



HIT Policy Committee Quality Measures Task Force Final Transcript July 24, 2015

Presentation

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – 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 Policy Committee's Quality Measurement Task Force. 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'll now take roll. Kathy Blake?

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Here.

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

Hi, Kathy.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Greetings.

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

Dan Riskin? I think Dan was on earlier.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer - Vanguard Medical Technologies

Oh, I was and I had trouble with the mobile App so now I'm on voice only.

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

Okay, thanks, Dan. David Lansky? Elizabeth Mitchell? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Present.

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

Hi, Floyd. Frank Opelka? Ginny Meadows?

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

I'm here.

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

Hi, Ginny. Jason Mitchell? Joe Kimura? Lori Coyner? Sally Okun? And from ONC do we have Stephanie Lee?

Stephanie Lee – Public Health Analyst – United States Department of Health and Human Services

Here.

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

Hi, Stephanie. Samantha Meklir?

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

Here.

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

Hi, Sam. Julia Skapik?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Here.

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

Hi, Julia and Michael Wittie?

Michael Wittie, MPH – Program Analyst - Office of the National Coordinator for Health Information Technology

Hi, I'm here.

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

Hi, Michael. Okay, with that I'll turn it back to you Kathy.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Hey you...this is Mike Mirro you missed me.

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

Hi, Mike, you're not on our official member list as you are just joining a few meetings, but yes, thank you for joining Michael.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Okay, thank you, yeah.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Yeah, don't go away.

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

Michelle, this is Lauren.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Okay.

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

Oh, sorry, Lauren.

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

No problem.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Well, so this is Kathy and I thank everybody for joining us on a Friday afternoon. Today's call will be a bit shorter than the one we had earlier in the week so just an hour and we have outlined for you an agenda which if we could go to the next slide...oh, past there, past there, keep going. So this slide deck we're working our way through it. If we could go to our next slide.

I thought I had seen a slide that had our agenda, but not seeing that right now I'll just remind the group that on our last call we did a deep dive into appropriate use criteria for radiology, clinical decision support and what we'll be bringing to you today is a summing up of the content that came out of that last call put together with really a heroic effort in a short period of time by our staff at ONC and we'll be bringing those to you so that you can see whether the sample principles that have been outlined are ones that should be proposed to the Health IT Policy Committee as a whole.

We will then start to examine the issue of revision of certified EHR technology to require clinical quality measures reporting using CMS's QRDA IG for providers who choose to submit eQMs. We will not, at this call, be addressing the Meaningful Use measure for Accountable Care Organizations that will be the subject of a later call. As before though you do have some, I would say, slides there to help you think about and to forecast what that conversation will include. So, if we could go to the next slide.

You saw this slide and this outline in terms of our approach and the kinds of questions that we wanted to answer when we discussed the appropriate use criteria. And so, next slide.

What we would like next is to get the group's feedback on really a distillation of what we might call some potential principles that we heard coming out of the conversation last time. And so the question we're answering is what are the key attributes or principles for how certified Health IT would support the processes described in a particular section of the law in the future going forward and what would be the vision specifically for how Health IT supports this ecosystem.

So, in going through the sampled principles I thought what we might do is look at each in turn and just get a sense of the group. Are these principles that you think should go forward to the full committee? So, the first being that ordering professionals should be able to use certified Health IT to access AUC for advanced diagnostic imaging seamlessly at the point of care. So, any...I'll open it up for discussion on that.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Kathy, this is Mike Mirro, so that's a great goal but as you know most of the systems they lack usability because they are designed about administrative datasets and so if that can be achieved that would be great.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Any other comments from the group?

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Hi, this is Chip Truwit, I think the previous comment is spot on but I think these are...we're talking about goals so, yeah, absolutely.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

So, these are I would say principles. We also talk about the vision for how it would support and so acknowledging all the current challenges. I think we can also say what it is we'd like to see going forward or for everyone in this space to be working on together. Any other comments from the group?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, this is Floyd, I like Mike Mirro's comment and I'm wondering if there is a way to modify the wording a little bit to say "yes, they should be able to use certified Health IT to access this with addressing common usability principles something like that.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Yeah that sounds great Floyd.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Or maybe heuristics if we want to sound smarter.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

This is Dan and I completely agree with the usability requirement. It would be powerful to include that.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

So, other comments from the group? Ginny?

