then testing for the alternative basis of the measure. So yeah, anything in this area where the requirement doesn't technically change, however, the final rule ends for stage three, I think that would be a very meritorious comment.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Other comments on the—I believe that that's the end of our measures. Is Liz on yet?

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

It doesn't look like she ever was able to join.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Okay. So, did we have any other work today before we open it up for public comment?

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

I think that's all. Thank you so much for stepping in, Sarah.

**Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Sure, no problem.

**Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Sorry about that. Operator, can you please open the lines?

## **Public Comment**

### **Lonnie Moore – Meetings Coordinator – Altarum Institute**

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

### **Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Did we have any written public comments?

### **Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

We did. From Ben West of Health eFilings, his quick comment was, “Why shouldn’t vendors support C-CDAs? They seem pretty common and widely useful.” And that’s all.

### **Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Vendors do support the C-CDA. I think we're talking about some of the data, the document types, the different document types.

### **Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

And we don’t have any commenters on the phone. We do have another call on May 19th, which is the day before the Senate committee meeting. We'll have to check with the chairs to see if there’s a need for that meeting. We might use that time to just review with the group last comments before Cris and Liz present to the committee on the 20th, or we may do that offline just via e-mail and share with the group, so we will get back to you with that. But thank you so much to all of our leads, especially today for you, Sarah, for helping us walk through and—thank you, everyone, and we'll be in touch soon.

### **Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems**

Thank you, Michelle.

### **Male**

Yep, thanks.

### **Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.**

Thank you, all.

### **Male**

Thank you. Bye bye.

### **Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology**

Thanks. Bye.

**Male**

Bye bye.

**Public Comment Received During the Meeting**

1. Why shouldn't vendors support CCDs? They seem pretty common and widely useful. – Ben West, Health eFilings