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

No, I think that's reasonable to include, absolutely.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

And a thought as I'm listening to this discussion is that perhaps we might want to actually reposition just some of the wording so that the focus I think here if we want something to happen that is not currently happening is to say, start the sentence with certified Health IT used to access AUC for advanced diagnostic imaging should enable something along the lines of enable ordering physicians to or professionals to order advanced diagnostic imaging seamlessly at the point of care. So, it says...it focuses on what's needed from the system and brings that sort of front and center.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Well, that's fine, but I think you left usability out there and I want to make sure...

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Yeah.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

That's there.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Yes.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

If we want to get really specific I would say the usability heuristics as outlined in NSTIR 7804 which lists specific usability principles that need to be applied to decision support.

M

Floyd that's a great suggestion maybe put that in parentheses or something?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, it's a lot more specific I recognize that. Just things like for recall you don't have to go through a bunch of other steps to see why it's asking you to do that. The reason is right there or easily accessible when a recommendation is provided just one of the heuristics that I think is important but that's why I thought the general one...

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

But one of the advantages, just to remind the group, is that first off that the call is being recorded so we will be able to capture all of the suggestions that have been made and secondly, also that with the revisions that result from our conversation today we'll bring these back to you and ask for you to comment on them and say "did we get it right, are we summarizing the views of the group as you thought that we should?"

If there are no further comments on that one let's go to the second if we could. Certified Health IT should support access to AUCs that is updated on a continuous basis and delivered through certified Health IT tools. And I'll open that for the group.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

This is Chip Truwit, I would agree with that. I think this is really where the seamless or usability stuff is going to be important. If it is supporting access and it requires 20 minutes of computer time to do it you haven't helped anybody. So, you know, this is the backbone of the CDS and if you don't have easy access or ready access, seamless access then you're defeating the purpose. So, I think this is where you want to put the punch in it.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

And this is Floyd, I agree with that. I like some of the wording here specifically because it doesn't require the EHR to embed the information. The way it is worded, if I interpret it correctly, it allows the EHR to use third-party Apps as long as it enables them or web services to provide the CDS. It does not all have to be embedded within the software. As long as I interpret that correctly I'm in support.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

I agree with both those comments, this is Mike Mirro again, and I think we have to make sure that the vendors have the flexibility to do what they do best but it needs to be, as Chip pointed out on a previous call, it needs to be continuously updated, the AUC tool so that it's timely and up-to-date.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I also think we might want to add, I don't know exactly how to phrase this, but appropriate AUC. So, depending on who the person requesting the test is and what test they're ordering, if they're ordering for instance a cardiac CTA some of the population will end up in a radiology venue and some of it will end up in a cardiology venue, and there may be different AUC that are used for those and I think we're not getting into the question of which AUCs are better or not thankfully, but just maybe it's just access to AUC, but maybe it's okay the way it is. But maybe we need to be more clear about that. Mike do you have a thought?

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Yes, Chip, we ought to get together and maybe try to harmonize where there is overlap, you know, I think we could do that. I think that would be ideal, but then, you know, either ACR or ACC takes ownership of whatever, you know, the actual tool for maybe where there is overlap and I think we could

probably get that figured out. That may be more complicated than I think, but I think we could both work on this stuff so we should be able to work it out so that we're...

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Sure, I don't speak for the ACR but I know that I have contacted them to make sure that they're paying attention to this and they were and they are so I'm sure they're listening or will be listening to this.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Okay.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I have no doubt that the left and the right hand will meet.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Sure, good, perfect.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

This is Kathy and I would have a question and it partly gets us to the third bullet point, if the word "approved" was inserted in the second bullet point right before AUC does that help get us to some of what I thought I was hearing that said, well, we don't want it to be just anything but there should be some approval process that underlies all of this.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Yeah, I agree with that.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Yeah, I think I'm good with that as well. I mean, at the end of the day we want evidenced-based, you know, AUCs as much as possible and whose literature they come from and how they get there, you know, we ought to have some mechanism that, you're right, they're approved. I don't know who does the approval or whatever, but that's a great idea.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

And...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd...

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Sorry, go ahead, Floyd.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

I'm a little concerned. I like all the comments I'm hearing but when I look at each of these statements I tend to think at some point someone is going to measure whether we got here or not and if we say appropriate, while I think it's true, it should be what's appropriate, but is the EHR responsible for a client that decides to connect to perhaps not the most appropriate, that the vendor can provide the tools to allow the connection, but it's what's chosen by the provider that's going to...especially if we're talking about web services or Apps, it's what the provider chooses that it's up to them to make sure they use the appropriate guidance. So, that's one.

And the other is when we say "approved" there is the question of who does the approval? Are we talking about endorsement of content? Are we talking about certification? Just wonder where is that going?

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Floyd this is Mike Mirro, I actually think the approved AUC process should be part of the certification process so ONC. And obviously there is a lot of interest in tightening up the certification process for the vendors and this would be one area that we could explore and actually come to consensus on so that you could be sure that you, you know, only the certified Health IT solution will only recommend an approved AUC tool.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Well and that's fine as long as the thing being certified is the knowledge entity creating the tool not necessarily the EHR that enables it. We have to be careful there.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I guess I...this is a great comment and a conversation, do you want this to be at the ONC, the certification of the EHR that's doing this or do you want it to be at the certification or accreditation of the sites that are delivering the imaging?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Or is it an endorsement of by a third-party consensus body of the content and being delivered by different sources like ACR or ACC.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Well, I think...

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

Yeah.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

So this is Kathy and I would maybe it's a good time to look at this third bullet point which hopefully people have in front of them on their screen because it does get to the certified Health IT should enable users to easily switch between approved AUC content providers and I thought from our last discussion that we had said probably it's more important that the content providers be approved rather than the

blow-by-blow details of every single aspect of the content itself. So, does this third bullet point address some of the concerns that have been mentioned?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

It does for me, this is Floyd, the thing that I question is what does “approved” mean? By whom and how does that happen? Maybe this is a principle so it doesn’t matter but that to me is the next question.

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

Yeah, I agree with you Floyd, this is Ginny Meadows, I was actually thinking about this earlier. And when we think about the fact that we have discussed a lot around the common principles between clinical decision support and clinical quality measures there is, you know, currently an approval so to speak methodology for quality measures so how do we get to that same point in making sure that the CDS that providers can select has got some kind of process that validity and reliability is endorsed so to speak by somebody.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

So, other thoughts from the group, are we moving towards thinking there should be an additional, maybe explicit statement to the effect of that there is a need for or that a process should be in place or a mechanism should be in place so that AUC content providers are approved developers or is it that the AUC content itself is what gets approved?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, Floyd with a comment on that. I think it’s not...it can’t just be the developer the same way as if we use the measure example, measures are...measure developers may be very adept at creating measures and doing them well but not every one of the measures each developer creates gets endorsed because of issues around reliability, validity, feasibility and I think if we were to think about doing this we would want the content to be reviewed and approved in some manner, I’m trying to watch my words here, because words have a lot of extra meaning to them, but, I think it also needs to be regularly updated and having some organization probably non-governmental, do that kind of review with appropriate stakeholders would be a good way to go.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

This is Dan, I like the comments, I think that there is a real risk in pushing toward certification of the content itself that will flow updating of content and compared with quality measures I’d expect CDS would be updated as frequently as the literature is updated, which is to say, all the time. So, it might be that the approval goes toward a process approval in terms of how the literature is used and with what frequency it’s used rather than a content approval which might really slow innovation through this space.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Great comment, this is Mike Mirro, I definitely think an approved AUC content provider would indicate that the provider was evaluated by presumably ONC and approved that they have a process in place that is using the up-to-date literature and I totally agree with the comment that it has to be content that is continuously being updated.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

I think we're touching on the fact that we all know that there are challenges as well as benefits with the regular updating of the quality measures that are in place and you then do get into cycles that sometimes just don't allow a learning health system to keep up or to have a good match between what's been approved or endorsed and what might be the most currently literature.

So, I think we've gotten a lot...if I were to ask the group...I'm hearing but I want to be sure it's not just my ears, that there's agreement that there should be some kind of approval for AUC content providers, some way in which we know that they are following best practices, good practices, whatever we might call them. I'm hearing concerns about the issues of, is the content itself something that should be reviewed.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, Floyd here, since I'm the first one who brought up reviewing based on content, I think I do understand the need to keep it up-to-date that a regular review could make...that could be problematic because it could delay things. However, I think that some kind of certification or approval can't just be a one-time thing either. The organization would need to be evaluated repeatedly not every six months, but at some regular interval to make sure it's still keeping up with the principles.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

So, Floyd, Mike Mirro again, so a surveillance arm of ONC is expected to do that for certified Health IT vendors. So, if there is some element of surveillance that they are actually performing in the field like they performed in a test environment so no different, same thing here that there is some sort of surveillance where there is intermittent audits of these approved AUC content providers if they continue to perform as expected.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

So, my sense, just thinking about what we'll send forward to the full committee, is that if we use words like "audits" and "surveillance" that might be challenging but that we could also say that there should be some regular updating or it could be an attestation process but to just be confident that the AUC content providers are continuing to adhere to best practices and then we can leave that issue of exactly how we would do it perhaps to another day.

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

Hey, this is Alex, from ONC, I just want to chime in briefly, sorry, I had to drop off for a bit, but I think as folks saw, if you were able to review, you know CMS is proposing a fairly detailed process at this stage for what the first round of approval will be for AUC content providers and so would, you know, certainly invite us to sort of think forward about, you know, how we would eventually like to see the process look because this will be an iterative kind of thing, but I think that's right to not spend too much time on operational details and stay focused on, you know, the current round of what that will be.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Okay, thank you. With that said I think we're ready to go to the 4th bullet point which came out of our last call, which is the mention that sometimes there is information about why AUC were not followed and that it would be important to capture that and provide meaningful performance feedback over time. Any comments or thoughts on that?

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

This is Dan the feedback is so important I wonder if we're being a little too narrow by just saying not followed, if we should look at other areas where feedback should be expected.

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

So, this is Ginny, and I agree that this is a good thing to aspire to. The one thing I would caution is that whenever additional information needs to be captured it often puts a burden on the user who is having to document things that they don't always see as being necessary to the care of the patient and what they're doing.

So, I think we need to be careful about how we would word this in order not to make it a burdensome workflow issue. As we know kind of looking back at the similarities between quality measures there is often a lot of extra documentation required by the clinical quality measures because of the need to satisfy the really specific data requirements. So, that would be my caution here.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, this is Floyd if I can track the last two comments into one, I think that just saying why they weren't followed, why wouldn't we want to know why they were followed or how many were and not just the negatives but it's the because there is nuance around both.

But I also think it would be important to append this in some way to indicate and identify or determine best practice in collecting such information non-intrusively because I don't think there is a standard practice, there may be more than one, but there may be several best practices for how it could be done, but we don't want to cause usability problems to collect information that because it's not very usable won't be very valuable either.

So, if there is a way to indicate and seek out and establish best practice in collecting this type of information that would be helpful.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Yeah, this is Mike Mirro, I totally agree with that statement. I do think we have to be very cautious because again the enterprise EMR systems one of their major challenges besides interoperability is usability and so if we add increasing burden to the clinicians with workflow it will be a major pushback on the whole program.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah and this is Floyd, I mean, there is some work by folks like Dean Sittig and others about looking if something was recommended how long do you have to wait to see if it occurred and if it didn't how do you figure out why not without having to ask the provider and there are others who have done some of

that work, but that's why I was thinking if we could establish best practices in figuring that out that might be very helpful.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Other thoughts from the group? Because what I'm hearing is that it's really two things that we are talking about, one of them is what are the best practices for capturing that information with the least amount of disruption to normal workflow and yet also capturing it very effectively in terms of the EHR vendors because it can be challenging to capture what is essentially exceptions for following a particular rule.

And then the second is wanting the provider who is being evaluated if they have information that supports proceeding even though the AUC score would suggest not proceeding we'd want that to be captured as well. So, I think those could be principles that we could separate out in terms of the capturing the information and capturing the exceptions. So, it's two processes.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, and this is Floyd, I think two things about capturing that information. The wording as it is, at least in my reading, assumes that performance, low performance, means the provider is the problem. It might be the AUC that's the problem if there is a lot of low performance for certain reasons and that can inform the information as much as it can inform outliers. So, I think we want to be cautious not to just blame the user because of being an outlier.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Okay.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Okay.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Can I add something also? This is Chip Truwit. I'm wondering and I had spazzed out for a minute so maybe somebody said this already, but not just to me following the performance, that they didn't follow the AUC recommendations but many people will get back a recommendation that isn't optimal and then they change it and maybe somebody already mentioned this when I was on mute, but if they're changing it then that means the system is actually working and we want to recognize that. We want to at least get the data back that recognizes that the thing is working the way it's supposed to.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

So, what I think I was hearing you say is that it's almost an automating or auditing the usage or the response rate sort of the number of orders changed in response to feedback received at the time of the initial order. Is that right?

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I think I hope...I think that captures it. I think we should look at this as a tool for education as well, just constantly giving feedback that you ordered the wrong exam, you ordered the wrong exam, you know, maybe the mechanism is not working right if they don't start to change their practice and we shouldn't have to be phone calling everybody all the time to say, you know, you keep ordering the wrong exam type thing.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Right.

Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

So, there are plenty of people that will see, oh, you know, either I didn't think about it properly or I clicked on the wrong thing or whatever and they will go and do the right thing and that's feedback that we should be having I think.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Other thoughts from the group before we go to the next?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Well, I would agree, this is Floyd, that we're looking for behavior change related to it. We tend to be talking a lot about, I've done something and this is changing my behavior. I'm tending to think decision support also means presenting it up front so I don't do the wrong behavior and I do the right thing first. So, there is nothing to correct and I'm not sure quite how to measure that but we shouldn't ignore that.

Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

That's a really good point. We just went through in our system...and if people get it right the first time we're not going to bring up the green, red and yellow we're going on, we move on. They understand they're doing the right thing.

But not capturing the data is a separate thing and I think that it would be great to be able to go back to a clinic of nine providers and say “you've ordered these tests” you know “here's your performance” seven people they never even see the green because they get it all the time, we don't have to give them the who's who and there are two that are somehow always tripping up that they're ordering the test that isn't right and so at that point you know Floyd that it's not the mechanism that isn't working right it's that we haven't educated those two providers properly because seven are getting it right, you know, 100% of the time.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Right.

Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

So, that's really why I'm saying it's good to capture the good information as well not just the bad, it's nice to have a denominator.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Totally agree.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

So, it says that it should be a system that facilitates learning, learning and improvement and in order to do that you have to be able to have some metrics for that learning and improvement because if everybody gets a green light right off the bat 100% of the time there is no learning going on and you've implemented something for which really there might not be any need.

Whereas if it's scattered red, yellow and green to start with and then moves to everyone being green or all of those orders being green then you may say "got it" it's embedded let's focus on some other areas where we have opportunities to improve.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I love being able to remove a metric because we succeeded.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Yes, yes, aspirin at the time of a heart attack. So, let's, if we could, we'll go to the next to the last bullet, certified Health IT should deliver actionable recommendations to clinicians based on third-party data derived from AUCs. Comments from the group?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, I'll start with that one again, sorry, to be first in some of these. What do you mean by actionable? Actionable can mean it tells you what to order so I can act on it or does it mean because I read it in my EHR I can click right there and order it which is a different thing. So, what do we mean by actionable?

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

I think that we can say, since these are principles, that actionable could be in any of a variety of different ways. So, I guess the question I'd put back to the group as a whole is do we need to be more specific about the recommendations those actionable recommendations?

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

So, actionable to me, this is Mike Mirro again, would be that it triggers a clinical action, an order or some modification of an order.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So you're saying it triggers the system to provide the clinical action not that it triggers the physician's mind to go somewhere and do the action. Is that what you're saying?

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Yeah, that it's the clinician uses the system to demonstrate an action that's clinically relevant either, you know, verifying that it is correct or modifying the order like, you know, Chip gave some examples in the last call where contrast was ordered inappropriately or something.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Right, so I just want to describe a use case and understand what you meant. If it lets me say "yes, I will do this" but then I have to go to ordering find it and order it that's different than my "yes" actually processes that order in the system. So, which of those or are both okay?

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Well, I would try to make it as simple as possible because again getting back to usability principles if we're clicking around to satisfy it is a nonstarter; I think we have to make it as simple as possible.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Right, well I think that's what I was trying to address. I think we do...when we say actionable it should cause...the system should make whatever you're asking it to do happen rather than have to go through extra steps.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

But I think that, and this is Kathy, I would just say that it really is a matter of putting before the eyes of the clinician what the recommended option or options would be, substitute options, and the clinician still then confirms or makes a more appropriate selection. So, that's how I had interpreted this.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

No, I'm not disagreeing, I'm just saying, once the physician makes that decision and clicks the thing they want I don't think we're saying...they're saying "I'll follow this one" and then have to go look for it.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Right.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

I think what we're looking at is one...it's still a cognitive decision of the clinician to decide what to do the computer shouldn't do it for them. They're giving them the red, yellow, green and they decide what to do.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

This is Dan, I wonder...I agree with the concern that's being highlighted and it comes right back to usability which is so important. I wonder whether adding useable or seamless, or easy to implement to this would highlight that issue.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

If you want to use the same sub-bullets as consistent with the NIST document that I mentioned 7804 that would help there too one way or the other.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

So, I'm going to ask a question of staff. Do you think that we have enough on this to be able to revise it and reflect the sense of the group?

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I vote yes.

W

I think...

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Okay.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Yes.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Then let's go to the last of the bullets which also hark back to our last call that AUC should be available in standardized formats that can be consumed by any certified Health IT application. Any issues or concerns on that one before we go to the next slide?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, I'll start again, this is Floyd, I think the way it's worded leaves it open enough that it's not forcing people into say an HED or specific FHIR profile that's not yet balloted because it's a standard, so it could be a standard API that maybe doesn't even use an HL7 standard. So, maybe keeping it open like this is most reasonable.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Other thoughts from the group? Maybe barring objection then let's go to the next slide. And so this gets us to strategic considerations for arriving at this vision and these were some of the areas that we thought CMS and ONC would need to focus on. And I'll ask people to comment on the first of those. We talked about just the standards not being ready and that we want ONC to address in its issuances what's the future readiness of standards really a plan for having standards ready to use going forward. So, the next...

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

This is Chip Truwit and I'm confused by the word "ready." It seems obvious but I think it's anything but obvious. Do you mean ready today or ready in January 2017?

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Right, so I think that where this came from in the conversation we had was we said some things are not ready today but we also note that there is a time in the pipeline that is important to consider and that ONC should be thinking about when standards will be ready for use in the future that they're not ready now but I think we'd all agree that two years, three years from now the standards that are available might well change.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, I...

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Does that...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

I think part of the reason for that concern...if there were a...say we were talking about an HL7 draft standard for trial use that is balloted and is in partial use and we could think, well, were in 2015 by 2017 there will be enough use an update to that that it should be working because people are starting to use it now. That's one thing.

If it hasn't even been balloted yet and therefore tested that's a bigger challenge and I think that was the concern we were coming up with because some of the CDS work is still...the FHIR work at least is going for ballot in September but it hasn't been balloted.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Other thoughts? So am I hearing that it is more along the lines of ONC should, in the course of its deliberations, should be explicit or should share what or should incorporate the anticipated timing for standards being ready to support these processes.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

I think what's implied in here too, because there are some questions when I read this, the statement perhaps continue to support pilot testing to assure that the standards will be more mature when needed.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Yeah, this is Mike Mirro, I agree with Floyd, this is very important because some of the standards are really not ready for primetime and if you get too aggressive here it could be a problem.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

So, we'll get some wording in with respect to pilot testing so that there is confidence then when it becomes more widely adopted that indeed these will operate as we hope that they will.

I think let's go to the second bullet and this has to do with an API or a link to a hosted service, we had the discussion about should things be in the cloud, should they be embedded in the EHR. I think the key word here is "or." We're not really saying it has to be one or the other.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

I would perhaps be...

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

By...

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

Oh.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Go ahead, I'm sorry.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

This is Dan; I would perhaps be a little more aggressive in saying that API transmissions should be enabled in these systems. I think that not doing that is failing to set us up for the future.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I totally agree.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Ditto.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, I would agree, I think the concern about "or's" are optionality tends to mean the EHR must do both when you're doing testing, but in this particular case I might say APIs should be required. I don't know that they have to do it, create the decision support embed in their system, if they're using APIs. So, my concern is not the API I agree with everybody it's are you forcing them to also embed decision support within the EHR where it may or may not have additional benefit.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

I'm a little bit confused, but I certainly want to use the power of the central...using the power of these documents or these intents to encourage the EHR, the certified EHR, that to be certified they have to either provide an API that is robust and encourages the use of the AUC per what we're talking about.

I don't want to deny, if an EHR wants to spend a ton of money developing this on their own to integrate either the ACC or the ACR, or some other approved set of standards and in its own robust manner integrate it within its system rather than through an API and what do I care that's not...the intent is to get them used.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Oh, I don't want to deny it either but I don't want to force the vendor that decides not to do that and exclusively use the API; I don't want to force them to embed it.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Agreed.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

That's what I'm...

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Agreed, yes we're on the same page, I just...maybe I didn't understand what you were saying.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Other thoughts? I mean, I think we're circling back to saying that vendors should be allowed to have flexibility, that the end goal is that these be accessible by users in the course of care and whether that accessibility is obtained with APIs or links to hosted services it doesn't...I hesitate to say it doesn't matter, it just has to be accessible some way or another.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

So, I agree with everything that I said previously with one caveat.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Ut-oh.

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

And that is that my experience with the EHRs is that they are somewhat unwieldy beasts and that they may take their time delivering on a commitment that they might make and so what we don't want to do is give, I think, the option that an EMR or EHR can deliver 30% of what we're expecting or 30% of what a third-party to an API would be able to deliver and say, well it's...we'll get there and we'll get there is three years later that they get anywhere close and so a toe in the water and this gets back to the original usability and seamless and this that and the other, but who is going to define all that.

So, while I don't care, at the end of the day, if they deliver a truly robust version from within as opposed to through an API the experience many of us I think have had is that this pathway is a slow pathway from within and that the third-parties or small startups they're trying to make success and that they make it work.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

This is Dan, I completely agree with that and I would say that we should, in that case, require API and whatever else they want to do that's fine, but the requirement is API at a minimum.

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

This is Michelle, Kathy; I just want to note the time.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Yes.

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

We're getting close to the end and we need time for public comment.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

So, I think maybe then what we should do Michelle is we can maybe skip the last of these. There is just a factual statement and then we raise the question about how content providers are likely to evolve. So, let's go ahead and open the lines for public comment and then we'll have the other topic right at the beginning of our next call.

Public Comment

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

Okay. Lonnie or Caitlin, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

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

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

We have no public comment at this time.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

So, Michelle, in terms of our next steps then we have another call that will be coming up on July 30th so in six days and that also is a one hour call. We'll meet at that time to go to...I think we'll present to the group or in advance the updated slides that would go recommendations and principles to the full Health Policy Committee and then dive in very quickly in terms of the revision of certified EHR technology topic. And then...

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

Yeah, hopefully, we'll be able to get the slides out to people in advance so they can provide feedback so we can wrap up this discussion and move onto the next one.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

And I'm actually assuming then that in that next call we'll also perhaps want to start to dive into the Meaningful Use measures for ACOs or will that be on our final call?

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

Stephanie?

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

We can see how, this is Samantha; we can see how we progress. We may list both on the agenda and just see how much time we need for the second topic but we just also want to encourage folks to take a look at, there is a summary document that takes some of the key provisions from the Notice of Proposed Rulemaking and Stephanie even highlighted in yellow the key questions and aspects to focus on.

So, in terms of preparing as we move onto the next two topics if folks are able to take a look at that in advance that will be very helpful.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Okay.

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

And that was attached as a document for today's discussion. It's a Word document.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Any questions from the group before we sign off?

Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Good call.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Challenging topics. All right, well I thank everyone for their participation and hope you have a wonderful weekend.

Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System

Thanks for including me.

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

Thank you everyone, have a nice weekend.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

You too.

Daniel J. Riskin, MD, MBA, FACS – Chief Executive Officer – Vanguard Medical Technologies

You too, bye.

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

Bye-bye.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Bye.

Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems

Thank you.